

# **Residency Manual**

## **Residency in Ocular Disease**

Department of Veterans Affairs, VA Southern Nevada Healthcare System  
Las Vegas, Nevada

and

Southern California College of Optometry  
Fullerton, California

Revised 2013

## **Orientation Checklist**

### **Prior to start of residency:**

Go to the following website and complete the required paperwork.

[www.lasvegas.va.gov/Trainee\\_processing/Resident\\_Student\\_Intern\\_Processing.asp](http://www.lasvegas.va.gov/Trainee_processing/Resident_Student_Intern_Processing.asp)

Print all of the paperwork after filling it out and prior to saving it on your computer. Some of the paperwork does not save to disk correctly so you should print it out prior to saving it. Make sure to sign and date the paper work where indicated and fax or send it to Ms. Joyce Henderson or Ms. Janet Newhart.

## **Orientation Checklist continued**

### **Prior to start of residency**

- \_\_\_\_\_ SCCO Residency Contract submitted to SCCO
- \_\_\_\_\_ Pre-Employment physical through the VA
- \_\_\_\_\_ Copies of Diploma and Optometry Licenses submitted to Dr. Fujimoto
- \_\_\_\_\_ National Provider Identifier (NPI) number submitted to Dr. Fujimoto

### **During the first 2 weeks of residency**

- \_\_\_\_\_ Attend VA New Employee Orientation Program
- \_\_\_\_\_ Participate in VASNHS Eye Clinic Orientation Program
- \_\_\_\_\_ Participate in SCCO Orientation via telephone conference call
- \_\_\_\_\_ Issuance of VA Identification Badge (PIV Badge)
- \_\_\_\_\_ Issuance of keys to clinic outer door and Omnicell Medication Room
- \_\_\_\_\_ Overview on CPRS Eye Clinic Note template
- \_\_\_\_\_ Orientation on how to enter a progress note
- \_\_\_\_\_ Orientation on how to review the patient's medical record (i.e. viewing past visits, vital signs, radiology results, laboratory results, remote data)
- \_\_\_\_\_ Orientation on how to respond to consults from another service
- \_\_\_\_\_ Orientation on entering Doctor's Orders
  - \_\_\_\_\_ Entering medication orders
  - \_\_\_\_\_ Entering lab and radiology orders
  - \_\_\_\_\_ Requesting consultations

## **Introduction**

The staff of the VA Southern Nevada Healthcare System (VASNHS) Eye Clinic would like to welcome you to our program. This manual is intended to be an introduction to the program and a guideline for the policies, procedures, and protocols of the clinic. Residents are responsible for knowing and complying with the contents of this manual. Please familiarize yourself with the material contained within and ask for clarification on any points which you do not understand.

## **General Information about the VASNHS Eye Clinic**

The VA Southern Nevada Healthcare System (formerly the VA Outpatient Clinic and VA Ambulatory Care Center) has had a long-standing academic affiliation with the Southern California College of Optometry (SCCO) dating back to 1982. Due to sustained population growth in southern Nevada and the increasing demand for veteran healthcare, the affiliation between the VASNHS and SCCO has expanded from one intern per rotation (six interns a year) in 1982 to five interns per rotation (twenty interns a year) at present. A secondary affiliation with the Illinois College of Optometry commenced in 2005 with two interns per rotation (eight interns a year); this gives a grand total of twenty-eight optometric interns who rotate through the VASNHS per year.

In addition to the intern program, the VASNHS started a one year residency in Ocular Disease affiliated with SCCO in June 2004 under accreditation pending status from the American Council on Optometric Education (ACOE). In April 2005, The VASNHS received a seven year accreditation status from the ACOE. The VASNHS had one resident for both the 2004-05 academic year and the 2005-06 academic year. In the 2006-07 academic year the VASNHS residency program was temporarily increased to two residents because of difficulty with recruitment of residents at other facilities. A petition for a permanent second residency position was made in 2006, and approved in January 2007. The VASNHS continued with two residents for the academic years 2007-10. In the 2010-11 academic year the VASNHS residency program was temporarily increased to three residents because of difficulty with recruitment of a fellowship program at another facility. After petitioning for a third permanent residency position in October 2010, the VASNHS received approval for it in January 2011. The VASNHS continued with three residents for the academic year 2012-13. After petitioning for a fourth permanent residency position in November 2012, the VASNHS received approval for it for the academic year 2013 and beyond.

At present, the VASNHS Eye Clinic clinical staff is comprised of ten full-time optometrists, one of whom is residency trained in low vision rehabilitation, three optometric residents and a low vision therapist. The low vision rehabilitation trained optometrist and low vision therapist were hired to staff the VASNHS Intermediate Low Vision Clinic, which began operations in February 2009.

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## General Information

### I. Mission Statement, Goals and Objectives

#### A. Mission Statement:

The mission of this program is to provide optimal eye care in an ambulatory advanced clinical and educational setting serving a predominantly geriatric population. While working as a part of an interdisciplinary team, the resident's ability to diagnose and manage ocular disease and the ophthalmic manifestation of systemic disease will be enhanced. Additionally, didactic and scholarly activities will be performed to promote optometric education and research.

#### 1. Goal 1:

To strengthen the resident's optometric skills and train the resident in advanced competencies in ocular disease and secondary eye care.

##### Objectives:

- a. The resident will complete numerous encounters of direct patient care activities in ocular disease and secondary eye care.
- b. The resident will be trained in advanced techniques during workshops.
- c. The resident will observe ophthalmic surgical procedures.

#### 2. Goal 2:

To expand the resident's knowledge base with emphasis on the diagnosis and management of ocular disease, ophthalmic manifestations of systemic disease, and ophthalmic side effects of systemic medications.

##### Objectives:

- a. The resident will complete a thorough and accurate record of examination.
- b. The resident will diagnose and manage a variety of interesting case presentations
- c. The resident will review a variety of ophthalmic and healthcare literature.

#### 3. Goal 3:

To have the resident work in an interdisciplinary healthcare environment for ambulatory patients. In addition, the resident will experience treating patients with complex systemic diseases and inter-related ophthalmic and systemic conditions.

##### Objectives:

- a. The resident will be part of an interdisciplinary team.
- b. The resident will utilize clinical and support services
- c. The resident will be able to directly interact with other healthcare providers.
- d. The resident will receive urgent and routine consultations from primary care in regards to requested eye care; in turn, the resident will write consultations to primary care and other specialty services as indicated.
- e. The resident will complete administrative activities and be subject to quality assurance measures.

#### 4. Goal 4:

To develop the resident's contribution to optometric education and research through didactic and scholarly activities.

##### Objectives:

- a. The resident will attend optometric didactic grand round lectures, workshops, and clinical educational activities.
- b. The resident will be encouraged to attend interdisciplinary didactic lectures.

- c. The resident will be guided in the process of lecture presentation.
- d. The resident will gain experience to become a clinical instructor.
- e. The resident will be guided in the process of manuscript publication.

## II. Activities of the Resident

- A. To meet the objective of providing direct patient care activities the resident is to:
  - 1. Provide direct primary and secondary optometric care to outpatients at the VASNHS Eye Clinic.
  - 2. Complete a minimum of 1100 direct patient encounters during the residency year.
- B. To meet the objective of being trained in advanced techniques the resident is to:
  - 1. Participate at least quarterly in the clinical workshops on scleral indentation, four-mirror gonioscopy, venipuncture, fundus photography, dilation and irrigation of the lacrimal drainage system, and pressure patching.
  - 2. Teach the advanced techniques learned in the first quarter of clinical workshops to the interns participating in the following intern workshops during the residency year.
- C. To meet the objective of observation of ophthalmic surgery the resident is to:
  - 1. Observe surgical procedures performed by a general ophthalmologist or view them online.
- D. To meet the objective of completing a thorough and accurate record of examination the resident is to:
  - 1. Utilize a template in CPRS to enter patient examination records.
  - 2. Review assessments and plans for each patient with an attending optometrist and have each chart reviewed and cosigned by an attending optometrist.
- E. To meet the objective of diagnosing and managing a variety of interesting cases, the resident is to directly examine a minimum of 1100 patients.
- F. To meet the objective of reviewing a variety of ophthalmic and healthcare literature the resident is to:
  - 1. Sign up for the Journal Review Program sponsored by SCCO at the beginning of the residency and order articles for review via the program.
  - 2. Participate in the monthly Resident's Journal Conference on the fourth Friday of every month.
  - 3. Review journal articles that the attending optometrist suggests and/or provides to the resident.
  - 4. Review a minimum average of three journal articles a month during the residency.
  - 5. Research literature on various topics as discussed or experienced in the course of patient care.
- G. To meet the objective of being a part of an interdisciplinary team the resident is to:
  - 1. Review consultation requests from other clinics and primary care providers for eye care services.
  - 2. Make appropriate referrals to other clinics and primary care providers for patients who require additional services.



- H. To meet the objective of utilizing clinical support services the resident is to:
1. Order appropriate lab work to aid in the diagnosis and management of patients.
  2. Order appropriate radiology examinations to aid in the diagnosis and management of patients.
- I. To meet the objective of completing administrative activities and being subject to quality assurance measures, the resident is to:
1. Fill out the Patient Encounter and Diagnosis Logs, Resident Referral Log, Resident Activity Log, and Resident Reading Log and hand in copies of them to the Academic Affiliate on a quarterly basis.
  2. Complete the quarterly Residency Faculty Evaluation, quarterly Residency Program Evaluation, and End-of-the-Year Program Evaluation and hand in copies of them to the Academic Affiliate.
  3. Complete a thorough record of Examination into the CPRS system, which is subject to chart review by the Quality Management Section of the VASNHS.
  4. Have each entry made by the resident into the patient's medical record reviewed by an attending optometrist and cosigned by said optometrist.
- J. To meet the objective of participating in didactic activities the resident is to:
1. Complete the VASNHS Optometric Clinical Conference program.
    - a. Clinical conferences are scheduled on the first Friday afternoon of every month starting in August and ending in June. A total of nine conferences will be presented.
  2. Complete the VASNHS Residents Case Conference program.
    - a. Each resident will present an interesting case from the preceding month to the fellow residents, staff, and optometric interns of the VASNHS Eye Clinic. The Resident Case Conference is scheduled for the second Friday afternoon of every month starting in August and ending in June. A total of nine Resident Case Conferences will be held.
  3. Attend the American Academy of Optometry Annual Meeting (strongly encouraged, not required).
  4. Attend Council on Optometric Practitioner Education (COPE) approved continuing education programs provided by local ophthalmologists (encouraged, not required).
- K. To meet the objective of lecture presentation, the resident is to:
1. Complete a lecture to the fellow residents, staff, and optometric interns of the VASNHS Eye Clinic. The recommended topic is the subject of the residency thesis paper. Other topics may be considered with approval of the Program Coordinator.
  2. Complete case presentations to the fellow residents, staff, and optometric interns of the VASNHS Eye Clinic at the Residents Case Conference program.
- L. To meet the objective of gaining experience as a clinical instructor the resident is to:
1. Act as a preceptor to optometric interns during the last month of the academic year while under the supervision of an attending optometrist.
  2. Instruct interns in the clinical workshops during the last three quarters of the residency.
- M. To meet the objective of manuscript publication the resident is to:
1. Prepare a manuscript of publishable quality by the end of the residency with the aid of the attending optometrists. A manuscript committee made up of at least two attending optometrists will provide assistance with topic selection and design of concept, literature

search, and drafting or revision. Each manuscript committee member must give final approval prior to submission of the manuscript. All committee members will be granted authorship and the resident will retain primary authorship of the manuscript.

2. Base the manuscript on a case report, case series, or research project approved by the Program Coordinator.

### III. Structure of the VA Southern Nevada Healthcare System

The current operational of the locations of the VASNHS are noted below.

- VA Medical Center
- Core
- Education Learning Center
- Energy Plant
- Healthcare for Homeless Veterans
- Mike O'Callaghan Federal Hospital
- Northeast Primary Care Clinic
- Northwest Primary Care Clinic
- Pahrump Clinic
- Rancho Courtyard
- Southeast Primary Care Clinic
- Southwest Primary Care Clinic
- Veterans Recovery Center
- Warehouse

#### A. Optometry Staff at the VA Southern Nevada Healthcare System

1. Geoffrey F. Chiara, O.D.
2. Theresa Chong, O.D.
3. Lane T. Fujimoto, O.D.
4. Russell L. Jew, O.D.
5. Brian S. Kawasaki, O.D., M.B.A.
6. Michelle E. Matson, O.D.
7. David J. Mietzner, O.D., M.S.
8. Jennifer L. Monarrez, O.D.
9. Nina T. Tran, O.D.
10. Paul A. Vejagul, O.D.

#### B. Ophthalmology Staff at the VA Southern Nevada Healthcare System

Marc G. Bodman, M.D.

- C. Additional Eye Clinic Staff at the VA Southern Nevada Healthcare System include one Low Vision Therapist, one Blind Rehabilitation Outpatient Specialist, three Medical Support Assistants, one Program Support Assistant, one Program Specialist and two Health Technicians.

## Tour of Duty

### I. Duration of Residency Program

The residency will be one year in length commencing on July 01 continuous through June 30.

### II. Clinic Hours.

- A. The VA Southern Nevada Healthcare System Eye Clinic operates on Monday from 7:30 am to 4:00 pm, on Tuesday through Friday from 7:30 am to 6:00 pm, and on Saturday from 8:30 am to 5:00 pm.
- B. There are two main weekly work schedules that the resident will be expected to work during the residency year. The resident's work schedule may in some instances vary from these two schedules. The work schedule of the resident will correspond to the attending doctor he or she is working with. The resident is required to remain until all patient care activities are concluded, which may extend beyond the listed hours. The resident does not have on-call duties.
  1. Monday through Friday from 7:30 am to 4:00 pm when working with Dr. Geoffrey Chiara, Dr. Theresa Chong, Dr. Lane Fujimoto, Dr. Russell Jew, Dr. Brian Kawasaki, or Dr. Paul Vejabul.
  2. Tuesday through Friday from 9:30 am to 6:00 pm and Saturday from 8:30 am to 5:00 pm when working with Dr. Michelle Matson, Dr. Jennifer Monarrez, or Dr. Nina Tran.

Weekly schedules for each attending doctor (note that the weekly schedules are subject to change without notice):

|          | Monday                | Tuesday | Wednesday  | Thursday                  | Friday   | Saturday |
|----------|-----------------------|---------|------------|---------------------------|--|----------|
| Chiara   | AM none<br>PM regular | ADMIN   | ADMIN      | AM meetings<br>PM regular | AM none<br>PM clinical conf<br>1 <sup>st</sup> , res case conf<br>2 <sup>nd</sup> , res journal<br>conf 4 <sup>th</sup>  | off      |
| Chong    | regular               | new pt. | low vision | AM regular<br>PM post op  | low vision<br>except<br>AM FA 1 <sup>st</sup><br>PM clinical conf<br>1 <sup>st</sup> , res case conf<br>2 <sup>nd</sup> , res journal<br>conf 4 <sup>th</sup>  | off      |
| Fujimoto | DM screen             | regular | regular    | AM post op<br>PM new pt.  | AM new pt. 1 <sup>st</sup> ,<br>2 <sup>nd</sup> , 5 <sup>th</sup> . FA 3 <sup>rd</sup> .<br>regular 4 <sup>th</sup><br>PM clinical conf<br>1 <sup>st</sup> , res case conf<br>2 <sup>nd</sup> , res journal<br>conf 4 <sup>th</sup> . intern<br>prof 3 <sup>rd</sup> . | off      |

|          |                      |                          |                          |                             |   |                          |
|----------|----------------------|--------------------------|--------------------------|-----------------------------|---|--------------------------|
| Jew      | telehealth           | regular                  | regular                  | AM post op<br>PM telehealth | AM telehealth<br>PM clinical conf<br>1st, res case conf<br>2 <sup>nd</sup> , res journal<br>conf 4 <sup>th</sup> , intern<br>prof 3 <sup>rd</sup> .                   | off                      |
| Kawasaki | new pt.              | DM screen                | AM regular<br>PM post op | regular                     | AM regular<br>PM clinical conf<br>1st, res case conf<br>2 <sup>nd</sup> , res journal<br>conf 4 <sup>th</sup> , intern<br>prof 3 <sup>rd</sup> .                      | off                      |
| Matson   | off                  | new pt.                  | AM post op<br>PM regular | regular                     | regular except<br>PM clinical conf<br>1st, res case conf<br>2 <sup>nd</sup> , res journal<br>conf 4 <sup>th</sup> , intern<br>prof 3 <sup>rd</sup> .                  | DM screen                |
| Mietzner | AM new pt.<br>PM SRx | C&P exam                 | AM new pt.<br>PM SRx     | C&P exam                    | AM new pt.<br>PM SRx except<br>clinical conf 1 <sup>st</sup> ,<br>res case conf 2 <sup>nd</sup> ,<br>res journal conf<br>4 <sup>th</sup>                              | off                      |
| Monarrez | off                  | AM post op<br>PM regular | regular                  | new pt.                     | new pt.<br>except clinical<br>conf 1st, res case<br>conf 2 <sup>nd</sup> , res<br>journal conf 4 <sup>th</sup> .<br>intern prof 3 <sup>rd</sup> .                     | AM new pt.<br>PM regular |
| Tran     | off                  | regular                  | DM screen                | AM post op<br>PM regular    | new pt.<br>except clinical<br>conf 1st, res case<br>conf 2 <sup>nd</sup> , res<br>journal conf 4 <sup>th</sup> .<br>intern prof 3 <sup>rd</sup> .                     | AM new pt.<br>PM regular |
| Vejabul  | regular              | AM regular<br>PM post op | AM regular<br>PM new pt. | DM screen                   | AM none<br>FA 3 <sup>rd</sup> .<br>PM clinical conf<br>1st, res case conf<br>2 <sup>nd</sup> , res journal<br>conf 4 <sup>th</sup> , intern<br>prof 3 <sup>rd</sup> . | off                      |

Key for above table:

ADMIN: administrative time.

clinical conf: a three hour lecture presented by the attending staff and guest lecturers on the first Friday afternoon of the month.

DM screen: clinic for performing dilated fundus examinations for diabetics to screen for retinopathy. No refractions are performed in this screening clinic.

FA: Fluorescein angiography clinic in which the residents start IV lines, photograph, and interpret angiograms on the first and third Friday morning of the month.

intern prof: Intern proficiency-advanced procedures workshop which the residents attend twice and then begin teaching to the interns on the third Friday afternoon of the month.

low vision: patients who are seen in the Intermediate Low Vision clinic who have best, corrected vision equal to or worse than 20/70 in the better seeing eye.

new pt.: clinic for new patients who have never been seen in the eye clinic or have not been seen for the past 3 years

post op: clinic for patients who are returning after having a surgical procedure

regular: clinic for established patients

res case conf: Resident's case conference-each resident researches and presents a case from the preceding month to the interns and attending staff on the second Friday afternoon of the month.

res journal conf: Resident's journal conference-each resident reads, summarizes, and presents a journal article to the interns and attending staff on the third Friday afternoon of the month.

### III. Holidays, annual leave (vacation leave), and sick leave.

#### A. The following days are federal holidays with paid time off for the resident(s):

1. Independence Day (July)
2. Labor Day (September)
3. Columbus Day (October)
4. Veterans Day (November)
5. Thanksgiving Day (November)
6. Christmas Day (December)
7. New Year's Day (January)
8. Martin Luther King, Jr. Day (January)
9. Presidents' Day (February)
10. Memorial Day (May)

#### B. Residents accrue 4 hours of annual leave and 4 hours of sick leave time per 2 week pay period.

1. Requests for annual leave must be submitted prior to the time of leave.
2. Annual leave may not be advanced. You may only use annual leave that you have accrued.
3. Due to patient scheduling considerations, requests for annual leave must be submitted at least 90 days prior to the date(s) requested.
4. Annual leave will not be granted during the last 2 weeks of residency, with the exception of an emergency.
5. The VA will reimburse residents after the residency year is completed for any unused annual leave.
6. Sick leave is not to be used for "moonlighting" purposes.
7. The program coordinator must be contacted as soon as possible to report sick leave use.
8. An electronic request in DHCP/VISTA for annual leave or sick leave must be submitted in the computer system.

### IV. Schedule for the resident(s).

#### A. The resident will usually work one of the two following schedules, which will coincide with the attending doctor to whom he or she is assigned.

1. Monday through Friday from 7:30 am to 4:00 pm.
2. Tuesday through Friday from 9:30 am to 6:00 pm, and Saturday from 8:30 am to 5:00 pm

Afternoon Discussions will be held during the last half hour of the day. The resident will present interesting cases from the day's encounters to the attending doctor. From this case presentation, an impromptu discussion may take place regarding the diagnosis,

management and treatment of the patient; or the resident may be assigned a topic to review and present at a later day; or the resident may be given a relevant article to read.

B. Clinical conferences, resident case conferences, and resident journal conferences.

1. A total of ten clinical conferences will be held on the first Friday afternoon from 1:00 pm to 4:00 pm of each month starting in August and ending the following June. Clinical conferences are presented by the Attending Staff and guest lecturers on various pertinent topics which include, but are not limited to glaucoma, ocular inflammation, ocular vascular disease, ultrasonography, and macular degeneration.
2. Dr. Paul Vejagul is responsible for coordinating a total of 10 resident case conferences to be held on the second Friday afternoon from 1:00 pm to 2:00 pm of each month starting in August and ending the following June. Dr. Vejagul will assign a case from the preceding month to each resident and assist them with research and creating a presentation. The cases will then be presented to the optometric interns and staff of the Eye Clinic.

C. The resident will participate in a monthly, bimonthly, or quarterly Journal Review Program (depending on the availability of the journal) sponsored by the Southern California College of Optometry. The resident is to review an article chosen from each journal and record them in the Reading Log, which is submitted quarterly to the Residency Coordinator and the Director of External Programs. The resident will also complete the monthly Residency Journal Conference in which each resident presents an article to the fellow residents, optometric interns, and staff of the Eye Clinic.

D. Quality management meetings will be conducted as determined by the Chief of the Optometry Section. Resident chart reviews will be conducted on a quarterly basis per peer review guidelines determined by the VA Southern Nevada Healthcare System.

V. Clinical Research and Scholarly Activity

- A. The resident is required to complete a thesis paper of publishable quality in a peer-reviewed journal. Early topic selection is highly encouraged. Due dates for topic selection, abstract, and rough draft are published in the Southern California College of Optometry Residency Manual.
- B. Attendance at the American Academy of Optometry annual meeting (recommended, but not required).
- C. The resident is to participate in the Journal Review Program sponsored by the Southern California College of Optometry and a monthly Resident's Journal Conference.
- D. The resident is to read articles provided by attending doctors.
- E. The resident is to research literature on various topics that arise during afternoon discussions, and as assigned by attending doctors.

VI. Optometric Didactic Activity and Clinical Education

- A. The resident is to complete the Residents' Case Conference and the Clinical Conference Programs and to pass an examination in June of the academic year.
- B. Attendance at COPE approved continuing education courses during the residency

year (recommended, but not required).

- C. The resident is to gain proficiency in advanced procedures, including, but not limited to scleral indentation, fluorescein angiography, dilation and irrigation, venipuncture, fundus photography, and four mirror gonioscopy through a minimum of quarterly attendance at a clinical workshop.

## Program Policies

### I. Compensation and Benefits

- A. The annual residency stipend is determined by VHA Headquarters. There are no stipulations regarding productivity.
- B. Optional healthcare insurance coverage is offered to the resident; biweekly premiums will be deducted if the resident elects to enroll in such insurance. Information on healthcare insurance will be provided by the Human Resources Management Service during orientation.
- C. Each resident accrues 4 hours of annual leave and 4 hours of sick leave per two week pay period.
- D. Authorized absence may be granted for attendance at a professional continuing education conference such as the American Academy of Optometry or American Optometric Association annual meetings at the discretion of the Chief of Optometry Section. No travel or tuition stipend is granted.
- E. A resident who has taken a leave of absence for personal or medical reasons must be remediated for an amount of time equivalent to the duration of the absence.
- F. Residents are paid every two weeks via Direct Deposit. Pay is deposited by the end of Friday for the previous two week pay period and paystubs are distributed on the following Tuesday.

### II. Professional Liability

- A. Optometry residents are provided with liability coverage for activities within the scope of the Optometric Residency Training Program under provisions of the Federal Tort Claims Act. Liability coverage is limited to VA-related patient care only.
- B. The resident must seek liability/malpractice insurance, at his or her own expense, for any external clinical settings in which the resident participates.

### III. Requirements for residency completion and awarding of certificate.

- A. Patient care and curriculum criteria must be met.
- B. Reporting requirements, to include, but not necessarily limited to, Patient Encounter and Diagnosis Log, Faculty Evaluation, Resident Referral Log, Resident Activity Log, Resident Reading Log, and Final Evaluation of Residency Program must be met.
- C. Final version of the resident thesis paper must be approved.
- D. All multimedia and/or library materials on loan to the resident must be returned.
- E. All VA property in the possession of the resident must be returned (i.e. ID badge, keys, etc.).

### IV. Counseling, remediation, and dismissal of the resident.

#### A. Counseling and remediation

Residents who develop deficiencies in any area of patient care as identified by the Program Coordinator or Attending Staff must participate in a corrective program designed



by the Program Coordinator to address these deficiencies including, but not limited to counseling and remediation. The resident is expected to review SOP-02-05-146 Resident Counseling, Remediation, and Dismissal.

1. The Program Coordinator, in consultation with the Attending Staff if applicable, will meet with the resident within 48 hours to discuss the identified area(s) of deficiency and how this may affect patient care. The Program Coordinator or Attending Staff will monitor the resident in the area(s) identified as deficient to ensure that corrective action has been effected.
2. When a resident has been counseled regarding an area or areas of patient care identified as being deficient, the Program Coordinator or Attending Staff will monitor the progress and performance of the resident in weekly intervals. If the identified deficiencies remain, the Program Coordinator will be responsible for designing an individualized program that addresses the fundamental concepts and the proper procedures necessary to bring the resident's performance to an acceptable level to ensure quality patient care and safety.

#### B. Dismissal

When it is determined that a post graduate resident should be separated for deficiencies in performance, suitability or conduct that could not be successfully addressed with counseling and remediation, the Program Coordinator will prepare a separation recommendation and will send it through the Chief of the Care Line, Service Line, or Section, the Chief of Staff, and the Director of Residency Programs for review and comment, then to the Director for a decision. The recommendation must be supported by a thorough documentation of the resident's deficiencies. If the Director elects for separation, it will be implemented within 15 days.

#### V. Grievance Procedures:

- A. Residents with a grievance are to seek assistance from the Program Coordinator.
- B. A meeting with the Director of Residency Programs and/or Associate Dean of Clinical Education should be arranged if the resident is unable to satisfactorily resolve his or her grievance via assistance from the Program Coordinator.
- C. The Director of Residency Programs and/or Associate Dean of Clinical Education will investigate the resident's grievance and provide a response as soon as reasonably possible.
- D. Should the resident seek to pursue the matter further, he or she may submit a request to meet with the President of the Southern California College of Optometry. Any decision reached by the President or designated representative will be considered final and binding on all parties.

## Department Policies

- I. Pertinent Medical Center Memoranda (MCM), Standard Operating Procedures (SOP) and VHA Handbook guidelines index for review by each resident. The resident is responsible for understanding and complying with Medical Center Memoranda, which are available on the VA Southern Nevada Healthcare System intranet.
  - A. MCM 05-10-02 Drug-Free Workplace Program
  - B. MCM 138-10-01 Fire Protection/Evacuation Plan
  - C. MCM 07B-10-14 Violence in the Workplace Prevention
  - D. MCM PRV-10-03 Facsimile Policy
  - E. MCM 136-10-03 Patient Scheduling
  - F. MCM 05-12-28 Dress Code/Staff Image Policy
  - G. MCM 02-06-83 Smoking Policy
  - H. MCM 138-10-07 Green Environmental Management Systems Policy
  - I. MCM 05-10-17 Employee Conduct
  - J. MCM 11-10-15 Informed Consent
  - K. MCM 136-10-14 Medical Record Charting Guidelines
  - L. MCM 138-10-28 Hazard Communication Program
  - M. SOP 02-05-146 Resident Counseling, Remediation and Dismissal
  - N. MCM 05-10-24 Time and Attendance for Full and Part-Time Physicians, Dentists, Optometrists, and Podiatrists
  - O. MCM IC-10-01 Infection Prevention and Control Plan
  - P. MCM IC-10-03 HIV Consent Policy
  - Q. MCM PS-10-02 Patient Safety Program
  - R. MCM IC-11-09 Hand Hygiene
  - S. MCM 123-10-01 Laser Safety Program
  - T. MCM 123-10-02 Issuance of Optical Aids
  - U. MCM 119-10-11 Proper Destruction of Medication
  - V. MCM ACOSE-10-1 Computerized Patient Record System Entry
  - W. MCM ACOSE-10-2 Supervision of Postgraduate Residents
  - X. MCM 11-10-10 Credentialing and Privileging

- Y. MCM ACOSE-10-3 Monitoring of Resident Supervision
- Z. MCM 118-10-13 Cardiopulmonary Resuscitation Certification Program
- AA. MCM QM-10-06 Peer Review for Quality Management
- BB. VHA Handbook 1400.1 Resident Supervision
- CC. MCM 00-06-16 Internet/Intranet Policy

## II. Patient Process through the Eye Clinic

- A. Check in at reception desk.
  - 1. Patients must present VA identification card at the reception desk.
  - 2. Patients arriving early or on time will be checked in by a clerk and placed in a queue to be seen at their appointed time.
  - 3. Patients arriving less than 15 minutes after their appointed time will be checked in and seen in as timely a manner as possible.
  - 4. Per Medical Center Memoranda 136-10-03 Patient Scheduling, patients arriving 15 minutes or more after their appointed time may be considered a "no show". The clerk is to ask the Attending Staff if the patient may be absorbed into the schedule or if rebooking is necessary. Please see MCM 136-10-03 Patient Scheduling for further details.
- B. Clerk prepares a chart with the following items and places them in a chart rack:
  - 1. Blank progress note.
  - 2. Most recent previous eye examination if the patient is an existing patient.
  - 3. Next appointment scheduling sheet.
- C. The resident is to call the patient from the waiting room to the examination room and conduct the examination.
- D. A patient who is receiving a primary care eye exam or glasses prescription eye exam and is eligible under MCM 123-10-02 Issuance of Optical Aids will be receiving glasses at VA expense. A patient who is ineligible to receive glasses through the VA will be provided with a copy of his or her prescription with the words not to be filled at VA expense printed across the top.
- E. The resident is to enter the examination results into the Computerized Patient Record System in accordance with MCM ACOSE-10-01 Computerized Patient Record System Entry.
- F. The resident is required to consult with Attending Staff regarding all laboratory testing orders, radiology imaging orders, consultation requests for other clinics, topical or oral therapeutic medication changes, and fluorescein angiography.
- G. The resident is required to consult with Attending Staff prior to patient departure from the clinic for relatively complex cases or cases in which the resident is unsure of the diagnosis and/or management.
- H. The resident is to consult with Attending Staff on all new patients to the Eye Clinic

- I. The resident is to consult with the Attending Staff to schedule the appropriate time frame for the next patient visit. If further follow up in the Eye Clinic is not needed, the patient is discharged back to his or her primary care provider.

### III. Patient Care Protocols

#### A. Primary Care Eye Examination

1. Notes are to be entered in a subjective complaint, objective findings, assessment and plan format.
2. Residents are required to review the patient's medical and optometric records and be familiar with the following:
  - a. Patient's medical history
  - b. Systemic medications being taken
  - c. Ophthalmic history
  - d. Ophthalmic medications being taken
  - e. Patient's problem list, labs, vital signs, medication list, radiology reports and other pertinent clinics' notes
  - f. Patient's drug allergies and adverse drug reaction history
  - g. If the patient is an established patient, the previous visit's plan and the patient's chief complaint are to be used to determine what procedures are to be preformed
3. The examination sequence may include, but is not limited to the following:
  - a. Patient history
  - b. Entering visual acuity with pinhole testing if reduced.
  - c. Entrance or preliminary testing to include, but not limited to
    - i. Gross observation of patient
    - ii. Pupil testing
    - iii. Versions
    - iv. Cover test
    - v. Confrontation visual field testing
  - d. Refractive analysis may include, but is not limited to
    - i. Measurement of the patient's habitual optical correction
    - ii. Objective measurement of patient's refractive status (e.g. autorefraction data or retinoscopy)

- iii. Subjective measurement of patient's refractive status and measurement of the patient's monocular best, corrected visual acuity.
    - iv. Trial frame demonstration of patient's proposed glasses prescription
  - e. Ocular health assessment
    - i. The anterior segment may be evaluated with a biomicroscopy (slit lamp) examination, which is to include, but is not limited to an assessment of the following:
      - Lids, lashes, and adnexa
      - Cornea
      - Conjunctiva
      - Anterior Chamber
      - Angles
      - Iris
      - Lens
      - Anterior Vitreous
    - ii. Intraocular pressure reading using contact applanation tonometry
    - iii. The posterior segment may be evaluated with binocular indirect ophthalmoscopy, direct ophthalmoscopy, and fundus lens (contact and non-contact) examination, which is to include, but is not limited to an assessment of the following:
      - Cup to disc ratio
      - Neural rim tissue of the optic nerve
      - Macula
      - Posterior pole
      - Peripheral retina
      - Retinal vasculature
      - Vitreous

\*Note: All primary care eye examinations are performed with a dilation of the pupils. With extremely rare exceptions, dilation is not performed (e.g. patient has an iris fixed intraocular lens implant or has documented allergy to dilating agents). If a patient is found to have narrow angles with gonioscopy, dilation may be deferred until prophylactic peripheral iridotomy is completed.

- 4. The resident is required to complete an assessment and plan in the Computerized Patient Record System to the highest level of his or her understanding and to consult with the

Attending Staff regarding each case. The assessment should include, but is not limited to the following:

- i. Addressing of the patient's chief complaint
  - ii. Justification for best corrected visual acuity below 20/20
  - iii. Justification for change in best corrected visual acuity from what was previously documented
5. Medication reconciliation must be performed for each patient.
  6. The resident must electronically sign each note after the entry into CPRS is completed.

B. Follow-up visit eye examination

1. Notes are to be entered in a subjective complaint, objective findings, assessment and plan format.
2. The resident is to review the previous visit's assessment and plan to determine what needs to be done for the patient. The resident should also take into account the patient's chief complaint and any significant findings to determine the course of the examination.
3. Minimum procedures for an intraocular pressure check follow up visit:
  - Chief complaint
  - History to include inquiring about adverse reactions to glaucoma medications, compliance and time of instillation of last drop
  - Visual acuity with pinhole testing if necessary
  - Pupil testing
  - Slit lamp examination
  - Intraocular pressure reading
  - Pachymetry if indicated
  - Heidelberg Spectralis testing if indicated
  - Gonioscopy if indicated
  - Inquire regarding the need for renewal of Rx for glaucoma medication.
  - Demonstration or review of drop instillation technique if indicated.
  - Assess how intraocular pressure compares to target value
  - Review chart to determine if intraocular pressure control is adequate and what needs to be performed at the next visit.
4. Minimum procedures for a glasses prescription check

- Chief complaint and history
  - Visual acuity with pinhole testing if necessary
  - Lensometry on habitual glasses
  - Pupil testing
  - Autorefractometry or retinoscopy if indicated
  - Subjective refraction and measurement of patient's best, corrected monocular visual acuity
  - Trial frame demonstration of patient's proposed glasses prescription
  - Slit lamp examination
  - Intraocular pressure reading
5. Minimum procedures for other follow up visits
- Review of previous examination notes
  - Chief complaint and history
  - Visual acuity with pinhole testing if necessary
  - Pupil testing
  - Slit lamp examination
  - Intraocular pressure reading if possible.

#### C. Glaucoma examination protocol

1. The resident is expected to follow the standard of care in the community for glaucoma suspects and patients. The resident is to review the Clinical Practice Guidelines from the American Optometric Association regarding the care of glaucoma suspects and patients.
2. Items to be considered at every visit for a glaucoma suspect or patient:
  - i. Fundus photographs
    - Baseline optic nerve head photographs should be taken
    - If it has been two or more years since the last fundus photos were taken or if a change in cupping, peripapillary atrophy, or NFL is suspected, additional photos should be considered
  - ii. Gonioscopy
    - Baseline gonioscopy should be performed
    - If it has been two or more years since the last gonioscopy was performed or if a change which would indicate a repetition of gonioscopy occurs, it should be considered

- iii. Threshold visual field testing
  - Baseline threshold visual field should be performed
  - If it has been one year or more since the last threshold visual field was performed, another test should be considered.
  - Threshold visual field testing should be run two or more times per year if indicated by the patient's level of glaucoma
  - With rare exception, visual field testing is performed through dilated pupils
- iv. Pachymetry testing
- v. Nerve fiber layer analysis
- vi. Target intraocular pressure may depend on, but is not limited to the following considerations:
  - Type of glaucoma
  - Stage of the disease (early, intermediate, advanced)
  - Pretreatment intraocular pressure
  - Stability or progression of the disease
- vii. Adverse reactions to ophthalmic medications
- viii. Changes in the patient's medical history
- ix. Diurnal variation in intraocular pressure
- x. If medical therapy is insufficient, refer patient for surgical intervention after consultation with the Attending Staff
- 3. The resident must consult with the Attending Staff regarding any change to a patient's glaucoma therapy medication regimen
- D. Visual field protocols
  - 1. With rare exception (e.g. iris-fixed IOL), threshold visual field and kinetic visual fields are performed through dilated pupils
  - 2. Patients presenting for primary eye care examinations are to have at minimum a confrontation visual field performed
  - 3. Items to be considered to determine if threshold visual field or kinetic visual field testing is to be performed
    - a. Patient history of glaucoma
    - b. Patient risk of glaucoma



- c. Examination findings necessitating visual field testing (e.g. abnormal intraocular pressure readings, optic atrophy, nerve fiber layer defect, cupping of the optic nerve neural rim tissue)
  - d. Patient complaint of loss of peripheral vision
  - e. Patient history of head/brain trauma
  - f. Patient history of cerebrovascular accident
  - g. Patient history of retinitis pigmentosa
  - h. Patient history of taking medications toxic to vision function
- E. Macular degeneration examination protocol
- 1. The resident is expected to follow the standard of care in the community for macular degeneration patients. The resident is to review the Clinical Practice Guidelines from the American Optometric Association regarding the care of macular degeneration patients.
  - 2. Items to be considered at every visit for a macular degeneration patient:
    - i. Best, corrected visual acuity
    - ii. Amsler grid testing
      - Test should be performed in office
      - Inquire about compliance with daily monitoring
      - Remind patient that immediate contact with the Eye Clinic is necessary if changes are noted on the amsler grid
    - iii. Optical Coherence Tomography scan of the macula
    - iv. Fluorescein angiography if CNVM is suspected
    - v. Smoking cessation counseling
    - vi. AREDS formulation recommendation
- F. Other patient protocols
- 1. The resident is expected to follow the standard of care in the community for the particular condition being managed. The resident is expected to review the Clinical Practice Guidelines from the American Optometric Association regarding patient care protocols.

#### IV. Medication control

- A. The medication supply in the Eye Clinic is for diagnostic or therapeutic use in-office only.
  - 1. Medications may not be dispensed to patients
  - 2. Medications may only be dispensed to patients from the pharmacy

- B. The date on which a medication is opened in the Eye Clinic must be written on the bottle
- C. Outdated, returned, contaminated, or deteriorated drugs must be disposed of according to MCM 119-10-11 Proper Destruction of Medication.
- D. Notify the Program Coordinator or Attending Staff when items from the medication supply are running low

V. Infection control

- A. The resident is expected to review MCM IC-10-01 Infection Prevention and Control Plan
- B. The resident is expected to review and implement MCM IC-11-09 Hand Hygiene
- C. All surfaces on the biomicroscope that come into contact with patients is to be cleaned with isopropyl alcohol
- D. A new, disposable tonometer tip is to be used on each patient
- E. Latex gloves and surgical masks are available

VI. Resident supervision

- A. Attending Staff or supervising practitioners are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires personal involvement with each patient and each resident who is participating in the care of that patient.
- B. Within the scope of the training program, each resident must fall under the supervision of Attending Staff or supervising practitioners.
- C. This Residency Program is designed to encourage and permit each resident to assume increasing levels of responsibility commensurate with his or her progress in experience, skill, knowledge, and judgment
  - 1. The resident will participate in a system of graduated increasing level of responsibility
    - a. The determination of a resident's ability to provide patient care without an Attending Staff or supervising practitioner present is based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill.
      - i. The resident will be allowed to perform primary care examination of the eye and adnexa with diagnostic pharmaceutical agents without direct supervision of the Attending Staff. The documentation for allowing this is the requirement that the resident graduate from an ACOE accredited school of optometry, the successful passing of the National Board of Examiners in Optometry Parts I, II, and III, and the obtaining of a license to practice optometry in one of the fifty states of the United States of America or the District of Columbia.
      - ii. The resident will be permitted to perform diagnostic procedures such as scleral depression, fundus photography, dilation and irrigation of the lacrimal system, and fluorescein angiography after he or she has demonstrated proficiency during the Clinical Workshops program. The documentation allowing for this will be the entry of completion of the Clinical Workshops program in the resident's activity log.

- iii. The resident will be allowed to act in a teaching capacity beginning in the Clinical Workshops program under the supervision of Attending Staff. The resident must successfully complete a session of the Clinical Workshops as a student prior to assuming a role as an instructor. The documentation allowing for this will be the entry of completion of a session of the Clinical Workshops program in the resident's activity log.
  - iv. The resident will be allowed to act in a teaching capacity as a Staffing Doctor to optometric interns during the final month of the residency program. The resident will work under the supervision of an Attending Staff and all requirements for resident supervision will be followed. The documentation allowing for this will be the completion of 10 months of residency training, receiving of no less than a rating of 2 on each section of the previous three quarters of residency evaluations by Attending Staff or the successful remediation of any section on which the resident received less than a rating of 2.
- D. The resident is required to consult with Attending Staff regarding all laboratory testing orders, radiology imaging orders, consultation requests for other clinics, topical or oral therapeutic medication changes, and fluorescein angiography.
- E. The resident is required to consult with Attending Staff prior to patient departure from the clinic for relatively complex cases or cases in which the resident is unsure of the diagnosis and/or management.
- F. Documentation of all patient encounters must identify the Attending Staff or supervising practitioner and indicate the level of involvement.
  - 1. Acceptable supervision documentation
    - a. Attending Staff or supervising practitioner progress note or other entry into the medical record.
    - b. Addendum to the resident progress note by the Attending Staff or supervising practitioner
    - c. Co-signature of the progress note or other medical record entry by the Attending Staff or supervising practitioner. Note that the Attending Staff's co-signature signifies that the Attending Staff has reviewed the resident's note and absent an addendum to the contrary, concurs with the content of the resident's note or entry. Use of CPRS function "Additional Signer" is not acceptable for documenting supervision.
    - d. Resident documentation of Attending Staff or supervising practitioner supervision. [Includes involvement of the Attending Staff or supervising practitioner (e.g. "I have seen and discussed the patient with my supervising practitioner, Dr. 'X' and Dr. 'X' agrees with my assessment and plan", at a minimum, the responsible Attending Staff or supervising practitioner should be identified (e.g. "The attending of record for this patient encounter is Dr. 'X'"))]
- G. The following guidelines must be followed for the Eye Clinic as an outpatient clinic
  - 1. The Attending Staff or supervising practitioner for the resident must be physically present in the clinic area during clinic hours
  - 2. The Attending Staff or supervising practitioner must be physically present in the clinic. Every patient who is new to the facility must be seen by or discussed with an attending. An independent note, addendum to the resident's note, or resident note description of attending

involvement is required for documentation. Co-signature by attending alone is not sufficient documentation.

- H. The resident is to read and familiarize himself or herself with VHA Handbook 1400.1 Resident Supervision

#### V. Patient records

- A. All patient records are considered confidential.
- B. Any and all paper work must be placed in an approved secure box for proper disposal. Trash cans or other non-approved receptacles should not be used
- C. All patient records are to be entered into the Computerized Patient Record System as per MCM 11-06-02 Computerized Patient Record System Entry.
- D. Visual fields, Color vision test results, Heidelberg Spectralis nerve fiber analysis, and any other testing that cannot be entered manually into the Computerized Patient Record System will be submitted for scanning into the patient record under VISTA imaging

#### VI. Dress code-MCM is currently being revised. Residents are to follow these guidelines.

- A. Clinic attire appropriate for physicians is required on all patient care days. This includes Grand Rounds, Clinical Conference, and Clinical Workshops

- Males are required to wear dress shirts, ties, and long pants

- T-shirts, jeans, shorts, caps and ripped clothing are unacceptable for clinic

- If wearing a skirt, the hem length must extend below the knee

- bare feet, open toed shoes, sandals, and athletic shoes are prohibited

- Jewelry, cosmetics, perfume, and other adornments must be professional and conservative

- clinic jackets or lab coats are to be worn at all times during patient care activities

- B. Identification badges are to be worn at all times in the Eye Clinic

#### VII. Telephone and internet use

- A. Personal use of telephones and internet is restricted. If necessary, be brief and do so during "off-patient" hours

- B. Telephone

- 1. Telephone directories are listed on the VA Southern Nevada Healthcare System Intranet

- 2. Local service or toll free numbers are reached by dialing 9 first

- 3. Long distance numbers are reached by dialing 9 first, then a 1 followed by the area code and number.

- C. Internet

1. Users are responsible for adhering to all VA Southern Nevada Healthcare System policies and applicable laws and regulations related to external networks.
2. Internet use is a privilege not a right
3. The following applies to all internet users:
  - Internet users must not use the Internet for personal use when they are expected to be performing official duties
  - Internet users must not download games from or play games on the Internet or participate in non-VA related chat rooms
  - Internet users must not access inappropriate sites (e.g. those displaying pornographic material, those inappropriate in a business environment)
  - Internet users must not transmit personal data or government owned data across the Internet
  - Internet users must obey all copyright laws
  - Internet users must not be harassing, libelous, or disruptive to others or send threatening, racially harassing, or sexually harassing messages while using VA-provided Internet resources
  - Internet users must not attempt to exceed access privileges or use VA-provided access or systems as a staging ground or platform to gain unauthorized access to other systems whether federal or private
  - Internet users must not make any personal use of the Internet that could cause congestion, delay or disruption of service to any government system or equipment (e.g. continuous data streams, video, sound, or other large file attachments that can degrade the performance of the network), or for any activities that are illegal, inappropriate, or offensive to fellow employees and the public
  - Internet users must not participate in unlawful or malicious activities or use objectionable language while using the Internet
  - Internet users must not knowingly introduce computer viruses, worms, Trojan horses or other types of malicious computer software to government computers
4. The resident is expected to review and familiarize himself or herself with MCM 00-06-16 Internet/Intranet Policy

#### VIII. Housekeeping

- A. Keep all exam rooms neat and clean
- B. Cover all instruments with the appropriate covers at the end of the day
- C. No food or drinks are allowed in the exam room or any other patient care area

## Eye Examinations

### I. Supplies and Equipment

#### A. Examination room equipment

- Computer workstation
- Examination chair and stand
- Chart projector
- Near point reading card
- Feinbloom chart
- Slitlamp biomicroscope
- Digital slitlamp photography/observation system
- Goldmann applanation tonometer
- Lensometer
- Phoropter
- Auxiliary cylinder lenses for phoropter
- Binocular indirect ophthalmoscope
- Direct ophthalmoscope
- Streak retinoscope
- Condensing lenses (20D and 90D)
- Gonioscopic lenses (3 mirror and 4 mirror)
- Occluder with pinhole
- Amsler grid
- Trial lenses and frame
- Loose prisms

#### B. Other available equipment for examinations

- Farnsworth D-15 color vision test
- Ishihara color vision test
- Hand held Jackson cross cylinder
- Epilation forceps

- Punctal dilator and irrigator

- Hertel exophthalmometer

- Alger brush

- Foreign body spud

- Scleral depressor

#### C. Ancillary equipment

- Octopus 101 automated perimeter

- A/B scan ultrasonography unit

- Ultrasound biomicroscope

- Pachymetry/A-scan unit

- Electrodiagnostic testing unit

- Heidelberg Spectralis nerve fiber layer analyzer

- Autorefractor/Autokeratometer/Topographer unit

- Topcon Imagenet system for fundus photography and fluorescein angiography

- Automated blood pressure/pulse rate/temperature unit

- Digital camera for external photography

- Hand held electrolysis unit

## II. Optometry Clinics

### A. General optometry clinics

1. Each Attending Staff has general optometry clinics listed as days in which direct patient care is rendered.
2. See the weekly attending schedule under Tour of Duty for schedule details
3. See Patient Care Protocols under Department Policies for details

### B. Diabetic Retinal Screening (DRS) clinic

1. Most Attending Staff have one day per week of Diabetic Retinal Screening clinic
2. See the weekly attending schedule under Tour of Duty for schedule details
3. Protocol
  - a. Examinations for eyeglasses are not performed in DRS clinic

- b. Patient history is to include, but is not limited to:
  - How long patient has been diagnosed with DM
  - Status of insulin use
  - Last blood glucose reading taken by the patient
  - Last HbA1c reading
- c. Entrance testing is to include, but is not limited to:
  - Pupil testing
  - Versions
  - Confrontation visual field
- d. Applanation tonometry is to be performed
- e. Ocular health assessment is to include, but is not limited to:
  - i. Anterior segment evaluation with a biomicroscopy (slit lamp) with, at minimum, an assessment of the following:
    - Lids, lashes, and adnexa
    - Cornea
    - Conjunctiva
    - Anterior Chamber
    - Angles
    - Iris
    - Lens
    - Anterior vitreous
  - ii. Dilated posterior segment evaluation which may include binocular indirect ophthalmoscopy, direct ophthalmoscopy, and fundus lens examination with, at minimum, an assessment of the following:
    - Cup to disc ratio
    - Neural rim tissue of the optic nerve
    - Macula
    - Posterior pole
    - Peripheral retina



- Retinal vasculature

- Vitreous

Note: Dilation is not to be done on patients with iris fixed intraocular lens implant.

iii. Significant negative findings are to include, but not limited to:

- No neovascularization of the iris (NVI)

- No neovascularization of the disc (NVD)

- No neovascularization elsewhere (NVE)

- No clinically significant macular edema (CSME)

### C. Low vision clinic

1. Dr. Chong has low vision clinic three days per week.

2. Low vision clinic meets all day on Wednesday and Friday, and in the AM on Thursday.

3. Protocol

a. Patients are referred to the low vision clinic from general clinic

b. The patient should have received an examination in general clinic with refraction and diagnosis of cause of low vision

c. Patient history is to include, but is not limited to:

- Cause of low vision

- Length of time that the patient has had low vision

- Treatment for cause of low vision received by the patient (e.g. Avastin, Lucentis, visudyne, macugen, laser)

- Previous training in low vision or vision rehabilitation received by the patient

- Patient's goals from low vision training (e.g. reading, spotting signs, writing checks, watching TV, etc.)

- Assessment of patient's needs for non-optical low vision aids (e.g. check writing guides, talking watch, needle threader, filters, etc.)

d. Entrance testing is to include, but is not limited to:

- Pupil testing

- Versions

- Confrontation visual fields

- e. Applanation tonometry is to be performed
  - f. Determination of patient's refractive status if needed
    - Retinoscopy
    - Autorefraction
    - Trial frame refraction
  - g. Determine patient's response to magnification
  - h. Record all low vision aids that were demonstrated to the patient and acuity through the aid if applicable
  - i. Order appropriate aids through CPRS for the patient.
- D. Fluorescein Angiography Clinic
1. Fluorescein Angiography Clinic occurs on the first and third Friday mornings of each month.
  2. Protocol
    - a. Patients are referred to the Fluorescein Angiography Clinic from general clinic, new patient clinic, or diabetic clinic.
    - b. The patient should have received an examination in general clinic, new patient clinic, or diabetic clinic, and been screened for contraindications to fluorescein angiography.
    - c. The patient checks in at the front desk
    - d. The optometric residents or optometric interns call the patient into the examination room, re-screen the patient for contraindications to fluorescein angiography, and if none are found proceed with preparing the patient. Visual acuity is to be taken, entrance testing is to be performed, slitlamp examination is to be performed, Goldmann applanation tonometry is to be taken, and dilating drops are to be instilled.
    - e. The optometric resident then explains the risks and benefits of fluorescein angiography to the patient and obtains informed consent from the patient documented with IMED Consent in CPRS.
    - f. The optometric residents obtain fundus photographs on the patient. The optometric residents administer fluorescein dye intravenously to the patient under the direct supervision of an Attending Staff or supervising practitioner. The optometric residents take fluorescein angiography photographs of the patient.
    - h. The optometric residents review the fluorescein angiography with an Attending Staff or supervising practitioner and the patient is either referred for further care or a follow up appointment is made for monitoring.
- E. New patient clinic
1. Each Attending Staff has new patient clinic scheduled during the week
  2. See the weekly attending schedule under Tour of Duty for schedule details

3. The New Patient Clinic was created to meet the director's performance standard for examining new patients in a timely manner
4. See protocol for Primary Care Eye Examination under Patient Care Protocols

### III. Clinical Practice Guidelines

- A. The resident is expected to follow the standard of care in the community for all patient encounters. The resident is to review the Patient Care Protocols under the Department Policies section of the Resident's Manual as well as the Clinical Practice Guidelines from the American Optometric Association regarding examination protocols.
- B. Monitoring for ocular toxicity
  1. The resident is expected to be familiar with all the medications a patient is taking and to be familiar with all the anticipated ophthalmic side effects
  2. In particular, the resident must monitor patients on the following:
    - a. Anti-tubercular medicines
    - b. Anti-malarial medicines
    - c. Phenothiazines
    - d. Long-term corticosteroid therapy
  3. In general, most patients require the following testing:
    - a. Threshold visual field (consider macular threshold visual field)
    - b. Monocular D-15 color vision test
    - c. Amsler grid test
    - d. Optical coherence tomography
    - e. Multifocal ERG (equipment will be available in June 2012)
  4. Significant negative findings should be documented in the patient's record
  5. Consider fundus photographs when appropriate
- C. Glaucoma patient progress monitors and management protocol
  1. In general, glaucoma patients are to be examined every 3-6 months. Patients with more complex cases may be examined more frequently
  2. Intraocular pressure is to be measured on every visit
  3. Baseline testing should include, but is not limited to, the following:
    - a. Pachymetry

- b. Gonioscopy
  - c. Heidelberg Spectralis testing
  - d. Threshold visual field testing
  - e. Fundus photography
4. Repeat of baseline tests should be done at the appropriate intervals as determined by the standard of care in the community
  5. The resident must review the patient's history, intraocular pressure findings, threshold visual fields, and fundus photography prior to examining the patient so that trends may be seen
  6. The resident is to make a determination as to whether the patient's glaucoma is adequately controlled or if modification in therapy is required
  7. The Attending Staff must be consulted prior to change in medication, addition of medication, or deletion of medication is implemented
  8. The Attending Staff must be consulted prior to referral of patient for surgical intervention for glaucoma

#### IV. Eyeglasses

- A. Eligibility is determined by VHA Handbook 1173.12 Prescription Optics and Low-Vision Devices
  1. The following categories of veterans are eligible for glasses:
    - a. Those with any compensable service-connected disability
    - b. Those who are former prisoners of war (POW)
    - c. Those who were awarded a Purple Heart
    - d. Those in receipt of benefits under Title 38 United States Code (U.S.C.) 1151
    - e. Those in receipt of an increased pension based on being permanently housebound and in need of regular aid and attendance
    - f. Those with vision or hearing impairment resulting from diseases or the existence of another medical condition for which the veteran is receiving care or services from VHA, or which resulted from treatment of that medical condition, e.g., stroke, polytrauma, traumatic brain injury, diabetes, multiple sclerosis, vascular disease, geriatric chronic illnesses, toxicity from drugs, ocular photosensitivity from drugs, cataract surgery, and/or other surgeries performed on the eye, ear, or brain resulting in vision or hearing impairment.
    - g. Those with significant functional or cognitive impairment evidenced by deficiencies in the ability to perform activities of daily living.
    - h. Those who have vision and/or hearing impairment severe enough that it interferes with their ability to participate actively in their own medical treatment and to reduce the impact of dual sensory impairment (combined hearing and vision loss). **NOTE:** The term "severe" is to be interpreted as a vision and/or hearing loss that interferes with or restricts

*access to, involvement in, or active participation in health care services (e.g., communication or reading medication labels). The term is not to be interpreted to mean that a severe hearing or vision loss must exist to be eligible for hearing aids or eyeglasses.*

2. Glasses may also be provided for patients upon approval of the Chief of Optometry on a per-patient basis provided a medical need exists and justification is given for the prescription (e.g. monocular patients, insulin-dependent diabetics)
- B. Orders for glasses are to be written up on an the provided order form
  - C. A second pair of corrective eyeglasses will not be issued to any beneficiary unless there are compelling medical circumstances requiring a second pair
  - D. Beneficiaries are allowed one pair of bifocal or trifocal glasses or two pairs of single vision glasses, one for reading and one for distance, in cases where bifocal lenses are contraindicated
  - E. Replacement of corrective eyeglasses necessitated by fair wear and tear, loss or breakage due to circumstances beyond the control of the veteran, or due to required change of prescription, may be made at any time
    1. When replacement eyeglasses are prescribed because of a change in refractive error, the change must require a change of at least the following:
      - a. Sphere change of at least + or – 0.25 diopter
      - b. Cylinder change of at least + or -0.50 diopter
      - c. Axis change of at least the following:
        - five degrees for 0.25 to 0.75 diopter of cylinder power
        - three degrees for 1.00 to 2.00 diopters of cylinder power
        - two degrees for 2.25 or more diopters of cylinder power
    2. Replacement eyeglasses can be prescribe at any time due to required refractive change of prescription to improve one line of visual acuity
    3. If one or both lenses are broken and there is any indication that the veteran's vision has changed, or if it has been more than 1 year since the veteran's eyes were last examined, the veteran is to be referred to an optometrist or ophthalmologist before replacement eyeglasses are ordered.
  - F. Medical justification is needed for tinted lenses (e.g. post-operative cataract patients, aphakic patients, patients with ocular photosensitivity due to medications, etc.). Tinted lenses will not be provided solely for comfort.
  - G. Orders are written up on forms that are provided
  - H. The Health Technicians (opticians) do all orders, adjustments, and repairs of glasses
  - I. Glasses are mailed to the patient at their home address

## V. Coding

A. Diagnostic codes (ICD-9)

1. Code all relevant diagnoses for the patient on the encounter form in the Computerized Patient Record System.
2. Choose the most pertinent diagnosis as the primary diagnosis.

B. Procedure codes (CPT)

1. Residents are advised to not use the evaluation and management codes (99XXX codes)
2. Optometry/Ophthalmology specific codes should be used instead
  - a. Comprehensive eye examination codes are 92004 for new patients and 92014 for established patients
  - b. Intermediate eye examination codes are 92002 for new patients and 92012 for established patients
3. Other procedure coding will be discussed at the resident orientation to the Eye Clinic

VI. Patient recall

- A. The Eye Clinic operates as a specialty clinic and as such there is no recall for routine eye examination
- B. Non-service connected patients in need of a routine comprehensive eye examination must be referred to the Eye Clinic by their primary care provider
- C. Service connected patients are allowed to call for an appointment for a routine comprehensive eye examination. Service connected patients are encouraged to call approximately 6 months prior to their requested examination date
- D. Patients who must be seen in less than one year for a non-comprehensive eye examination must be scheduled according to the needed procedure (i.e. IOP check, cataract post op follow up, threshold visual field testing, Heidelberg Spectralis testing, dilated fundus examination, glasses prescription check, etc)

## Electronic Records

### I. Background:

#### A. Decentralized Hospital Computer Program (DHCP) information system

-An automated patient information system utilized in Department of Veterans Affairs medical centers beginning in 1985

#### B. Veterans Health Information Systems and Technology Architecture (VISTA)

-An enhancement over DHCP information system

-Includes the Computerized Patient Record System, which was implemented in 1997

-CPRS provides a single interface for health care providers to review, update, and add to a patient's medical record.

-CPRS allows a health care provider to place orders for medications, radiology testing, special procedures, consultations, lab testing, etc.

### II. Review of electronic records

- A. The resident is to review the patient's active problem list, active medication list, known allergies and adverse reactions list, previous eye examination records, pertinent lab tests, pertinent radiology tests and pertinent VISTA Imaging information prior to examining each patient

### III. Entry of electronic progress notes

- A. All notes are to be entered in a subjective complaint, objective findings, assessment and plan format into CPRS
- B. Standardized optometric templates are available for use by the resident. The process of using the templates will be demonstrated to the resident during orientation

### IV. Ordering medications

- A. The resident is allowed to prescribe therapeutic agents necessary to treat the patient's ocular condition within the scope of the Attending Staff's privileges.
- B. The resident is required to consult with the Attending Staff regarding all changes, additions, and/or deletions to a patient's medication profile
- C. Medication prescriptions are to be entered electronically via CPRS
  - 1. The procedure for ordering medications will be demonstrated to the resident during orientation and at the first opportunity during patient care activities
- D. The VASNHS has a limited formulary from which medications may be prescribed. The formulary is located in the CPRS system
- E. Non-formulary drug requests are made in rare cases when all formulary items have proved to be ineffective or contraindicated for the patient

1. There must be adequate documentation that the existing formulary medications have been unsuccessful or contraindicated in both the electronic record and the non-formulary drug request
2. The procedure for placing a non-formulary drug request will be demonstrated to the resident at the first opportunity that arises during patient care activities

V. Ordering radiological testing

- A. The resident is allowed to order radiology testing when indicated by a patient's ocular condition
- B. The resident is required to consult with the Attending Staff prior to placement of a request for radiological testing
- C. Consultations for radiological testing are to be entered electronically via CPRS
  1. The procedure for entering a consultation for radiological testing will be demonstrated to the resident at the first opportunity during patient care activities
- D. The tests that are available for ordering are as follows:
  1. X-ray
  2. Computerized Tomography (CT) Scan
  3. Magnetic Resonance Imaging (MRI)
  4. Magnetic Resonance Angiography (MRA)
  5. Carotid Doppler ultrasonography
- E. Once test is complete, results are sent back to the ordering clinician and will appear in the Notifications window of CPRS and in the imaging section of the Reports tab

VI. Ordering laboratory testing

- A. The resident is allowed to order laboratory testing when indicated by a patient's ocular condition
- B. The resident is required to consult with Attending Staff prior to the placement of a request for laboratory testing
- C. Requests for laboratory testing are to be entered electronically via CPRS
  1. The procedure for entering a request for laboratory testing will be demonstrated to the resident at the first opportunity during patient care activities
- D. Laboratory testing ordered by optometrists includes, but is not limited to the following:
  1. CBC with differential
  2. Chem 7
  3. HbA1c
  4. ESR



5. C reactive protein
  6. RPR first then FTA-ABS if needed
  7. ACE
  8. Rheumatoid factor
  9. ANA
  10. Lyme serologic testing
  11. HLA-B27 typing
  12. Creatinine
  13. Blood urea nitrogen
- E. Once a test is complete, results are sent back to the ordering clinician and will appear in the Notifications window of CPRS and under the Labs tab

## VII. Vista Imaging

- A. Vista Imaging is a medical imaging system that integrates clinical images and scanned documents into a patient's electronic medical record
1. The resident is to submit threshold visual field results and Heidelberg Spectralis testing results for scanning into Vista Imaging
  2. The process for entering a patient's digital retinal photographs or retinal fluorescein angiography results into CPRS is as follows:
    - a. Open the patient's chart in CPRS
    - b. Click the Consults tab
    - c. Click the New Consult button
    - a. Click on Other Consults
    - b. Type Eye Care Imaging in the Consult to Service/Specialty box
    - c. Click on the Provisional diagnosis box and enter either "fundus photos" or "FA photos"
    - d. Click on the Reason for Order box and enter either "fundus photos" or "FA photos" again
    - e. Click the Accept Order button
    - f. Close the Consult window
    - g. Click the file tab
    - h. Click review/sign changes...
    - i. Enter your signature

- j. Take the patient's fundus photographs or fluorescein angiography photographs and save them in the Imagenet system
  - k. Click Utilities
  - l. Click Dicom Copy
  - m. Select the patient's name from the list
  - n. Click Copy and the patient's images are saved to Vista Imaging in CPRS
- B. Vista Imaging may not be used to scan in paper records of eye examinations performed by the resident. Eye examinations performed by the resident must be entered into CPRS manually
- C. Paper records produced by non-VA physicians may not be scanned into the Vista Imaging system

## Resources

### I. VA Medical Library

The VA Medical Library is located in the VA Medical Center. In the Eye Clinic, *Ophthalmology*, *American Journal of Ophthalmology*, *Survey of Ophthalmology*, and the *Journal of the American Optometric Association* are among the many titles available through the virtual library. Residents may also submit requests for medline articles from the VA Medical Library as needed.

### II. Southern California College of Optometry (SCCO) Library

The library at SCCO is available with full access and extended checkout periods for materials for residents. The librarians are also able to perform a literature search on a given subject of study. Additionally, the SCCO Library sponsors the Journal Review Program in which residents are allowed to select an article from a journal on a regular basis (according to the circulation frequency of the requested journal) for review. The article is sent to the resident through email.

### III. University Medical Center Library

The University Medical Center Library is affiliated with the University of Nevada School of Medicine. VA residents have access to this facility for medline searches.

### IV. Computer and Internet Resources

- A. Micromedex is a subscribed online reference for drug information that is available for residents.
- B. E-med Library on the VA intranet provides links to search engines such as Pubmed and OVID. Online, full text articles are available from various journals.

## Administrative Responsibilities

### I. Quality Management

- A. All patient notes are to be entered into the Computerized Patient Record System by the resident.
- B. All fundus photographs are to be entered into the Fundus Photography Log kept on the Imagenet digital camera system. The log is to include patient identifiers, condition, and date of photograph.
- C. All patient visual field results, Heidelberg nerve fiber layer scanning results, and B-scan results are to be submitted for scanning into the VISTA imaging system.
- D. The resident is to keep a log of his or her patient encounters on the patient log sheet prescribed by SCCO.
- E. Chart review of all of the resident's charts by the Attending Staff will take place on a daily basis. In addition to this, the Chief of Optometry service or his designee will perform a biannual or more frequent chart review on each resident. The Program Coordinator will be made aware of any deficiencies and so that immediate corrective action may be undertaken.

A. MCM 05-10-02

### **Drug-Free Workplace Program**

1. **PURPOSE:** To establish policy and procedures for conducting pre-employment and employee drug testing at VA Southern Nevada Healthcare System (VASNHS).
2. **POLICY:** It is our policy that the medical center be free from illegal use, possession, or distribution of controlled substances by employees of the VA. The possession and distribution of controlled substances will be dealt with promptly in accordance with legal and administrative disciplinary procedures. However, the policy's primary goal is to ensure that illegal drug use is eliminated and that the VA workplace be safe, healthful, productive, and secure.
3. **ACTION:** Drug testing will consist only of urinalysis. VA will test for marijuana, cocaine, opiates, amphetamines, and phencyclidine (PCP). When conducting reasonable suspicion, injury, illness, unsafe, or unhealthful practice testing, VA may test for any drug identified in Schedule I or II of the Controlled Substance Act. The VA plan includes the following types of drug testing, defined as follows:
  - a. **Applicant Testing:** All applicants tentatively selected for VA employment in a testing designated position are subject to urinalysis to screen for illegal drug use prior to appointment. Selection for testing will be based on terminal social security number matching. Applicants who refuse to be tested will be denied employment with the VA.
  - b. **Random Testing:** Employees who occupy positions designated as Testing-Designated Positions are subject to a random selection process on a monthly basis. The VA PAID computer system located in Austin, Texas will randomly select employees to be tested and forward a name listing to the Drug-Free Workplace Coordinator who will initiate testing procedures.
  - c. **Reasonable Suspicion:** This testing may be required of any employee in a position which is designated for random testing when there is a reasonable suspicion that the employee uses illegal drugs whether on or off duty. Reasonable suspicion testing may also be required of any employee in a position when there is a reasonable suspicion of on-duty use or on-duty impairment. This must be based upon observable phenomena; a pattern of abnormal conduct or erratic behavior in the workplace indicative of illegal drug use; arrest or conviction for a drug-related offense or the identification as the focus of a criminal investigation into illegal drug possession, used or distribution; information provided either by reliable and credible sources or independently corroborated; or newly discovered evidence that the employee has tampered with a previous drug test. Although reasonable suspicion testing does not require in certainty, mere "hunches" are not sufficient to meet this standard. When reasonable suspicion has been established, the appropriate supervisor will promptly detail, for the record and in writing, the circumstances which formed the basis to warrant the testing. A written report will be prepared to include, at a minimum, the appropriate dates and times of reported drug related

incidents, reliable/credible sources of information, rationale leading to the test, finding of the test, and the action taken. Reasonable suspicion testing should be ordered and conducted as soon as possible after the event(s) giving rise to the suspicion.

The supervisor will be the individual authorized to approve a reasonable suspicion test once they have coordinated with Chief, Human Resources Management Service.

d. **Injury, Illness, or Unhealthful Practice:** Employees involved in accidents may be tested if there is reasonable suspicion that they caused or contributed to an accident that results in a death or personnel injury requiring immediate hospitalization, or the accident resulted in damage to property estimated to be in excess of \$10,000.

e. **Voluntary Testing:** To demonstrate their commitment to VA's goal of a drug-free workplace and to set an example for federal employees, employees not in testing designated positions may volunteer for unannounced random testing by notifying the Director, VASNHS. Their names will then be placed in the pool of testing designated positions and will remain there for the duration of the position which the employee holds, or until the employee withdraws from participation.

f. **Follow-up:** Employees referred through administrative channels that undergo counseling or rehabilitation program for illegal drug use through Employee Assistants Program (EAP) will be subject to unannounced testing following completion of such a program for a period of one year, at an increased frequency of at least six times per year through placement in a separate random pool.

g. **Test Procedures in General:**

(1) Employees selected for testing shall be notified in writing on the day of the test, directing them to report to a collection room located in the Laboratory (the MOFH Laboratory will not be used for this purpose). Employees shall be permitted to provide urine specimens in private. However, collection site personnel of the same gender of the person tested may observe the individual providing the urine specimen when such personnel have reasons to believe the individual may alter or substitute the specimen to be provided. Specimen will be sent to the Minneapolis, Minnesota VA Medical Center for testing.

(2) Employees in Testing-Designated Positions (TDP) may, upon notification and prior to testing, document any medications they may be currently taking. This documentation can be accomplished by completing the forms when collecting and submitting the specimen in the Laboratory Section.

(3) Failure to appear for testing will be refusal to participate in testing, and will subject an employee to the range of disciplinary actions, including removal, and an applicant to the cancellation of an offer of employment.

(4) When a confirmed positive test result is received, the employee will be given the opportunity to provide supplemental medical information for consideration. If the positive test

result is confirmed, the employee will be referred to the Employee Assistance Program; however, such referral does not preclude institution of disciplinary proceedings.

VA will verify positive drug tests, except that VA will not initiate any disciplinary actions against an employee who voluntarily identifies him or herself as a user of illegal drugs prior to being notified of a scheduled drug test, obtains counseling or rehabilitation, and thereafter refrains from using illegal drugs. Removal action will be initiated against an employee who is found to use illegal drugs and who refuses to obtain counseling or rehabilitation through EAP.

#### **4. RESPONSIBILITIES:**

a. The Director, VA Southern Nevada Healthcare System has overall responsibility for the VA Drug-Free Workplace Program and will provide space, facilities, personnel, and resources to accomplish program goals.

b. The Chief, Human Resources Management Service will appoint a Human Resources Specialist as the Drug-Free Workplace Coordinator (DFWC), responsible for the overall operation of the drug-testing program; for providing advice and assistance to top management; for coordinating the program with involved Care/Service Lines or Sections; for monitoring the program to ensure compliance with established procedures; and for preparing reports on the program as required by Veterans Health Administration (VHA) Headquarters and other pertinent directives.

c. The Employee Health Physician is designated as the Medical Review Officer (MRO) and is responsible for receiving and reviewing test results.

d. The Manager, Laboratory Service is responsible for implementing proper specimen collection procedures.

f. The EAP Coordinator is responsible for implementing and operating the EAP at the facility by providing counseling, treatment, and education services to employees and supervisors in accordance with EAP policy.

g. Supervisors and Managers who are responsible for notifying their employees for random testing are responsible to provide to the DFWC, the original document at attachment D, giving the date time the employee was notified that they were to take a random drug test.

#### **5. REFERENCES:**

Executive Order 12564, Drug-Free Federal Workplace, September 15, 1996.

VA Directive 5383, VA Drug-Free Workplace Program, April 11, 1997.

VA Handbook 5383.1, VA Drug-Free Workplace Program and VA Handbook 5383.2, Urine Drug Testing: Collection and Transportation of Urine Specimens.

National Agreement Between Department of Veterans Affairs and AFGE Employees Council, Subject: VA Drug-Free Workplace Program.

6. **RESCISSION:** Medical Center Memorandum 02-07-02, "Drug-Free Workplace Program", dated February 2007.

7. **RECERTIFICATION:** February 2013.

Concur/Do not Concur

Concur /Do not Concur

Ramu Komanduri, MD  
Chief of Staff

Shirley L. Caldwell-Butts, MSN, RN  
AD Patient Care/Nurse Executive

Concur/Do not Concur

Approved/Disapproved

Deborah Dort, MD  
Acting Associate Director

John B. Bright  
Director

Attachments A, B



**Drug-Free Workplace Program****TESTING DESIGNATED POSITIONS**

**Section 1B. General Schedule Occupations** (This section includes positions listed in Title 38 U.S.C., Sec. 7401(3))

| <u>Series</u> | <u>Title(s)</u>  |
|---------------|--|
| GS-081        | Firefighter/Fire Protector   |
| GS-083        | Police Officer/Detective   |
| GS-085        | Guard  |
| GS-101        | Coordinator, Alcohol/Drug Treatment Program  |
| GS-101/102    | Readjustment Counseling<br>Manager/Specialist/Technician/Assistant/Addiction<br>Specialist |
| GS-180        | Psychologist   |
| GS-401        | Hematologist, Histologist, Biologist, Research Biologist                                   |
| GS-403        | Microbiologist/Research Microbiologist   |
| GS-405        | Pharmacologist/Toxicologist  |
| GS-601        | Histotechnologist, Cytotechnologist  |
| GS-601        | Nuclear Medicine Technologist  |
| GS-601        | Registered Respiratory Therapist   |
| GS-610        | Occupational Health Nurse  |
| GS-620        | Licensed Practical Nurse   |
| GS-621        | Nursing Assistant  |
| GS-622        | Medical Supply Technician/Aid  |
| GS-633        | Physical Therapist   |
| GS-640        | Certified Respiratory Therapy Technician   |
| GS-640        | Health Technician  |
| GS-642        | Nuclear Medicine Technician  |
| GS-644        | Medical Technologist   |
| GS-645        | Medical Technician   |
| GS-646        | Histopathology/Cytology/Pathology Technician   |
| GS-647        | Diagnostic Radiologic Technologist/Technician  |
| GS-648        | Therapeutic Radiologic Technologist/Technician   |
| GS-649        | Cardiac Catheterization Technician   |
| GS-649        | Electrocardiograph Technician  |
| GS-649        | Electroencephalograph Technician   |
| GS-649        | Heart-Lung Machine Technician  |
| GS-649        | Hemodialysis Technician  |
| GS-649        | Hyperbaric Chamber Technician  |
| GS-649        | Medical Machine Aid  |
| GS-649        | Medical Machine Technician   |

|         |   |
|---------|---|
| GS-649  | Pulmonary Function Technician           |
| GS-651  | Respiratory Therapist                   |
| GS-660  | Pharmacist                              |
| GS-661  | Pharmacy Technician                     |
| GS-681  | Dental Assistant                        |
| GS-682  | Dental Hygienist                        |
| GS-858  | Clinical/Biomedical Engineer            |
| GS-1306 | Health Physicist                        |
| GS-1320 | Chemist                                 |
| GS-1601 | Biomedical Equipment Support Specialist |
| GS-1811 | Criminal Investigator                   |

## Attachment A

### Section 1c. Federal Wage System Occupations

| <u>Series</u> | <u>Title(s)</u>            |
|---------------|----------------------------|
| WG-4805       | Medical Equipment Repairer |
| WG-5703       | Motor Vehicle Operator     |
| WG-5823       | Automotive Mechanic        |

### Section 1d. Key Management Positions

- a. All Senior Executive Service (SES) Employees.
- b. The following positions are covered only if the incumbent is required to have a top secret or secret security clearances and/or has direct patient care responsibilities (e.g., Chiefs, Nursing Service are included because Registered Nurses are covered).

Non-SES Directors  
 Associate Directors  
 Assistant Directors of all VA field facilities  
 VHA Service Chiefs  
 VBA Division Chiefs  
 Regional Counsels  
 GS-15 positions in Headquarters

**Section 2. Presidential Appointees:** Presidential Appointees in VA are as follows (Note: in accordance with Executive Order 12564, these are drug testing designated positions):

Secretary  
 Deputy Secretary  
 Inspector General  
 General Counsel  
 Under Secretary for Health

Under Secretary for Benefits  
Under Secretary for Memorial Affairs  
Chairman, Board of Veterans' Appeals

Date \_\_\_\_\_

Service Manager, Human Resources Management Service (05)

**30-Day Specific Notice – Random Drug Testing**

Name of Employee \_\_\_\_\_ Position Title \_\_\_\_\_

1. On September 15, 1986, the President signed Executive Order 12564, Drug-Free Federal Workplace, establishing a policy against the use of illegal drugs by Federal employees, whether on or off duty. In accordance with the Executive Order, VA has established a Drug-Free Workplace Program to include random testing for the use of illegal drugs by employees in sensitive positions.
2. This is to notify you that your position is sensitive as defined in Section 7(d) of the Executive Order and has been designated as a testing designated position; and therefore, you will be subject to random drug testing. The testing procedures, including the collection of a urine specimen, will be conducted in accordance with Department of Health and Human Services (HHS) Guidelines for Drug Testing Programs. Random testing will begin no sooner than thirty days from the date you receive this notice.
3. You can be assured that the quality of testing procedures is tightly controlled, that the test used to confirm use of illegal drugs is highly reliable and that the test results will be handled with maximum respect for individual confidentiality, consistent with safety and security.
4. As an employee subject to random drug testing you should be aware of the following:
  - a. Counseling and rehabilitation assistance will continue to be available to all employees through existing Employee Assistance Programs (EAP) at VA facilities. **VASNHS EAP points of contact are Pat Duncan, LCSW, ext. 4433 and Sean Zielinski, Ph.D, ext 4405, Mental Hygiene Clinic.**
  - b. You will be given the opportunity to submit supplemental medical documentation of lawful use of an otherwise illegal drug to a Medical Review Officer.
  - c. VA will initiate action to discipline any employee who is found to use illegal drugs on the basis of a verified positive drug test except that VA will not initiate any disciplinary action against an employee who voluntarily identifies him or herself as a

user of illegal drugs prior to being notified of a scheduled drug test, obtains counseling or rehabilitation, and thereafter refrains from using illegal drugs.

**VA HANDBOOK 5383.1**  
**APPENDIX B**  
**Attachment B**

d. Removal action will be initiated against an employee who is found to use illegal drugs and who refuses to obtain counseling or rehabilitation through an Employee Assistance Program.

e. You have the opportunity to voluntarily identify yourself as a user of illegal drugs willing to receive counseling or rehabilitation, in accordance with paragraph 4c of this notice, in which case disciplinary action will not be taken.

f. An employee found to use illegal drugs will be referred to VA EAP. Such referral, however, does not preclude institution of disciplinary proceedings.

g. VA will initiate action to remove from service any employee who is found to use illegal drugs a second time.

h. An employee found to use illegal drugs will not be allowed to remain on duty in a sensitive position prior to successful completion of rehabilitation through an EAP. However, as part of an EAP, the authorized VA official may, in his/her discretion, allow an employee to return to duty in a sensitive position if it is determined that this action would not pose a danger to public health or safety or national security.

i. Disciplinary action up to and including removal will be initiated against any employee who refuses to be tested.

5. You may contact **Vicky King, Assistant Chief, Human Resources, 636-3033** for additional information regarding the VA Drug-Free Workplace Program.

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Vicky L. King, Program Coordinator

Date

**VA HANDBOOK 5383.1**  
**APPENDIX B**  
**Attachment B**

Department of Veterans Affairs, Southern Nevada Healthcare System (05)

Acknowledgment of Notice of Employee Whose Position is Designated Sensitive for  
Drug Testing Purposes

I acknowledge receiving and reading the notice which states that my position has been designated for random drug testing, and that refusal to submit to testing will result in initiation of disciplinary action, up to and including removal.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

TO:

**This acknowledgment may be typed on the notice or retained separately.**

### **Fire Protection /Evacuation Plan**

1. **PURPOSE:** To establish guidelines for employees to follow in the event of a fire and during fire drills.

2. **POLICY:** To provide a safe working environment to develop and implement evacuation procedures in the event of a fire at the VA Southern Nevada Healthcare System (VASNHS) facilities. VA employees at the Mike O'Callaghan Federal Hospital (MOFH) will follow Air Force policy on fire evacuation procedures.

3. **ACTION:**

a. Procedures for Responding to a Fire:

(1) When a fire is discovered, the nearest fire alarm box will be activated in those VASNHS facilities that are equipped with them. Facilities that do not have fire alarm boxes will call 9-911, upon discovery of fire, and a call will be placed to the Directors Office Ext 3100 / 3010. Facilities that do have Security Officers will also notify them as well.

(2) The center handle on the fire alarm box is pulled completely down to activate the alarm.

(3) Once the alarm is activated, emergency number 9-911 will be called. The operator will be given the scope and location of the fire.

(4) When an alarm is sounded or fire is discovered:

(a) Proceed immediately to assist in the evacuation (RACE) Rescue, Alarm, Contain, Extinguish / Evacuate of patients, visitors and any handicapped person from your immediate area to outside parking lot, remaining at least 100 ft. from the building. Personal effects will be needed if you are unable to return to your worksite, should be taken when evacuating

(b) Do not block the parking lot from incoming Fire Department vehicles.

(c) Upon exiting, close all doors and leave lights on (KEEP DOORS UNLOCKED).

(d) Await further instructions from the Security, Site Manager or designee.

(e) If on the SECOND FLOOR, DO NOT USE THE ELEVATORS.

(5) Stairwell: Direct handicapped persons to the nearest stairwell and standby with persons until Fire Department arrives to assist them down the stairs. If immediate evacuation down stairwell is deemed necessary, then assist them down stairs following wheelchair evacuations procedures.

b. Procedures for Fire Drills:

(1) Fire drills will be conducted at least once a year at Business Occupancies. When the alarm is sounded, the Site Manager will contact Directors Office @ 3100/ 3010 and building security to inform them of the drill and all employees will comply with the above directions. In a fire drill, employees will use clinical judgment in deciding whether or not to interrupt a patient's treatment.

(2) Handicapped persons in facilities that have a second floor will be moved to the stairwells following evacuation of able-bodied persons down stairwells but not immediately assisted out of the building.

(3) Upon completion of the fire drill, "All Clear", will be announced by Security, Site Manager or designee and or the Safety Officer. At this time, it is clear to re-enter the building.

(4) Fire drills will be critiqued by the Safety Officer, Site Manager, and Security Officer if available and then submitted to the Environment of Care Council (ECC) for review and appropriate recommendations. The recommendations will be forwarded to the Director for review and approval.

**4. RESPONSIBILITIES:**

a. Employees are responsible for:

(1) Reporting fires, sounding the alarm and notifying 9- 911 of the scope and nature of the situation.

(2) Providing assistance in the evacuation of patients and employees from the building.

(3) Being knowledgeable of their Site-Specific Fire Plan.

(4) Participating in fire drills.

b. Each Care Line /Service Chiefs and Site Managers will be responsible for the evacuation of their respective areas including assignment of employees to assist in the evacuation, especially the handicapped. A list of employees in each Service/Care Line or



Section will be maintained in the supervisor's area to reference during evacuation emergencies accounting for employees during evacuation.

c. Care Line /Service Chiefs will provide each new employee with a full safety orientation, (part of the Service Safety Policies), within thirty (30) days following employment and will review all related procedures annually.

d. The Security Officers or Site Manager are responsible for:

(1) Assessing and determining the need for evacuation.

(2) Notifying the Director's office immediately of the situation.

(3) Ensuring the Clinic is clear, fire/smoke doors are closed and evacuation from building is complete.

(4) Directing the Fire Department to the fire and nearest water source.

e. The Safety Officer is responsible for:

(1) Conducting fire drills at regular intervals to ensure employee proficiency in fire safety.

(2) Providing all employees with fire safety training annually.

(3) Ensuring Contract Security is trained on VA Fire plan and procedures.

(4) Ensuring that designated employees of business occupancies are periodically instructed in the use of portable fire extinguishers.

f. Human Resource Management Service (HRMS) is responsible for providing each new employee with a copy of this policy as part of the employee orientation.

## 5. **REFERENCES:**

VHA Directive 7700 and Handbook 7700.1, Occupational Safety and Health and National Fire Protection Association ( NFPA) 101, Life Safety Code, 2009.

6. **RESCISSION:** Medical Center Memorandum 02-03-08 dated [August 2006](#)

7. **RECERTIFICATION:** February 2013

Concur/Do Not Concur

Ramu Komanduri, MD  
Chief of Staff

Concur/Do Not Concur

Susan Kane, FACHE  
Associate Director

Concur/Do Not Concur

Shirley L. Caldwell-Butts, MSM, RN  
AD Patient Care / Nurse Executive

Approved/Disapproved

John B. Bright  
Director

## **VIOLENCE IN THE WORKPLACE PREVENTION**

**1. PURPOSE:** This memorandum establishes a policy to promote a safe working environment for all employees, patients, visitors and contractors. This policy is intended to protect any person at or in any way connected with this workplace. All employees are required to report incidents of workplace violence in accordance with the procedures outlined below.

**2. POLICY:** Violent or threatening behavior will not be tolerated at any VA Southern Nevada Healthcare System (VASNHS) location. Immediate actions will be taken to eliminate/minimize violent behavior upon notification of appropriate staff. Persons committing acts of violence or threats will be reported to the VA Police Service at ext 3052 or 653-3280 at the Michael O'Callaghan Federal Hospital (MOFH) and will be prosecuted to the fullest extent of the law allowed. Appropriate disciplinary action will be instituted against employees that are verbally or physically aggressive.

**3. ACTION:**

a. All employees are prohibited from committing acts or threats of violence at or in connection with the workplace as defined below.

(1) For the purpose of these procedures, violence is defined as:

(a) The unjustified use of physical force.

(b) An act or threat of violence in any form or manner, which is intended or which could be reasonably foreseen to intimidate, or cause fear of harm.

(2) Employees in violation of this procedure will be subject to disciplinary action up to and including termination of employment.

b. Employees who have been the recipients or observers of violence or threats of violence as defined above are to proceed as follows:

(1) Report each incident to your immediate supervisor and VA Police & Security immediately after the incident as possible.

(2) In emergency situations, employees are to proceed as follows:

(a) Protect yourself from harm

(b) Dial 3052 and/or click on the "Police Emergency" computer desktop icon to report the emergency;

(c) Notify any available supervisor.

(3) Employees who have been threatened by or feel that they may be recipients of violence in the workplace from co-workers, patients, family, etc. are to proceed as follows:

(a) Notify your immediate supervisor as soon as possible.

(b) Contact VA Police & Security at extension ext 3052 or 653-3280 (MOFH) and provide them necessary information to include names, descriptions of person(s), copies of photos, copies of restraining orders, etc. This will allow VA Police to conduct a thorough investigation and coordinate efforts with outside law enforcement agencies.

c. All employees have the right to seek confidential assistance through the Employee Assistance Program to deal with any issues of violence wherever they may happen, including outside of the workplace. Supervisors will advise employees as to the availability of the Employee Assistance Program, but participation is strictly voluntary.

#### **4. RESPONSIBILITY:**

a. Medical Facility Director is responsible to ensure that employees and volunteers are provided as safe a working environment as possible.

b. Chief, Police and Security Service will serve as the facility Workplace Violence Prevention Program Coordinator and is responsible to:

(1) Investigate when anyone is assaulted as a result of direct/indirect employment-related involvement with the workplace.

(2) Notify the Office of the VA OIG and provide all information in order for completed joint investigation, where possible.

(3) Ensure that all High Risk employees (Nurses, Mental health personnel) are provided Prevention and Management of Disruptive Behavior Training. Training is a hands-on 8 hours course and can be scheduled under the mandatory training for employees on the VASNHS home page. Other VA Employees can obtain the web-based training located under the mandatory training for VA personnel. Service Chiefs that employ staff that do not have access to a medical center computer can request training through the office of the Chief, Police & Security Service.

(3) Review the facility's Violence in the Workplace Prevention Program to insure that the Program is current and that it addresses the needs of the VASNHS.

(4) Review incident investigation reports prepared by supervisors, to conduct incident investigations, as deemed appropriate, and to identify corrective actions to preclude incidents of violence at the VASNHS.

(5) Provide the facility Environment of Care Committee annual reports concerning Program effectiveness.

c. Supervisors are responsible to:

(1) Enforce VASNHS safety rules, regulations, and standards including those concerning violent behavior.

(2) Identify unsafe conditions and practices in the area of his/her responsibility and to take prompt corrective action, as appropriate.

(3) Notify VA Police & Security at extension 3052 or 653-3280 (MOFH) of work-related threats/acts of violence /injuries that occur to employees or to volunteers under his/her supervision.

(4) Initiate appropriate actions when witnessing patients in violent behavior injured as a result.

(5) Investigate threats/acts of violence/injuries that occur to employees/volunteers under their supervision, to document this investigation on a "Report of Contact" and VA Form 2162, "Report of Accident", and to institute/recommend corrective actions intended to preclude recurrence of similar threats/acts of violence/injuries.

(6) Ensure that employees under their supervision receive prompt and appropriate medical attention in the event of injury.

(7) Complete CA-1/2 compensation forms, when appropriate.

(8) Instruct employees/volunteers under their supervision in safe work practices and to correct employees/volunteers that do not follow safe work practices.

(9) Ensure that employees/volunteers verbally/physically assaulted, who witness violence in the workplace, or who have demonstrated warning signs associated with potential violent behavior, are provided counseling and professional support, as appropriate.

(10) Initiate appropriate disciplinary action against employees/volunteers who assault/threaten anyone.

(11) Ensure that all employees/volunteers assigned to them complete appropriate Annual Mandatory Violence in the Workplace Prevention training, which can be located on the Southern Nevada Healthcare System web site ([http://vaww.las-vegas.med.va.gov/v22Training/courseList/las\\_DB-CPIR/index.htm](http://vaww.las-vegas.med.va.gov/v22Training/courseList/las_DB-CPIR/index.htm)).

d. Employees/Volunteers are responsible to:

- (1) Follow safe work practices (those that minimize the potential for violent behavior).
- (2) Recognize unsafe conditions and immediately take corrective action to eliminate those unsafe conditions, which are under his/her control.
- (3) **Report unsafe or stressful conditions with a potential for violence to supervisory personnel and VA Police& Security at 3052 or 653-3280 (MOFH)**
- (4) Report work-related injuries to supervisory personnel.
- (5) Notify supervisor and VA Police when witnessing anyone acting violently or being injured as a result of violence.
- (6) Complete Report of Contacts and Police & Security witness statements and participate fully with investigating officials regarding any follow-up investigations.
- (7) Attend OSHA training related to Violence in the Workplace Prevention.
- (8) Attend counseling and support meetings, as appropriate.

**5. REFERENCES:** OSHA Guidelines for the Prevention of Workplace Violence.

**6. RESCISSION:** MCM 02-07-11 "Violence in the Workplace Prevention", dated January 2007.

**7. RECERTIFICATION:** June 2013

Concur / Do Not Concur

Concur / Do Not Concur

Ramu Komanduri, MD  
Chief of Staff

Shirley L. Caldwell-Butts, MSN, RN  
AD Patient Care/Nurse Executive

Concur / Do Not Concur

Approved / Disapproved

Deborah Dort, M.D.  
Acting Associate Director

John B. Bright  
Director

### **Facsimile (Fax) Policy**

1. **PURPOSE:** To provide guidelines for receiving or transmitting information via facsimile (fax).

2. **POLICY:** Fax machines may be used to transmit VA documents including medical records provided Federal statutes and VA policies are followed, and if proper precautions are taken; including the use of the attached VASNHS approved fax transmittal cover sheet containing a conspicuous confidentiality statement. Fax Individually Identifiable Information (III) only when absolutely necessary.

3. **ACTION:**

a. Definitions:

(1) Employees: Administrative staff, managers, medical staff, nurses, allied health professionals, residents, students, volunteers, contractors, and others providing regular and ongoing services.

(2) Individually Identifiable Information (III): Any information, including health information maintained by VHA, pertaining to an individual that also identifies the individual, and is retrieved by the individual's name or other unique identifier.

(3) Individually-Identifiable Health Information (IIHI): A subset of health information, including demographic information collected from an individual, that is:

(a) Created or received by a health care provider, health plan, or health care clearinghouse;

(b) Relates to the past, present, or future condition of an individual and provision of or payment for health care; and

(c) Identifies the individual or a reasonable basis exists to believe the information can be used to identify the individual.

(4) **Protected Health Information (PHI):** Individually identifiable health information maintained, in any form or medium.

b. Process:

(1) Location: Fax machines for receiving PHI must be in non-public, secure areas. The Care Line Manager is responsible for limiting access to their use.

(2) Authorized recipients: Transmit PHI only to authorized recipients for the purpose of providing treatment, arranging payment or conducting health care operations; approved business associates of the facility or others with current data use agreements; to fulfill legally mandated regulatory reporting requirements; or when required by a third-party payer for payment for services rendered.

(3) Authorizations for disclosure: Except as above or as authorized by law, obtain a properly completed and signed authorization for disclosure of PHI before releasing patient information via fax.

(4) Sensitive medical information: Do not send especially sensitive medical information by fax, including, but not limited to, AIDS/HIV, mental health and developmental disability, alcohol and drug abuse, suspected sexual assault and child abuse, or sexually transmitted disease information.

(5) "Minimum Necessary" information: Limit PHI transmitted by fax to only that which is the minimum necessary to meet the requestor's needs.

(6) Confidentiality statement required: The fax cover page accompanying the fax transmission must include the number of pages, the name of the intended recipient, the name and phone number of the person sending the information and the facility's standard confidentiality notice (see Attachment).

(7) Accuracy in transmission:

(a) Transmit III via fax, when no other means exists to provide the requested information in a reasonable manner or timeframe; or when absolutely necessary. Limit fax machine transmittals to an immediate need to know.

(b) Each time a fax is sent, confidentiality may be breached. Breaches include faxes sent to unauthorized recipients, faxes intercepted or lost in transmission, and faxes not received by the intended recipient.

(c) Make reasonable efforts to ensure the fax is transmitted to the correct destination.

1 Verify the fax number before faxing III.

2 Notify the recipient before faxing III to ensure someone is there to receive the information; otherwise do not fax.

3 Check the fax confirmation slip to be sure that the confidential III went to the proper destination. If in error, immediately contact the incorrect recipient for return or shred of fax.

4 Call the recipient to verify receipt.



5 Protect fax machines by using a sensitive data cover sheet over the area where faxed information is received. No information should be left on a fax machine during normal duty hours.

6 Information received via fax after hours should be left on the fax machine under the sensitive data cover sheet until administrative staff return. Administrative staff should, upon arrival each morning immediately remove items from the fax machine and distribute appropriately.

(d) Pre-Programmed Numbers: For frequently used numbers, pre-program and test destination numbers whenever possible to eliminate errors in transmission from misdialing. Periodically remind those who are frequent recipients of III to notify the facility upon fax number changes. Departments will verify pre-programmed fax numbers annually and maintain a copy of the review including any deletions/additions made.

(e) For infrequently used numbers, verify the fax number before sending the document.

(8) Handling incoming fax messages: Each care line is responsible for ensuring incoming faxes are promptly distributed to the intended recipient, handled to protect confidentiality, and safeguarded until delivered to the recipient.

(9) Faxes received in error: Immediately notify the sender if a fax containing PHI is received in error; destroy after sender notification and/or attempted notification.

(10) Violations of fax policy: Report violations of this policy immediately to the supervisor and the Privacy Officer.

(11) Enforcement of fax policy: Care Line/Service Chiefs and Managers are responsible for enforcing this policy. Employees who violate this policy are subject to discipline up to and including termination of their relationship with the VA Southern Nevada Healthcare System.

(a) The attached VHA fax transmittal cover sheet is the official cover sheet adopted for use by the VASNHS. Discontinue use of any other fax transmittal cover sheets. The MCM identifying number, the word Attachment, and the page number, will be omitted prior to use.

(b) As appropriate, the various services/sections/units may overprint the attached fax transmittal cover sheet to fit their needs. Any overprint should include the fax number of the service/section/or unit identified for use.

#### **4. RESPONSIBILITIES:**

- a. Employees are responsible for ensuring that only the official fax transmittal cover sheet is used.
- b. Employees are responsible for preparing a Report of Contact (VA Form 119) when information is faxed to the wrong destination, with a copy to the Privacy Officer. (See VASNHS intranet under Administrative Links, then VASNHS/MOFH Forms, and click on VA Form 119).
- c. Care Line/Service Chiefs are responsible for ensuring that the fax transmittal cover sheet attached to this MCM is used in their service as it includes the appropriate confidentiality statement as shown at the bottom of the form.

**5. REFERENCES:**

VHA Directive 1907.1, dated August 25, 2006  
VHA Handbook 1605.1, Privacy and Release of Information, dated May 17, 2006

**6. RESCISSION: MCM 02-07-27, "Facsimile Policy," dated May 2007.**

**7. RECERTIFICATION: February 2013**

Concur/Do Not Concur

Concur/Do Not Concur

Ramu Komanduri, MD  
Chief of Staff

Shirley L. Caldwell-Butts, MSN, RN  
AD Patient Care/Nurse Executive

Concur/Do Not Concur

Approved/Disapproved

Susan Kane, FACHE  
Acting Director

John B. Bright  
Director

Attachment

**Care Line/Service Chief**

In reply refer to: 593/and routing code

Clinic Location  
Clinic Address

Las Vegas, NV 89030

**Mailing Address: PO Box 360001**  
**North Las Vegas, NV 89036**

**Telephone: 702-636-3000 Extension :**  
**Fax: 702-636-**

**VA SOUTHERN NEVADA  
HEALTHCARE SYSTEM**



*A Division of VA Desert Pacific  
Healthcare Network*

**Fax**

To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Re: \_\_\_\_\_ CC: \_\_\_\_\_

☐ Urgent    ☐ For Review    ☐ Please Comment    ☐ Please Reply    ☐ Please Recycle

●Comments:

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This fax is intended only for the use of the person or office to which it is addressed and may contain information that is privileged, confidential, or protected by law. All others are hereby notified that the receipt of this fax does not waive any applicable privilege or exemption for disclosure and that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please notify this office immediately at the telephone number listed above.

### **Patient Scheduling**

1. **PURPOSE:** To define policy, procedures, and responsibilities to schedule outpatient appointments.
2. **POLICY:** The VA Southern Nevada Healthcare System (VASNHCS) is committed to providing clinically appropriate quality care for eligible Veterans when they want/need it.
3. **ACTION:**
  - a. Definitions:
    - (1) **Desired date**-the desired appointment date is the date on which the patient or provider wants the patient to be seen.
    - (2) **New Enrollee**-a new enrollee is a previously non-enrolled Veteran who applies for VA health care and enrollment by submitting VA Form 10-10EZ, Application for Health Benefits.
    - (3) **New Patient**-any patient not seen by a qualifying provider type within a defined stop code or stop code group at the facility within the past 24 months.
    - (4) **No-show**-a patient who does not physically show at all for a scheduled appointment or does not call to cancel an appointment the same day the appointment occurs.
    - (5) **Electronic Wait List (EWL)**-used to list patients waiting to be scheduled or waiting for a panel assignment with a clinic or Team with whom the patient does not have an established relationship.
    - (6) **Recall Reminder**-used to manage appointments scheduled beyond the 3 to 4 month scheduling window
    - (7) **Encounter**-a contact between a patient and a provider for the purpose of diagnosing, evaluating, and treating the patient's condition. Includes face-to-face, properly documented telephone visits but not e-mail communications or those activities incidental to a provider visit such as taking vital signs, giving injections, etc.
  - b. All outpatient clinic scheduling profiles are entered in Veterans Health Information Systems Technology and Architecture (VistA).
  - c. All staff who schedule appointments will ensure correct entry of desired date for an appointment.

d. All staff that has the ability to impact outpatient scheduling activities will complete mandatory annual training.

e. For New Patients:

(1) Staff needs to ask the patient when they would like to be seen-this becomes the desired date.

(2) Once the desired date is established it must not be altered based on a clinic's capacity and the appointment is made on or as close to the desired date as possible.

(3) If a patient cannot be provided an appointment due to a clinic's capacity and all other avenues have been exhausted (Fee Services) the patient must be placed on the EWL and notified that they are on the wait list.

(4) If a Team's panel is full and a patient cannot be accommodated by assignment in another PC Team, the patient must be placed in the PCMM EWL for the Team they wish.

f. For Established Patients:

(1) A provider must document the return date in CPRS and must specify if the return appointment is for a specific day or a general timeframe.

(2) Staff needs to tell the patient that the provider wants to see them again, giving them the provider's specified date or general timeframe, and asking when the patient would like to be seen. The date the patient provides is the desired date.

(3) If a patient needs a follow-up appointment but cannot be immediately scheduled, this need is to be recorded in Recall Reminder.

g. Clinic cancellations should be kept to a minimum and provider leave should be planned as far in advance as possible to minimize conflicts.

h. When an appointment is cancelled and rescheduled by the clinic, the scheduler must enter the desired date from the cancelled appointment as the desired date for new appointment.

i. Tracking all unused appointments including no-shows, patient cancellations, and unscheduled appointment slots must occur to properly evaluate utilization of a clinic.

j. Annual competency assessments must occur with all staff that has impact on scheduling activities to include PCMM, EWL and Recall Reminder.

#### **4. RESPONSIBILITIES:**

- a. The Chief of Staff (COS) and the Associate Director (AD) have the overall responsibility to ensure patients are seen timely, appointments are made appropriately and clinical staff is available to meet the demand of patients.
- b. The Chief, Health Administration Service (HAS) in coordination with the Clinical Care Line Chiefs has the primary responsibility for outpatient scheduling activities.
- c. The Chief, HAS or designee will maintain the Master List of Schedulers to ensure continuity and mandatory training has occurred.
- d. Clinical Care Line/Service Chiefs or designees are responsible to ensure that the appropriate level and number of clinical staff are available to meet the demand of patients to be seen.
- e. Clinic Administrators and Clinical Care Line/Service designees are responsible to ensure that outpatient clinic appointments are monitored and utilized appropriately within VHA guidelines.

**5. REFERENCES:**

VHA Directive 2010-027, VHA Outpatient Scheduling processes and Procedures; Public Law 104-262; Title 38 United States Code (U.S.C.) Sections 1710 and 1703, 1705;  
Code of Federal Regulations, 17.52, 17.100, 17.36, 17.37, 17.38, and 17.49;  
CBO Procedure Guide 1601B.03, Outpatient Care.

**6. RESCISSIONS: MCM 02-05-42, Patient Scheduling, dated August 2005**

**7. RECERTIFICATION: October 2013**

Concur / Do Not Concur

Concur / Do Not Concur

Ramu Komanduri, MD  
Chief of Staff

Shirley L. Caldwell-Butts, MSN, RN  
AD Patient Care Services/Nurse Executive

Concur / Do Not Concur

Approved / Disapproved

Maria R. Andrews, MS, FACHE  
Associate Director

John B. Bright  
Director

### **Dress Code/Staff Image Policy**

1. **PURPOSE:** To provide standard guidelines for the dress, hygiene, and appearance of employees of VA Southern Nevada Healthcare System (VASNHS) in order to present a customer-focused, appropriate and professional image to patients, visitors, and staff and to adhere to required safety standards. These general guidelines apply to all employees, trainees, volunteers and contract staff regardless of the level of customer contact. This policy is relevant to all employees. Employees required to wear a uniform will follow the appropriate uniform policy regarding clothing as well as the general appearance standards contained in this policy.

2. **POLICY:**

a. The policy of the VASNHS is to project pride and self-awareness to the Veterans and other customers we serve. Professional dress and demeanor demonstrates respect for our customers, contributes to the overall image of the VASNHS, and builds customer confidence.

It is the policy of the VASNHS that employees wear appropriate clothing suitable to the professional health care environment and maintain standards of personal hygiene and grooming that promote safety and enhance infection prevention and control.

b. The accepted style of dress for VASNHS employees who are not required to wear a uniform is “Business Casual”. In general, business casual style of dress means dressing professionally, looking comfortably relaxed, yet neat and orderly in appearance.

c. All employees will be furnished a copy of this policy. New employees will receive a copy of this policy during New Employee Orientation and it will be reviewed by the appropriate supervisor during the service-level orientation.

d. Maintaining employee and customer safety is paramount.

3. **ACTION:**

a. Identification (ID) badges must be worn at all times in clear view, above the belt, with the employee’s name and picture visible. They may be attached to a necklace, chain or cord, subject to local safety practices.

b. Personal hygiene is essential for portraying a professional environment. Employees should be conscientious of good oral/personal hygiene and cleanliness at all times.

c. Strong smelling perfumes, colognes, or after-shave lotions are to be avoided, as strong scents can be offensive.

d. Employees who violate this policy are subject to the standards of progressive discipline. Employees will not be permitted to remain on duty if dressed in inappropriate attire and will be required to arrange leave status with the supervisor.

e. It is the prerogative of the Director to designate when/if the personal attire policy may be relaxed and to designate a “casual day”.

f. Exceptions to this policy are subject to the following guidelines:

(1) Exceptions may be made by a supervisor for special duties such as for the purpose of packing in preparation for a move;

(2) Requests for a deviation from the policy based on religious, ethnic, financial, or other needs will be made in writing to the Director for approval through the Service Chief for concurrence, Human Resources for technical review, and through the appropriate senior manager (Associate Director, Chief of Staff, AD/PCS Nurse Executive) for recommended approval;

(3) Requests for a deviation from the policy based on a medical issue not related to a disability will be considered expeditiously. Pending the outcome of the request, the employee may be detailed to another appropriate assignment.

(4) Requests for exceptions based on a disability will be submitted through the Service Chief in accordance with MCM-05-13, Reasonable Accommodation for Employees and Applicants with Disabilities.

g. General Guidelines:

(1) Clothing: All clothing will be neat, clean, in good repair, and appropriate to the position. Articles of clothing that are considered **inappropriate** include:

(a) Jeans worn by management or supervisory staff (Note: non-supervisory staff may only wear pressed, tailored, solid-colored jeans and only if worn with a collared or tailored shirt/top, or sweater);

(b) Slacks, including jeans, that are dirty, faded, worn, tie-dyed, torn, ripped, tattered, ill-fitting;

(c) Slacks worn above the ankle such as capri/cigarette/clam digger/peddle pusher;

(d) Sagging or low-rise slacks that reveal underwear; long, dragging, oversized or tight slacks



(e) Shorts, skorts, culottes, and stretch pants (Note: The Director may make an exception to allow appropriate shorts for employees who do not interact with patients and work in an excessively hot environment. In all cases, the shorts must be knee length and tailored.)

(f) Athletic wear such as sweatshirts and sweat pants, spandex, wind suits, and warm-ups;

(g) Miniskirts, shorts, skirts and dresses of a length that cause disruptions to the work group;

(h) Tank tops, clothing with spaghetti straps, muscle shirts, tube tops, and halter tops, unless sufficiently covered with a less revealing top, sweater, or jacket;

(i) Inappropriately revealing, sheer or see-through clothing; clothing that reveals cleavage, midriffs or other private body parts;

(j) Pajamas;

(k) T-shirts (except for VA or AFGE-approved logo wear);

(l) Garments with hate messages, sexual overtones, profanity, racial, and discriminatory slogans or messages;

(m) Hats, caps, skull caps, do rags, head wraps, or bandannas (except as part of a required uniform, part of cultural or religious attire, VA or AFGE-approved logo wear, or are otherwise necessary for safety/sanitation).

(2) Footwear:

(a) All footwear must be kept neat and clean;

(b) Footwear must be conducive to a quiet and safe health care environment: shoes that have taps or cleats or are otherwise excessively noisy are considered inappropriate;

(c) Clean sport shoes such as tennis and walking shoes are permissible;

(d) Flip-flops, thongs, beach sandals, “Croc” type footwear with holes, and house slippers are not permitted unless a reasonable accommodation for medical purposes is approved and safety concerns are minimal. Determinations made regarding the safety of footwear will be made in accordance with applicable laws, rules, and regulations regarding safety;

(e) For safety purposes, excessively high heels are not permitted;

(3) Jewelry, Medallions, and Buttons:

(a) Jewelry must be tactful and kept to a minimum;

(b) Political campaign buttons or advertisements are prohibited;

(c) Pins that represent time in service, customer service awards, nursing or school pins, CFC, charitable organizations, Veteran service organizations, VA Union affiliation, and patriotism may be worn;

(d) Employees who work around machinery may not wear hanging jewelry that may constitute a safety hazard to themselves or others.

(4) Fingernails:

(a) Natural nails are to be trimmed and kept clean;

(b) Nail polish, if not chipped, is permitted;

(c) Artificial nails, acrylic overlays, tips, extenders, gels, silk wraps, and nail jewelry may not be worn by personnel who are direct patient care providers, food service workers, or those preparing I.V. solutions.

(5) Eyewear: Dark-colored/sun glasses will not be worn inside the facility unless a medical statement is presented or the employee provides acceptable justification; standards of reasonable accommodation will apply.

(6) Hair: Hair, beards, sideburns and mustaches are to be clean, neatly groomed and must not interfere with or compromise safety standards.

(7) Tattoos: Tattoos will not negatively impact the professional image of the VA or our mission to the Veteran and their beneficiaries. Tattoos that are offensive, suggestive, obscene, sexually explicit, vulgar, politically incorrect, or demonic will be covered with proper clothing.

(8) Special Guidelines for Employees who are Direct Patient Care Providers (A “direct patient care provider” for the purpose of this policy is defined as one required to wear gloves in the performance of duty):

(a) Hanging jewelry, medallions or chains are not permissible where such items constitute a safety hazard or interfere with normal work production;

concern;

(b) Plain band rings may be worn if it would not pose a safety

(c) Small stud earrings are permissible (earrings that dangle are not permitted);

(d) Body jewelry other than earrings is not permissible;

(e) Closed-toed shoes must be worn at all times;

(f) Natural nails are to be trimmed and kept clean;

(g) Artificial nails, acrylic overlays, tips, extenders, gels, silk wraps, and nail jewelry are unacceptable for staff that work in the Emergency Department, Operating Room, Intensive Care Unit, or Post Anesthesia Recovery Unit (PACU); polished natural nails are permitted except for Operating Room Scrub Techs;

(g) Hair longer than shoulder length must be pulled back and contained.

(9) Electronic Equipment:

(a) Blue-tooth devices are prohibited from being worn by staff and volunteers in the performance of their duties during their working hours;

(b) Personal cell phones will be placed on vibrate or silent during working hours;

(c) Except in emergency situations, employees will refrain from making or answering personal calls during working hours except while on break or lunch;

(d) Cell phones are not to be used in areas posted as restricted for such use;  
Wireless headsets for VA telephone systems are permissible, if authorized;

(e) I-Pods, MP3 players, music headphones, personal information technology (IT) equipment, or any similar devices will not be used, worn, or displayed by staff or volunteers during working hours except while on lunch or breaks; personal IT equipment will not be connected to VA Information Systems

**4. RESPONSIBILITIES:**

a. Care Line, Service Chiefs and Supervisors are responsible for carrying out the provisions of this policy within their services and respective sections, addressing appropriate attire during the pre-hire interview and during New Employee Orientation, and establishing a service-level dress code policy to address specific service-level dress requirements within the scope and provisions of this policy. Service Chiefs/supervisors may allow short-term deviations from this policy for moving, cleaning or approved activity.

b. Human Resources Management Service is responsible for the overall administration of this policy. This responsibility includes overseeing policy and furnishing information and assistance to supervisory officials upon request.

c. Employees: Employees are responsible for adhering to the guidelines contained in this policy. Employees who have medical requirements that may cause a deviation from this policy will be required to provide a medical statement to their Care Line or Service Chief. Such requests shall be coordinated with Human Resources Management Service for final approval by the Director or designee.

5. **REFERENCES**: VA Employee Handbook; M-1, Part VII, Chapter 8, Employee Uniforms; OSHA CFR 29, Part 1910.136; MCM-05-10-13, Reasonable Accommodation for Employees and Applicants with Disabilities; AFGE Master Agreement, Article 29. Safety, Health, and Environment

6. **RESCISSION**: MCM 02-07-70, Proper Attire, dated February 2007

7. **RECERTIFICATION**: February 2015

Concur/Do Not Concur

Concur/Do Not Concur

Maria R. Andrews, MS, FACHE  
Associate Director

Shirley Caldwell-Butts, MSN, RN  
AD Patient Care/Nurse Executive

Concur/Do Not Concur

Approved/Disapproved

Ramu Komanduri, MD  
Chief Of Staff

John B. Bright  
Director

## SMOKING POLICY

### 1. PURPOSE:

a. To establish procedures to control smoking materials and provide a smoke-free environment at VA Southern Nevada Healthcare System (VASNHS) and to enhance safety for patient home oxygen use.

b. Cigarette smoking and secondhand smoke is widely recognized as major preventable causes of many disabling and lethal diseases today. Diseases caused by smoking include emphysema, bronchitis, and cancers of the lung, larynx, and bladder. Diseases for which smoking is a major contributory factor include coronary artery disease and peripheral vascular disease. VA, as the largest health care system in the country, has taken a leading role in disease prevention and health promotion. This is consistent with the weight of scientific evidence on the health effects of smoking, our obligation to provide a safe environment for patients, staff, and visitors, and the will of Congress as expressed in the preventative health provisions of P.L. 98-160.

### 2. POLICY:

a. All facilities and government vehicles in the VA Southern Nevada Healthcare System (VASNHS) are designated as smoke-free areas. This policy applies to all VASNHS facilities except the Mike O'Callaghan Federal Hospital (MOFH). Air Force policies apply at the MOFH. Smokers must avoid the enhanced fire hazard of supplemental oxygen systems.

b. Smoking is permitted ONLY in the designated areas and shelters. ***Thus, smoking is prohibited in all other areas including government vehicles, all buildings, all parking structures, near all external entrances at all locations within VASNHS.*** This policy applies to employees, volunteers, students, contract staff, patients, and visitors. The VA smoke-free policy has been implemented nationally at VA health care facilities and is consistent with VA's mission of health promotion and life safety. An exception to this policy may be granted where medically indicated as described in the smoking policy for patients with known or suspected tuberculosis, found later in this section.

c. Patient smoking: Indoor smoking is prohibited at all locations within VASNHS. Smoking in designated areas is prohibited if a patient uses portable oxygen. Inpatients who are being treated with therapeutic oxygen and who insist on smoking in designated areas will leave their oxygen supply on the ward or away from the designated smoking area.

d. Smoking areas will not be within 35 feet of any entrance of a VA health care or office building that is routinely used by patients, employees, volunteers, and/or other staff.

e. VASNHS will not participate in the sale of tobacco products. Free or discounted distribution of tobacco products by outside groups will not be permitted on VASNHS grounds or any locations.

f. Whenever possible, the designated smoking area for employees and staff needs to be separate from that of patients.

### **3. ACTION:**

a. Smoking is prohibited in all VASNHS buildings and leased spaces. Designated smoking areas are available at each operating location and will be used. Smoking outside on facility grounds is allowed to the extent that it does not interfere with safety and public access.

b. Smoking is prohibited in all Government-owned and leased vehicles and the contractor operated patient shuttles.

c. All employees are expected to assist in the promotion and enforcement of a smoke-free environment at all facilities within VASNHS. Individuals smoking in unauthorized areas will be asked to go outside to a designated smoking area or extinguish smoking materials. Tact and diplomacy should be used in all encounters.

d. Police and Security will report employee violations to the employee's supervisor. Supervisors are expected to take appropriate corrective action.

e. Smoking cessation clinics have been established through the Alcohol and Drug Treatment Program (ADTP) Coordinator to assist employees and patients who wish to stop smoking.

f. Employee smoking breaks will be included in, not in addition to, established breaks for all employees. Established break time for an eight-hour shift is 15 minutes in the morning, 30 minutes at lunch, and 15 minutes in the afternoon. For a twelve-hour shift there are three breaks, one per 4-hour period, with a 30-minute lunch.

g. Employees and/or supervisors not adhering to the provisions of this policy shall be subject to appropriate corrective action.

h. Oxygen cylinders and other oxygen delivery equipment are prohibited from designated smoking areas.

### **4. RESPONSIBILITY:**

a. Care Line / Service Chiefs and supervisors are responsible for enforcing the smoke-free environment policy. They shall ensure this policy is communicated to all of their employees and to take appropriate corrective action if violations occur.

b. Facility Management Service (FMS) is responsible for installing appropriate signage and cleaning of designated smoking areas.

c. Police and Security Service will assist in ensuring that all patients, visitors, volunteers, students, contract staff, and employees comply with this policy at locations patrolled by security personnel.

d. Mental Health Care Line is responsible for ensuring that smoking cessation classes and counseling sessions are available for patients and employees and offered on a recurring basis.

e. Human Resources Management Service is responsible for including discussion of the smoking policy in new employee orientation.

f. Voluntary Service is responsible for communicating the requirements of this policy to all volunteers and representatives of Veterans Service Organizations.

## **5. REFERENCES:**

VHA Directive 2008-052, Smoke-Free Policy for VA Health Facilities dated August 2008

VHA Directive 2008-081, National Smoking and Tobacco Use Cessation Program dated August 2003

Joint Commission Comprehensive Accreditation Manual for Ambulatory Care, July 2010

VHA Directive 2006-021, Reducing the Fire Hazard of Smoking when Oxygen Treatment is Expected, dated May 2006

**6. RESCISSION:** Medical Center Memorandum 02-09-83, "Smoking Policy", dated July 2009

**7. RECERTIFICATION:** August 2013

Concur/Do Not Concur

Concur/Do Not Concur

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Approved/Disapproved

Maria R. Andrews, MS, FACHE  
Associate Director

John B. Bright  
Director

### **Green Environmental Management Systems (GEMS) Policy**

1. **PURPOSE:** To assure that the VA Southern Nevada Health Care System (VASNHS) develops and implements an effective environmental management system consistent with Executive Order 13423, “Strengthening Federal Environmental, Energy, and Transportation Management” and Executive Order 13514, “Federal Leadership in Environmental, Energy, and Economic Performance”.
2. **POLICY:** The Mission of the VASNHS is to deliver quality healthcare to our nation’s veterans. In order to accomplish this mission, the VASNHS recognizes that it must operate so as to protect both the environment and the health and safety of patients, employees, and visitors. This Memorandum establishes a governing environmental policy to accomplish this mission.

### **3. ACTION:**

- a. Procedures: Refer to GEMS Standard Operating Procedures A-Z:

#### **STANDARD OPERATING PROCEDURES (SOPs)**

GEMS SOP A: Procedures  
GEMS SOP B: Air Quality Management  
GEMS SOP C: Affirmative Procurement Program  
GEMS SOP D: Bio-Hazardous Waste Management  
GEMS SOP E: Construction Waste Management  
GEMS SOP F: Energy Management  
GEMS SOP G: Fuel Storage Tanks, Underground (UST), Above Ground (AST)  
& Piping  
GEMS SOP H: Hazardous Material and Waste  
GEMS SOP I: Universal Hazardous Waste  
GEMS SOP J: Mercury (Hg) Pollution Prevention Program  
GEMS SOP K: Mercury (Hg) Reduction Program  
GEMS SOP L: Notification of Environmental Incidents  
(Spills/Releases/Discharges)  
GEMS SOP M: Lead Management and Abatement  
GEMS SOP N: Pollution Prevention Plan  
GEMS SOP O: Precautions in Handling Carcinogenic Chemicals and Cytotoxic  
Agents  
GEMS SOP P: Reclamation of Salvageable Material  
GEMS SOP Q: Silver Recovery Program  
GEMS SOP R: Storm Water Pollution Prevention Plan  
GEMS SOP S: Underground Storage Tanks  
GEMS SOP T: Waste Minimization Program  
GEMS SOP U: Hazardous Pharmaceutical Disposal and Waste Plan



GEMS SOP V: Department of Transportation Hazardous Materials Shipping  
Security Plan

GEMS SOP W: Reporting an Oil Spill at VASNHS Form

GEMS SOP X: Oil Spill Report Form

GEMS SOP Y: Management of Empty Containers

GEMS SOP Z: Repair, Renovation, and Work Order Projects

#### **4. RESPONSIBILITIES:**

a. All VASNHS employees must take the GEMS mandatory training courses and perform their functions consistent with regulatory requirements, VA environmental and other policies, and its overall mission.

b. The Director, VASNHS, is responsible for implementation of the GEMS program. Appoints key personnel, including the GEMS Coordinator and GEMS Committee members, to develop and implement the GEMS program.

c. GEMS Coordinator:

(1) The GEMS Coordinator is the Chairman of the GEMS Committee with technical expertise in environmental management systems and environmental technology and regulatory compliance.

(2) Coordinates the development and implementation of the VA Medical Center GEMS across organizational elements.

d. GEMS Committee: The GEMS Committee is composed of the following members and is tasked with the following responsibilities:

(1) Representing:

- (a) GEMS Coordinator
- (b) Chief of Facility Management Service
- (c) Industrial Hygienist
- (d) Information Technology
- (e) Infection Control
- (f) Logistics
- (g) Nursing
- (h) Pharmacy
- (i) Laboratory
- (j) Research
- (k) AFGE Local 1224

(2) Identifies significant aspects.

- (3) Sets targets and objectives and approves the plan to achieve them.
- (4) Approves the corrective action plans.
- (5) Monitors progress on achieving targets and objectives, implementation of GEMS, completion of corrective action plans and effectiveness of GEMS.
- (6) Submits an annual report on the effectiveness of the GEMS to the Director, VASNHS for approval.
- (7) Is responsible for ensuring that all aspects of this policy and implementation of the GEMS program maintain full compliance with all environmental laws, regulations and related statutes, VA policies and other environmental requirements.
- (8) Receive and document inquires from external public, private and regulatory organizations. These inquires will be routed through to the appropriate committee(s) or staff for response and resolution documented within the GEMS Committee minutes.

## 5. **REFERENCES:**

Executive Order 13423, Strengthening Federal Environmental, Energy, and Transportation Management  
 Executive Order 13514, Federal Leadership in Environmental, Energy, and Economic Performance  
 ISO 14001  
 VA Directive 0057, VA Environmental Management System and Governing Environmental Policy

6. **RESCISSION:** Medical Center Memorandum 02-07-39 dated September 2007

7. **RECERTIFICATION:** February 2013

Concur/Do Not Concur

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 Chief of Staff

Concur/Do Not Concur

Susan Kane, FACHE  
 Acting Associate Director

Concur/Do Not Concur

Shirley L. Caldwell-Butts, MSN, RN  
 AD Patient Care/Nurse Executive

Approved/Disapproved

John B. Bright  
 Director

## **EMPLOYEE CONDUCT**

1. **PURPOSE:** To describe policy, procedures and responsibilities for all employees in regards to conduct while employed at the VA Southern Nevada Healthcare System (VASNHS).

2. **POLICY:** Each VASNHS employee is expected to serve diligently, loyally, and cooperatively; to avoid misconduct and other activities which conflict with his/her employment; to conduct himself/herself both on and off duty in a manner that is creditable to the employee, the Federal government, the Department of Veterans Affairs (VA), and this Healthcare System. It is the policy of the VASNHS that each employee will exhibit sensitivity, compassion, and concern in dealing with veterans we serve. Failure to comply with conduct requirements may result in appropriate disciplinary action.

3. **ACTION:**

a. VA expects employees to interact with veterans, their families, and the general community with honesty, courtesy and compassion.

b. In return, employees will be treated in a fair and equitable manner.

c. Treatment of patients: The VA is committed to providing high quality care to its patients. Patients are in no way to be mistreated or abused, physically or verbally by a VA employee. The gross abuse of a patient will be cause for dismissal. Less severe penalties (counseling, reprimand, or suspension) may be imposed when the abuse is of a minor nature. However, speaking rudely to a patient, ridiculing a patient, indifference etc., may be deemed major abuse dependent on the circumstances. It is the responsibility of all employees to report any witnessed mistreatment of a patient.

4. **RESPONSIBILITIES:**

a. The Director is responsible for ensuring compliance with the Standards of Ethical Conduct.

b. Care Line/Service Chiefs and Supervisors are responsible for informing employees, at least annually, of the Standards of Ethical Conduct.

c. Human Resources Management Service (HRMS) is responsible for providing copies of Department of Veterans Affairs (VA) Regulations and this memorandum to all new employees; and providing assistance in the interpretation and application of the Standards of Ethical Conduct to employees, supervisors, and management officials.

d. Employees are responsible for:

(1) Becoming familiar with and following the laws and rules of conduct and related responsibilities.

(2) Assuring that any outside activities and/or employment do not conflict with VA responsibilities. Obtain prior authorization for such activities from Service Chiefs or HRMS when in doubt or when periodically required.

(3) Reporting to appropriate supervisors any information that gives reasonable cause to suspect that serious impropriety or criminal act (such as fraud, theft, or patient abuse) has occurred in an activity of the VASNHS. Employees who furnish such information shall not be penalized in any way.

(4) Avoiding any action that might result in or look as though they are:

(a) Using public office for private gain.

(b) Giving preferential treatment to any person, group or organization.

(c) Losing impartiality by giving in to influences or pressures from particular interests. This includes anything of monetary value offered to the employee or immediate family.

(d) Acting without authority or outside the scope of their jobs.

(e) Lowering the public's confidence in the government.

(5) Avoiding any discrimination on the grounds of race, color, sex, religion, national origin, politics, marital status, or handicap in any employment matter, or in providing benefits under any law administered by the VA.

(6) Refraining from attempts to accomplish indirectly through their immediate family or otherwise, any action which they are prohibited from doing directly.

5. **REFERENCES:** Standards of Ethical Conduct  
VHA Handbook 5025

6. **RESCISSION:** MCM 02-07-108, Employee Conduct, dated February 2007

7. **RECERTIFICATION:** February 2013

Concur / Do not Concur

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AD Patient Care/Nurse Executive

Approved / Disapproved

John B. Bright  
Director

## **Informed Consent**

1. **PURPOSE:** The purpose of this policy is to discuss the goals, scope, and key concepts related to patients informed consent for clinical treatments and procedures and the related responsibilities of the Veterans Administration Southern Nevada Healthcare System (VASNHS) staff with regard to informed consent; to recognize the patient's right to autonomous informed participation in making health care decisions; to establish a process for informing patients about health care options and obtaining consent prior to treatment; and to promote communication between the patient (or the patient's surrogate) and the health care team to help the patient achieve appropriate health goals.

2. **POLICY:**

a. In the Veterans Health Administration (VHA), patients have the right to accept or refuse any medical treatment or procedure recommended to them. All treatments and procedures require the prior, voluntary informed consent of the patient, or if the patient lacks decision-making capacity, the patient's authorized surrogate.

b. The scope of informed consent may be limited to a one-time, single treatment or procedure, or may encompass consent for routine care of a particular problem or condition (such as asthma), or for a series of treatments (such as dialysis). When the proposed treatment plan involves multiple or recurrent treatments and procedures, it is generally not necessary to repeat the informed consent discussion. There are, however, two circumstances where the informed consent discussion must be repeated and a new consent must be obtained:

(1) If there is a significant deviation from the treatment plan to which the patient originally consented, or

(2) If there is a change in the patient's condition or diagnosis that should reasonably be expected to alter the original informed consent.

3. **ACTION**

a. **DEFINITIONS:**

(1) **Best Interests:** The standard to be used by surrogate decision makers to guide health care decisions when the patient's specific values and wishes are unknown. The surrogate, together with the health care team, will use this standard to determine the optimal outcomes for patients and the interventions most likely to produce them. In making that determination, the surrogate must also take into account the patient's cultural, ethnic, and religious perspectives, if known.

(2) Close Friend: Any person 18 years or older who has shown care and concern for the patient's welfare and is familiar with the patient's activities, health, and religious beliefs, and values. The close friend must present a signed, written statement (to be filed in the medical record) describing (with specific examples) that person's relationship to and familiarity with the patient. Social Work Service, or other staff, must verify, in a signed and dated progress note, that this requirement has been met.

(3) Coercion: Influencing, or attempting to influence, the patient's (or surrogate's) choice of treatment by use of threat(s), inducement(s), or misleading information.

(4) Competency: In relation to decision-making capacity, competency is a legal determination, made by a court of law, that a patient has the requisite capacities to make a medical decision. This is in contrast to the term "decision-making capacity" which is a clinical determination made by the practitioner.

(5) Decision-Making Capacity: Decision-making capacity for health care decisions has four major components: understanding, appreciating, formulating, and communicating. The first two components represent the patient's ability to understand and appreciate the nature and expected consequences of each health care decision. This includes understanding the known benefits and risks of the recommended treatment options, as well as any reasonable alternative options including no treatment. The latter two components represent the ability to formulate a judgment and communicate a clear decision concerning health care. As used in this memorandum, "capacity" is a clinical determination made by the practitioner, in contrast to the term "competency", which is a legal determination made by a court of law.

(6) Health Care Agent: The individual named in a Durable Power of Attorney for Health Care (DPAHC) document executed by the patient prior to losing decision-making capacity. This individual acts on the patient's behalf to make sure health care decisions, including the use of life-sustaining treatment when the patient is unable to make such decisions. (See VHA Handbook 1004.02 and Department of Veterans Affairs (VA) Form 10-0137, VA Advance Directive: Living Will and Durable Power of Attorney for Health Care (DPAHC)).

(7) Legal Guardian or Special Guardian: A person appointed by a court of appropriate jurisdiction to make health care decisions for an individual who has been judicially determined to be incompetent. The appointment may be of limited duration. Under VHA policy, legal guardians and special guardians have the same authority to make health care decisions as any surrogate authorized under this policy. ***NOTE: Financial or other types of limited guardianship do not always include the authority to make health care decisions.***

(8) Next-of-Kin: A relative (18 years of age or older) of the patient who may act as surrogate in the following order of priority, as specified in Title 38 Code of Federal Regulations (CFR) 17.32: spouse, child, parent, sibling, grandparent, grandchild.

(9) Practitioner: Any physician, dentist, or health care professional who has been granted specific clinical privileges to perform the treatment or procedure. For the purpose of this memorandum, the term practitioner includes medical and dental residents, regardless of whether they have been granted clinical privileges.

(10) Risks: The possible undesirable outcomes of a treatment or procedure including side effects, complications, serious social or psychological harms, or other adverse outcomes.

(11) Signature Consent: The patient's (or surrogate's) signature on a VA authorized consent form.

(12) Substituted Judgment: The standard to be used by surrogate decision makers who have specific knowledge of the patient's values and wishes pertaining to health care choices. This standard requires that the surrogate decide based on what the patient would have wanted if he or she were capable of expressing those preferences. That decision may not necessarily coincide with what the surrogate and health care team otherwise would consider optimal for the patient.

(13) Surrogate Decision Maker ("surrogate"): An individual, committee, or decision-making process authorized under VHA policy to make health care decisions on behalf of a patient who lacks decision-making capacity.

(14) Telemedicine and/or Telehealth: Electronic communications and information technology used to provide and support health care when distance separates the participants. Telemedicine and/or telehealth include the remote monitoring of physiological data and video visits. Telemedicine and/or telehealth do not include the use of the telephone for direct audio consultation between practitioners and patients or surrogates.

(15) VA-Authorized Consent Form: For the purposes of documenting informed consent for clinical treatments and procedures that require signature consent, the VA-authorized consent form refers to the use of the iMedConsent software program to conduct the informed consent discussion, capture electronic signatures, and file the completed document electronically in the patient's record. Printed VA Form 10-431b, Consent for Transfusion of Blood Products is authorized for use if:

- (a) The patient declines to use the electronic signature pad, or
- (b) There is a temporary system failure that prohibits proper use of the iMedConsent software program, or
- (c) The patient is giving consent by telephone or fax, or
- (d) The use of the equipment that supports the iMedConsent software program would introduce infection control issues (e.g., inability to adequately



disinfect the signature pad used for a patient who is in isolation precautions). **NOTE:** *General Services Administration Optional Form (OF) 522, Authorization for Administration of Anesthesia and Performance of Operations, can no longer be used to document informed consent.*

b. DECISION-MAKING CAPACITY:

(1) In order to obtain informed consent, the practitioner must first determine whether the patient has decision-making capacity. Patients are presumed to have decision-making capacity unless an appropriate clinical evaluation determines that the patient lacks decision-making capacity, or the patient is a minor, or the patient has been ruled incompetent by a court of law (see 3b (5) and (6)). For patients who have decision-making capacity, the practitioner must undertake the informed consent process with the patient as described in Paragraph 3c. For patients who lack decision-making capacity, practitioners must comply with Paragraph 3c as well as Paragraph 3d.

(2) The practitioner must perform (or obtain) and document a clinical assessment of decision-making capacity for any patient suspected of lacking decision-making capacity.

(3) If the practitioner determines that the patient is likely to regain decision-making capacity, the practitioner must wait until the patient's decision-making capacity returns, and then undertake the informed consent process with the patient, provided that delaying the recommended treatment or procedure would not adversely affect the patient's condition. If the practitioner determines that the patient is unlikely to regain decision-making capacity within a reasonable period of time, an authorized surrogate must be sought.

(4) When the determination of lack of decision-making capacity is based on a diagnosis of mental illness, a psychiatrist or licensed psychologist must be consulted in order to ensure that the underlying cause of the lack of decision-making capacity is adequately addressed. However, even in this instance, the practitioner who will perform the treatment or procedure remains responsible for the final determination of decision-making capacity with respect to informed consent for that treatment or procedure.

(5) If the patient is considered a minor under State Law in the jurisdiction where the VHA facility is located, that patient is deemed to lack decision-making capacity for giving informed consent except as otherwise provided by law. Consent must be obtained from the patient's parent or legal guardian.

(6) Patients who have been judicially determined to be incompetent are incapable of giving consent as a matter of law. Such persons are deemed to lack decision-making capacity for the purpose of giving informed consent. If a practitioner believes that a patient who is legally incompetent does in fact have the capacity to make a

particular health care decision, the practitioner must discuss this with the legal guardian and seek advice from the local ethics program and/or Regional Counsel.

c. **INFORMED CONSENT PROCESS:**For patients who have decision-making capacity, the informed consent process involves the following outlined procedures. The same process applies to surrogates who make decisions for patients who lack decision-making capacity, except as noted in Paragraph 3d.

(1) **Informing the Patient:** During the informed consent process, the practitioner must:

(a) Provide information that a patient in similar circumstances would reasonably want to know.

(b) Describe the recommended treatment or procedure in language that is understandable to the patient. An interpreter must be provided, if necessary, to achieve this purpose.

(c) Give a clear and concise explanation of the patient's condition(s) or diagnosis (es) that relate to the recommended treatment or procedure.

(d) Describe the name, nature, and details of the recommended treatment or procedure and the indications for that course of action including the likelihood of success of the recommended treatment or procedure for that particular patient.

(e) Describe expected benefits and known risks associated with the recommended treatment or procedure, including problems that might occur during recuperation. Risks of minor seriousness do not have to be described unless they commonly occur. Risks that are extremely unlikely do not have to be described, unless the patient requests that information, or unless such risks may result in death or permanent disability.

(f) Describe reasonable alternative treatments and procedures. The practitioner must explain why the recommended treatment is thought to be more beneficial to the patient than the alternatives. Expected benefits and known risks associated with the alternative treatments and procedures must also be described. Reasonable alternatives discussed must include: the option of no treatment or procedure, and the expected benefits, and known risks of that option. Reasonable alternatives discussed must also include potential emergency responses to known complications of the treatment or procedure that the patient may wish to forgo (e.g., blood transfusion for bleeding during an operation, hysterectomy for complications of an obstetrical procedure, open-heart surgery for complications of an angioplasty).

(g) Identify by name and profession the practitioner who has primary responsibility for the patient's care. The names and professions of any other

individuals responsible for authorizing or performing the treatment or procedure under consideration must also be disclosed.

(h) Advise the patient if another practitioner will be substituted for any of those named. If the need for a substitution is known prior to initiating a treatment or procedure that requires signature consent, the patient must be informed of the change and this discussion and the patient's assent must be documented in the medical record.

(i) Advise the patient if the recommended treatment is novel or unorthodox.

(j) Where relevant, advises the patient of the patient's responsibilities when undertaking the treatment or procedure (e.g., taking medications at home, changing own bandages, etc.).

(k) Obtain specific consent for any aspect of the recommended treatment or procedure that involves research.

(l) Ensure that the patient indicates understanding of all the information provided. For example, the practitioner may ask the patient to describe the recommended treatment or procedure in the patient's own words.

(m) Encourage the patient to ask questions.

(2) Promoting Voluntary Decision-Making: The practitioner must promote the patient's voluntary decision-making during the informed consent process.

The practitioner must convey that the patient is free to choose among any recommended treatments and procedures, including no treatment, or to revoke a prior consent, without prejudice to the patient's access to future health care or other benefits. The practitioner is prohibited from attempting to persuade a patient to consent to a particular treatment or procedure by denying, or threatening to deny, the patient access to another procedure or treatment. However, in cases where in the medical judgment of the practitioner a particular treatment or procedure cannot be safely provided or performed without another treatment or procedure also being provided or performed, access to the first treatment or procedure may be made contingent on the patient's consent to the second treatment or procedure. Patients must not, as part of the routine practice of obtaining informed consent, be asked to sign consent forms "on the gurney" or after they have been sedated in preparation for a procedure. Exceptions may occur when there is an urgent clinical need.

(3) Documenting the Informed Consent Process: Prior to undertaking any treatment or procedure, the practitioner must obtain informed consent and document the informed consent process in the patient's electronic medical record. For certain

treatments or procedures, the practitioner must also obtain the patient's signature consent (see par.3a (1)).

(a) Treatments and Procedures that DO NOT Require Signature Consent: Treatments and procedures that are low risk and are within broadly accepted standards of medical practice (e.g., administration of most drugs or for the performance of minor procedures such as routine X-rays) require oral informed consent but do not require signature consent. However, the informed consent process must be documented in the medical record. In accordance with VHA policy on documentation of patient records, documentation must be sufficient to serve as a basis to plan patient care, support diagnoses, and warrant treatment (see VHA Handbook 1907.01). In most cases, a brief statement such as “patient consented to treatment plan” is sufficient. For tests that provide information that is particularly sensitive or may have significant consequences for the patient, the patient’s oral consent to each test must be explicitly documented.

***NOTE:** If specific consent is not obtained or documented, and the patient subsequently objects to the test, the patient must be notified of the patient’s right to request that information pertaining to the test be expunged from the patient’s electronic medical record consistent with VHA Handbook 1907.01.*

(b) Treatments and Procedures that Require Signature Consent: Prior to undertaking certain treatments and procedures, the practitioner must document the informed consent process in detail (as specified in sub-paragraph 3c (3) (b) 1 and subparagraph 3c (3) (b) 2, and obtain the patient's signature on a VA authorized consent form.

1) The patient's signature consent must be obtained for treatments and procedures that:

a) Can be reasonably considered to have a significant risk of complication or morbidity;

b) Can be reasonably expected to produce pain or discomfort to the patient that is substantial enough to require sedation, anesthesia, or narcotic analgesia;

c) Can be reasonably expected to produce significant pain or discomfort to the patient;

e) Require injections of any substance into a joint space or body cavity, (excluding the intravascular space); or

f) Are listed in Attachment .

***NOTE:** When sedation or anesthesia is administered in conjunction with a treatment or procedure, a single consent form that includes general information on anesthesia, along with information on the primary procedure or treatment, is sufficient.*

2) iMedConsent must be used to document patient consent for treatments or procedures that require signature consent (See VHA Handbook 1004.05) unless:

- a) The patient declines to sign using the electronic signature pad;
- b) There is a temporary system failure that prohibits proper use of the program;
- c) The patient (or surrogate) is giving consent over the telephone or by fax; or
- d) Use of the equipment that supports the iMedConsent software program would introduce infection control issues.

3) Documentation of the informed consent process for treatments and procedures that require signature consent must include all of the following items:

- a) The practitioner's assessment of whether the patient has decision-making capacity.
- b) The name(s) of all the practitioner(s) immediately responsible for the performance, and if applicable, the supervision of the treatment or procedure, such as the resident physician and the attending.
- c) A brief description of the recommended treatment or procedure.
- d) A statement that relevant aspects of the treatment, or procedure, including indications, benefits, risks, and alternatives including no treatment, have been discussed with the patient in language that the patient could understand; and that the patient indicated comprehension of the discussion.
- e) A statement that the patient had an opportunity to ask questions.
- f) A statement that the practitioner refrained from using coercion.
- g) The date and time the discussion took place and whether the patient consented to the treatment or procedure.
- h) The written or valid electronic signature of the practitioner writing the note (including the practitioner's legibly written name).

i) The written or valid electronic signature of the patient or the patient's authorized surrogate.

4) A properly executed VA authorized consent form is valid for a period of 60 calendar days from the date signed. If during this 60 day period there is a significant change in the patient's condition that would reasonably be expected to alter the diagnosis or therapeutic decision, the consent is automatically rescinded, and the informed consent process must be repeated for subsequent treatment. Rescission of content must be documented in the patient's medical record. The practitioner who obtained consent must certify or verify the patient's rescission.

5) When the patient's signature is indicated on the VA authorized consent form by an "X", two adult witnesses (not including the practitioner) are required.

6) The signed VA authorized consent form must be filed in the patient's medical record. The patient must be offered a copy of the completed consent form.

(c) When the patient chooses an alternative treatment, including no treatment, or revokes consent:

1) The patient may choose among recommended or alternative treatments and procedures, including no treatment. Or the patient may revoke a prior consent, even if that decision may increase the risk of serious illness or death, without prejudice to the patient's access to future health care or other benefits.

2) If the patient chooses an alternative treatment or procedure, including no treatment, that increases the risk of illness or death, or revokes a prior consent, the progress note must document the patient's reason(s) if known, and the expected outcome. The progress note must also state that the patient revoked the informed consent, document the date of the revocation, as well as the signing date(s) or any form(s) invalidated by this decision. The responsible practitioner must also request that the progress note be re-titled to note the rescission. For example, change the note titled "Informed Consent – General Surgery" to "Rescinded Informed Consent – General Surgery".

3) If the patient's choice of treatment or procedure poses a potential hazard to others (e.g., declining treatment for tuberculosis), the practitioner must notify the Chief of Staff or designee, and consult with the Integrated Ethics Program Manager and/or Regional Counsel.

#### d. PATIENT WHO LACKS DECISION-MAKING CAPACITY

If the patient is judged to lack decision-making capacity, the following procedures apply (in addition to the procedures in par. 3c):

(1) Identifying a health care agent or authorized surrogate:

(a) When a health care agent is authorized and available: when a patient lacks decision-making capacity, the practitioner must make a reasonable inquiry as to the availability and authority of an advance directive naming a health care agent. A health care agent has the highest priority as a surrogate.

(b) When no health care agent is authorized and available: the practitioner, with the assistance of other staff, must make a reasonable inquiry as to the availability of other possible surrogates according to the order of priority listed in subparagraph 3d(1)(c). Each facility must have a procedure in place for identifying surrogates including, if necessary, examining personal effects, medical records, and other VA records such as benefits and pension records. If a surrogate is identified, an attempt to contact that person by telephone must be made within 24 hours of the determination that the patient lacks decision-making capacity. If a particular surrogate is unavailable or unwilling to serve as surrogate, the next surrogate in the established priority order must be sought. A surrogate must be sought even if the recommended treatment or procedure does not require signature consent.

(c) Priority of Surrogates: the surrogate is authorized to give informed consent on behalf of the patient in the following order of priority:

- 1) Health Care Agent;
- 2) Legal guardian or special guardian;
- 3) Next-of-Kin. The next-of-kin is a relative, 18 years of age or older, in the following order of priority: spouse, child, parent, sibling, grandparent, grandchild; and
- 4) Close friend.

(d) Disagreement between surrogates at same priority level: when there are multiple surrogates at the same priority level in the hierarchy and they do not agree about the recommended treatment or procedure, the practitioner must make reasonable efforts to reach a consensus. If consensus cannot be reached, the practitioner must choose the surrogate who is best able to speak for the patient, and document the reasons for choosing that individual. In cases where the choice is unclear, the practitioner must consult with the Integrated Ethics Program Manager and/or Regional Counsel.

(e) Documentation of the process in identifying an authorized surrogate: the practitioner must document in the patient's electronic medical record the process and outcome of efforts to identify a surrogate.

(2) Patients who have a Surrogate. If it is determined that the patient lacks decision-making capacity and has a surrogate, that surrogate generally assumes the same authority and responsibilities as the patient in the informed consent process.

- (a) The requirements for obtaining informed consent are described in Paragraph 3c, except as noted below.
- (b) Disclosures otherwise required by this policy to be made to the patient must be made to the patient's surrogate to the extent permitted by law (see VHA Handbook 1605.1).
- (c) Even though the patient lacks decision-making capacity, the practitioner must explain to the patient the treatment or procedure to which the surrogate has consented, if feasible.
- (d) The surrogate's decision must be based on substituted judgment or, if the patient's values and wishes are unknown, on the patient's best interests. If the practitioner considers the surrogate to be clearly acting contrary to the patient's values and wishes, or the patient's best interests, the practitioner must notify the Chief of Staff, or designee, and consult with the Integrated Ethics Program Manager and/or Regional Counsel before implementing the surrogate's decision.
- (e) The requirements for documenting the informed consent process are described in subparagraph 3c (3); however, documentation for patients who lack decision-making capacity, but have a surrogate must also include the surrogate's name, relationship to the patient, authority to act as a surrogate (whether DPAHC, legal guardian, next of kin, or close friend), and how the consent was obtained (in person, by telephone, by mail, or by facsimile). If the surrogate is a close friend, the required signed, written statement of their relationship and familiarity with the patient must be included.
- (3) Patients who have no Surrogate. If none of the surrogates in subparagraph 3d(1)(c) is available, the practitioner may either contact Regional Counsel for assistance in obtaining a guardian for health care decisions, or the practitioner may follow the procedures in this paragraph that set out an alternative process for decision-making on behalf of patients who have no surrogate.
- (a) Treatments and procedures that do not require signature consent: medically appropriate treatments and procedures that do not require signature consent may be performed in accordance with the following procedures, provided the procedures are low-risk and are within broadly accepted standards of medical practice.
- 1) The decision to provide a treatment or procedure must be based on substituted judgment or, if the patient's specific values and wishes are unknown, on the patient's best interests. If there is doubt regarding whether a treatment or procedure is consistent with the patient's values and wishes or the patient's best interests, the practitioner must consult with the Integrated Ethics Program Manager and/or Regional Counsel.



2) Even if the patient lacks decision-making capacity, the practitioner must, where reasonable, attempt to explain the nature and purpose of the proposed treatment or procedure to the patient. The practitioner must indicate, in the medical record, whether it was possible to communicate with the patient and if the patient appeared to understand the explanation.

3) The practitioner must sign and date a progress note in the medical record that describes the treatment or procedure and its indications.

4) Treatment must not be provided indefinitely without periodic review by the primary treatment team and by an advocate for the patient. The primary treatment team must review the treatment plan to ensure that clinical objectives are being met.

Someone outside the primary treatment team who can serve as the patient's advocate must review the treatment plan at least every 6 months to ensure it is in the patient's best interests.

(b) Treatments and procedures that require signature consent: for medically appropriate treatments and procedures that require signature consent, but do not involve the withholding and/or withdrawal of life-sustaining treatment, the following procedures apply (see subparagraph 3c (3) (b) for an explanation of procedures requiring signature consent).

**NOTE:** *Procedures for withholding or withdrawal of life-sustaining treatment for patients who have no surrogate are described in subparagraph 3d (1) (e) and 3d (3) (c).*

1) The attending practitioner must sign and date a progress note in the medical record that describes the treatment or procedure and its indications; and

2) The Chief of Service, or designee, must provide a signed and dated concurrence, in the patient's medical record, with the decision to perform the treatment or procedure, and the treatment's or procedure's indications.

**NOTE:** *In addition to the preceding, the provisions in subparagraph 3d (3) (a) (1) through subparagraph 3d (3) (a) 4 also apply to treatments and procedures that require signature consent.*

(c) Withholding and/or Withdrawal of Life-sustaining Treatment: VA patients have the right to have unwanted life-sustaining treatment withheld and/or withdrawn even if this action results in death. In order to ensure a decision consistent with the patient's best interests, there is a special process that must be followed when considering the withholding and/or withdrawal of life-sustaining treatment for a patient who lacks decision-making capacity and has no surrogate. Implementation of decisions to withhold and/or withdraw life-sustaining treatments must follow the guidelines set out in VHA Handbook 1004.3, and VHA Handbook 1004.02. In addition, all the following procedures must be followed and documented in the medical record:

1) The attending practitioner participates in the discussion of the withholding and/or withdrawal of life-sustaining treatment with the treatment team, and recommends life-sustaining treatment be withheld and/or withdrawn in a signed and dated progress note in the medical record.

2) A multi-disciplinary committee appointed by the Facility Director must consider the procedural and ethical validity of the recommendation to withhold and/or withdraw life-sustaining treatments(s). **NOTE:** *An existing Integrated Ethics committee, a subcommittee of the Integrated Ethics program, or an independent group may serve this function.* The committee functions as the patient's advocate and may not include members of the primary treatment team. The committee must use the substituted judgment standard (where possible) or the best interests standard. To the extent feasible, the committee must seek input from representatives of the patient's cultural, ethnic, or religious group. The committee must then submit a written report to the Chief of Staff that describes its findings and recommendation(s).

3) The Chief of Staff, or designee, must approve or disapprove the committee's recommendation to withhold and/or withdraw life-sustaining treatment. The committee's recommendation(s) and the Chief of Staff's decision must be documented in the medical record.

4) The Facility Director must review the decision and may either concur, not concur, or request review by Regional Counsel. The final decision must be documented in the medical record. The withholding and/or withdrawal of life-sustaining treatment may only be undertaken with the concurrence of the Facility Director.

(4) Surrogate Consent by Mail, Fax, Telephone, or E-Mail. Ideally, the informed consent discussion and signature consent (where required) will be conducted in person; however, face-to-face discussions are not always possible. This subparagraph outlines the procedures to follow when it is impractical to obtain a surrogate's consent in person.

(a) Consent by Mail or Fax: when informed consent is sought by mail or fax, the practitioner must enclose a letter addressed to the surrogate with a VA authorized consent form. The letter must provide the same information that generally would be supplied to the surrogate in a face-to-face discussion and must be signed by the practitioner. A copy of the letter must be filed in the patient's medical record. A fax copy of a completed consent form signed by the surrogate is adequate to proceed with treatment. Reasonable efforts must be made to ensure that the original form that the surrogate signed is returned and filed in the patient's medical record.

(b) Consent by Telephone: when consent is sought by telephone, the conversation must either be audio-taped or witnessed by a second VA employee.

1) The practitioner must:

a) Call the proposed surrogate and identify and verify the parties on the line. **NOTE:** *This responsibility may be delegated.*

b) Ask the surrogate for permission to audio-tape the conversation or inform the surrogate that a second VA employee must witness the conversation. **NOTE:** *This responsibility may be delegated.*

c) Determine that the individual has the authority and is willing and available to act as surrogate and make health care decisions on behalf of the patient who lacks decision-making capacity.

d) Proceed with the informed consent discussion. **NOTE:** *This responsibility may not be delegated.*

e) Document the process.

2) Audiotapes: if the discussion is audiotaped, a typed transcript of the entire discussion with the date and time of the call must be filed in the patient's medical record.

a) The transcriptionist must sign the document to certify that the transcript is an accurate verbatim account of the audio-taped conversation. The audiotape must be clearly labeled with the:

1. Patient's name;

2. Social Security Number;

3. Name of treatment, or procedure, for which consent was obtained;

4. Name of surrogate and relationship to patient;

5. Date and time of conversation;

6. Name of the VHA medical facility; and

7. Name of the practitioner who obtained the consent.

b) Audiotapes must be kept under locked storage by the medical records custodian until replaced by a signed consent form or disposed of in accordance with VHA Records Control Schedule 10-1. **NOTE:** *The transcript must remain filed in the patient's medical record.*

3) If the discussion is not audio-taped, the practitioner must document compliance with the informed consent process in the medical record as described in paragraph 3c and in subparagraph 3d. If a second practitioner, or other VA employee, witnesses the conversation, both the practitioner and the second employee must sign a report of contact, or progress note that details the conversation.

(c) Consent by E-mail: signature consent by E-mail is not permitted.

e. CONSENT IN SPECIAL SITUATIONS:

(1) Medical Emergencies:

(a) In medical emergencies the patient's consent is implied by law. The practitioner may provide necessary medical care in emergency situations without the patient's or surrogate's express consent when all of the following conditions are met:

1) Immediate medical care is necessary to preserve life or avert serious impairment of the health of the patient or others; and

2) The patient is unable to consent; and

3) The patient has no surrogate or the practitioner determines that waiting to obtain consent from the patient's surrogate would increase the hazard to the life or health of the patient or others.

(b) In a medical emergency, reasonable attempts to contact the patient's surrogate must be made as promptly as possible, before or after treatment is begun, to explain the nature of the treatment or procedure, the indications, and the expected outcome. The patient's previously stated wishes must be followed to the extent that they are known.

If these wishes are contained in a written directive, the practitioner must ensure that the advance directive is valid and applies to the current situation.

(c) When the patient's consent is not obtained due to the emergency exception:

1) The practitioner must date and sign a progress note in the medical record documenting the:

a) The patient's inability to provide consent

b) Imminent danger to the health of the patient, or others

c) Decision to undertake a particular treatment or procedure, and its rationale; and

d) Attempts that were made to identify and contact a surrogate.

2) Whenever, due to the emergency exception, a treatment or procedure that requires signature consent has been provided without obtaining the patient's or surrogate's signature consent, the Chief of Staff, or designee, must be notified and must review the record to verify that the emergency exception to obtaining signature consent has been appropriately applied. The Chief of Staff, or designee, must document their review by either co-signing or writing an addendum to the progress note.

(2) Unusual or Extremely Hazardous Treatments and Procedures:

No patient will undergo any treatment or procedure considered to be unusual or extremely hazardous, such as psychosurgery, except under extraordinary circumstances, subject to the following:

(a) Before treatment is initiated, the patient (or surrogate) must be given adequate opportunity to consult with independent specialists, legal counsel, or other interested parties of the patient's or surrogate's choosing. The patient's or surrogate's signature on a VA authorized consent form must be witnessed by someone who is not affiliated with the VA health care facility (e.g. spouse).

(b) If a surrogate makes the health care decision, a multi-disciplinary committee, appointed by the Facility Director, must review the surrogate's decision before treatment is initiated to ensure that the decision to treat is consistent with the patient's wishes (or best interests, if the patient's wishes are not known). The committee functions as the patient's advocate and may not include members of the primary treatment team. The committee must submit its findings and recommendations in a written report to the Facility Director. The Director may authorize treatment consistent with the surrogate's decision, or authorize the practitioner to seek a legal guardian or special guardian to make the health care decision.

(c) If there is no available surrogate, the practitioner must follow procedures similar to those outlined in subparagraph 3d (3) (c) for the withholding and/or withdrawal of life-sustaining treatment, or request that a guardian be appointed to make health care decisions for the patient.

The practitioner must document compliance with all these procedures in the patient's medical record. **NOTE:** *Contact Regional Counsel for assistance.*

(3) Forced Administration of Psychotropic Medication: **NOTE:**

*Administration of psychotropic medication to an involuntary committed patient against the patient's (or surrogate's) wishes must meet Constitutional due process requirements and adhere to state law.*

(a) The patient (or surrogate) must be allowed to consult with independent specialists, legal counsel, or other interested parties of their choice concerning treatment with psychotropic medication.

(b) Any recommendation to administer or continue psychotropic medication against the patient's (or surrogate's) will, must be reviewed by a multi-disciplinary committee appointed by the Facility Director for this purpose. That committee must include a psychiatrist or a physician who has psychopharmacotherapy privileges. The committee functions as the patient's advocate and may not include members of the primary treatment team. The Facility Director must concur with the committee's recommendation to administer psychotropic medications contrary to the patient's (or surrogate's) wishes. The Director's decision must be documented in the patient's medical record.

(c) Continued therapy with psychotropic medication must be formally reviewed by the prescribing practitioner every 30 days and the results of the review documented in the patient's medical record.

(d) The patient, surrogate, or a representative on the patient's behalf may appeal the psychotropic medication treatment decision to a court of appropriate jurisdiction. The patient and surrogate, if applicable, must be informed of the right to appeal the decision.

(e) The practitioner must document compliance with these procedures in the medical record.

(4) Release of Evidentiary Information and/or Material(s): Information and/or other evidentiary material(s) that could be used for legal prosecutions include those collected during the diagnosis and treatment of a patient who is suspected of criminal wrongdoing or who is the victim of a suspected crime. The practitioner must ensure that proper informed consent for treatments and procedures is obtained from the patient (or surrogate, if applicable) and appropriately documented in the medical record. If there is concern that the surrogate is acting contrary to the patient's prior wishes or best interests because of involvement in suspected abuse or neglect, refer to subparagraph 3d (1)(d). Specific conditions must be met before such information may be disclosed without the patient's (or surrogate's) consent (see VHA Handbook 1605.1). Evidentiary material must be collected, retained, and safeguarded according to local VA medical facility policy.

(5) Research: Participation in any human subjects research sponsored by the VA, as well as any human subjects research conducted on VA premises, must meet requirements of 38 CFR Part 16 and must be obtained in accordance with VHA Handbook 1200.05, VHA Handbook 1058.03 or superseding regulation and policy.

(6) Consent for Disclosure of Title 38 United States Code Section 7332-Protected Information:

(a) VA-generated records that reveal the identity, diagnosis, prognosis, or treatment of VA patients related to drug abuse, alcoholism or alcohol abuse, infection with HIV or sickle cell anemia must be kept confidential (including the fact that an HIV test was conducted or the positive or negative results of HIV testing). This information may not be released without the patient's special written consent, unless the disclosure is otherwise authorized by law. VA Form 10-5345, Request For and Authorization to Release Medical Records, must be signed if the patient wishes to have this information shared with the patient's surrogate in the event that the patient loses decision-making capacity. Unauthorized release of any confidential information, such as HIV test results, may result in criminal penalties or substantial fines. **NOTE:** *For questions refer to VHA Handbook 1605.1 and consult the Privacy Officer or Regional Counsel.*

(b) Testing for HIV requires informed consent of the patient (or surrogate) according to the procedures described in Paragraph 3c and Paragraph 3d.

(7) Consent for Testing of a Source Patient after an Occupational Exposure:

(a) When an employee is inadvertently exposed to a patient's bodily fluids, tissues, or excretions (e.g., blood, urine, sweat, saliva, pus, fecal matter) there may be transmission of infectious pathogens, contaminants, toxins or other agents. When such an occupational exposure occurs, optimal treatment for the employee may depend upon the source patient's medical condition(s). Testing to determine the source patient's medical condition(s) may only be performed with the source patient's (or surrogate's) explicit informed consent and that consent must be documented in the patient's medical record. Source patients have the right to refuse testing or procedures requested for the purposes of diagnosis or treatment of employees who have experienced an occupational exposure.

(b) Informed consent for source patient testing may only be obtained after the occupational exposure has occurred. Consent may not be obtained prospectively. For example, prior to a surgical procedure, patients may not be asked to provide consent to undergo Hepatitis C testing that might be needed if a member of the surgical team experiences a needlestick injury during the upcoming surgical procedure.

(c) To prevent coercion or undue influence on the source patient, informed consent for testing of a source patient after an occupational exposure must be performed by an employee who does not have a personal relationship with the exposed employee (e.g., friend, family member, former spouse) and, whenever possible, by an employee who is not professionally related to the employee or the patient. The exposed employee may never seek consent from the source patient without incurring consequences.

(8) Consent for Treatments or Procedures Delivered Via Telemedicine and Telehealth:

(a) For most treatments or procedures that are delivered using telehealth, oral informed consent is sufficient. Signature consent is required for treatments or procedures delivered via telehealth if and only if the treatment or procedure meets one or more of the criteria listed in Attachment .

(b) All elements of the informed consent process apply to treatments or procedures delivered by telemedicine and/or telehealth:

1) Specifically, practitioners need to provide information about telemedicine and/or telehealth that a patient would reasonably want to know, including:

a) The likely differences between receiving care delivered using telemedicine and /or telehealth technologies and face-to-face care;

b) The benefits and risks of using telemedicine and/or telehealth in the patient's situation, the likely benefits and risks associated with the alternatives to using telemedicine and/or telehealth to deliver the treatment or procedure in the patient's situation; and

c) Whether the use of telemedicine and/or telehealth to deliver the treatment or procedure would be generally considered novel or unorthodox.

2) Practitioners need to tell patients that they are free to choose among treatments or procedures that use telemedicine and/or telehealth and those that do not use telemedicine and/or telehealth, and that a prior consent for telemedicine and/or telehealth can be revoked without prejudicing the patient's access to future care or other benefits.

#### **4. RESPONSIBILITIES:**

a. The Facility Director is responsible for ensuring informed consent processes outlined in this Memorandum are followed; for implementing the informed consent processes requiring multidisciplinary committee review for patients who lack decision-making capacity and have no surrogate, and for forced administration of psychotropic medications against the patient or surrogate's preferences; and for having a procedure in place for identifying a surrogate.

b. The Chief of Staff is responsible for oversight and monitoring of the informed consent process for patients who lack decision making capacity and have no surrogate as outlined in this Memorandum.

c. The practitioner who will perform the treatment or procedure must ensure that the informed consent process outlined in this Medical Center Memorandum is followed.

#### **5. REFERENCES:**



Title 38 United States Code (U.S.C.) & 7331, "Informed Consent".  
 Title 38 U.S.C. & 7332 "Confidentiality of certain medical records"  
 Title 38 U.S.C. & 7333, "Nondiscrimination against alcohol and drug abusers and persons infected with the human immunodeficiency virus."  
 Title 38 CFR & 17.32, "Informed Consent".  
 Title 38 CFR & 16, "Protection of Human Subjects"  
 VA, VHA Handbook 1004.02, Advance Health Care Planning (Advance Directive).  
 VHA Handbook 1605.1, Privacy and Release of Information  
 VHA Handbook 1907.01, Health Information Management and Health Records  
 VHA Handbook 1004.3, "Do Not Resuscitate (DNR) Protocols Within the Department of Veterans Affairs (VA)."VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures  
 Joint Commission, Comprehensive Accreditation Manual for Home Care.  
 Joint Commission, Comprehensive Accreditation Manual for Long-Term Care.

6. **RESCISSION:** MCM 02-07-119, "Informed Consent", dated March 2007

7. **RECERTIFICATION:** April 2013

Concur / Do not Concur

Concur / Do not Concur

Ramu Komanduri, MD  
 Chief of Staff

Shirley L. Caldwell-Butts, MSN, RN  
 AD Patient Care/Nurse Executive

Concur / Do not Concur

Approved / Disapproved

Deborah Dort, MD  
 Associate Director

John B. Bright  
 Director

## **TREATMENTS AND PROCEDURES REQUIRING SIGNATURE CONSENT**

NOTE: The following list is not exhaustive (see subparagraph 3c (3) (b) of the Memorandum for a general description of treatments and procedures that require signature consent).

1. Surgical or invasive procedures, including but not limited to:
  - a. Any procedure done within an operating room;
  - b. Acupuncture;
  - c. Aspiration of body fluids or injection of therapeutic or diagnostic agents through the skin or into a body cavity (e.g., arthrocentesis, bone marrow aspiration, lumbar puncture, paracentesis, thoracentesis);
  - d. Biopsy (e.g., breast, liver, muscle, kidney, genitourinary, prostate, bladder, skin);
  - e. Cardiac procedures (e.g., cardiac catheterization, cardiac pacemaker electrode insertion, electrical cardioversion, stress tests to include exercise and pharmacologic methods);
  - f. Central vascular access device insertion (e.g., arterial line, Swan-Ganz catheter, percutaneous intravascular catheter (PIC) line, Hickman catheter);
  - g. Electrocautery;
  - h. Endoscopy (e.g., bronchoscopy, colonoscopy, cystoscopy, laparoscopy);
  - i. Interventional radiology procedures (e.g., angiography, arthroplasty);
  - j. Photocoagulation;
  - k. Oral surgical procedures (including gingival biopsy);
  - l. Sterilization of reproductive capacity;
  - m. Thoracostomy;
  - n. Tracheostomy; and
  - o. Transjugular intrahepatic portal stent (TIPS).

Attachment (continued)

2. Sedation, other than anxiolysis (level one sedation)
3. Anesthesia, other than low risk local anesthesia (e.g., topical numbing agents)
4. Blood product transfusion

**NOTE:** *It is not necessary to obtain a separate signature consent for sedation, anesthesia, or blood product transfusion if the combined consent form for the procedure already contains consent for sedation, anesthesia, or blood product transfusion, as in iMedConsent.*

5. Delivery of a child
6. Hazardous drugs (e.g., cancer chemotherapy, methadone for narcotic dependence, Retin A, buprenorphine, thalidomide, clozapine).
7. Photochemotherapy in combination with psoralens or other topical agents.
8. High-risk imaging procedures where there is no other appropriate alternative diagnostic approach, such as:
  - a. Intravascular injection of iodinated radiographic contrast agents in high-risk patients (e.g., those with prior allergic reactions, renal failure or other risk factors);
  - b. Intravascular injection of gadolinium contrast agents in high-risk patients (e.g., those with prior allergic reaction to gadolinium or at risk of nephrogenic systemic fibrosis);
  - c. Radionuclide therapy (e.g., radioiodine for hyperthyroidism and thyroid cancer, radiostrontium or adiosamarium for palliation of painful metastases to bone, Zevulin or Bexxar therapy for lymphoma or other radionuclide therapies); and
  - d. Pregnant patient receiving intravascular contrast agents or x-radiation to the fetus.
9. Laser therapy
10. Botox treatment for dystonia
11. Dialysis (hemodialysis or peritoneal)
12. Electroconvulsive therapy
13. Lithotripsy

## 14. Forensic examination

### **Medical Record Charting Guidelines**

1. **PURPOSE:** To define policy, procedures and responsibilities for entries and documentation (charting) in VA Southern Nevada Healthcare System (VASNHS) health records and to provide guidelines for legal requirements.

2. **POLICY:** This policy defines the proper guidelines for documentation in health records at the VA Southern Nevada Healthcare System (VASNHS).

3. **ACTION:** This policy outlines the documentation standards both legal and ethical for ensuring entries in the medical record meet Department of Veterans Affairs and other accrediting and licensing agency standards.

a. Documentation of each event of a patient's care shall be entered into the Medical Record. Clinicians should refrain from re-entry of previously entered or captured data, such as copy and paste in Electronic Record or inserting copies into paper record. Avoidance of those practices ensures conveyance of most recent data, maintains record flow in accurate contiguous manner, and facilitates accurate and patient safe utilization of record by all clinicians.

b. The standard will be commitment to collect, manage and report data in an unbiased, honest, and ethical manner.

c. All entries must be dated, timed and signed by their author.

d. Handwritten entries must be sequential, i.e., no spaces left between notations.

e. Entries shall be made only by personnel authorized to do so.

Note: If an incident occurred prior to the last notation entered, the late entry should be labeled "late entry" and bear the actual date it is written with a statement that it refers to a previous time and date.

f. The provider who treats the patient is responsible for documenting and authenticating the care provided.

g. Entries are to be written at the time of occurrence. Entries must be prompt, legible, significant, accurate, concise, and complete. All entries will be signed immediately after they are written or entered in Computerized Patient Record System (CPRS). Dictated and transcribed reports will be signed at the time of the next Tour of Duty of the provider.

h. All entries will be in English and conform to acceptable English grammar.

- i. All clinical staff authorized to document in the health record will document every episode of care, as defined by their scope of practice.
- j. Health care providers will document according to regulatory standards and generally accepted documentation practices for completeness and timeliness.
- k. Nothing in an entry may be obliterated; i.e., errors are not to be erased or covered over by liquid erasure or correction fluid. To make a correction, draw a single line through the erroneous material, write "error", date and sign. Corrected information may be written above or below the lined out entry. All corrections will be signed by the person changing the entry and dated as to when the correction was made. If an error is made in the electronic medical record a VistA e-mail must be sent to the Chief, Health Information Management Section (HIMS). This VistA e-mail should state exact date and time of entry in error, author, and what the error was. For signed progress notes, add an addendum stating the note was entered in error. If it is an entry made in the wrong person's chart, it can be moved to the correct record if it has not been signed.
- l. If adhesive notes are placed in the record, they are not to be placed over any entry on the record; for example, adhesive progress note, informed consent adhesive note, etc.
- m. Avoid inconsistent and contradictory entries.
- n. Eliminate the use of terms such as Incident Report filled out. When incidents occur simply state the facts of the incident in the progress notes. Incident reports (VA Form 10-2633) are administrative documents and are not filed in the medical record.
- o. Handwritten entries must be made in black ink only.
- p. Each entry must be dated, timed, legible, and signed by the person making the notation along with his/her title or position. The person's full name and title are preferable, but the first initial, full last name and title are acceptable. Provider identification stamps should be used with the signature. Electronic signatures will be accepted as long as the person whose signature the electronic signature code represents authenticates a statement that he/she is the only one who has the electronic code and who will use it.
- q. All major reports written by students must be countersigned by their supervisors. For billing purposes, the teaching physician must personally document (in the medical record) his/her presence and participation in the services billed and/or the resident must designate within the progress note the name of the attending provider. The initial assessment by the resident must be cosigned by the attending physician. In addition, the attending physician must document his/her own assessment of the patient. The additional documentation guidelines as outlined in MCM ACOSE-10-03, Monitoring of Resident Supervision, also must be followed.

r. Signature stamps are not authorized. Providers shall use an identification stamp with their signature, especially if their signature is not legible.

s. Patient identification stamps are used to identify each page of the medical record unless the report is computer or word processor generated and the name and identification number(s) are a part of the format. Outpatient records will have, as a minimum, the patient's full name and social security number.

t. VA Form 10-1415, or the electronic medical record Problem List, will be initiated with the third visit of the patient to the VASNHS. Updated diagnoses/problems will be recorded at subsequent outpatient visits.

u. Content/Style: Charting should reflect the patient's current condition in a concise but descriptive manner, using the following guidelines:

(1) Notations should be accurate and specific enough so that a person who has never known the patient will have a good understanding of the patient and the situation.

(2) Notations should be professional in character, i.e., factual without slang/street language unless these are quoted from the patient, or moralistic judgments.

(3) Notations, requiring the use of psychiatric terminology should include a description of the behavior and the incident so that the meaning is clearly understood.

(4) Progress notes should give a pertinent chronological report of the patient's course in the VASNHS.

(5) When references to contacts with family, friends, or staff are made, the individual's name should be used cautiously and professionally. If reference is made to another person, use only the person's first name, and if necessary, the last initial and/or title. Full names of individuals will only be recorded as it is relevant to patient care and/or clinical judgment supports the need. Inappropriate comments such as pointing out problems with other individuals or sections are not allowed.

(6) Only approved abbreviations shall be used in the health record. Unapproved abbreviations will not be utilized. Symbols and abbreviations will not be utilized when documenting final diagnoses and procedures on patients released from inpatient and ambulatory and/or outpatient services. (Refer to MCM 136-18, Approved Abbreviation List).

v. Charting must be done at the VASNHS.

w. No health record may be removed from the VA Southern Nevada Healthcare System's jurisdiction except in accordance with VA regulations, court order, subpoena, or statute, or with the express permission of the Director VASNHS, or Chief, Health Information Management Section or designee.

**4. RESPONSIBILITIES:**

a. The VASNHS Medical Record Committee is responsible for establishing charting policies and implementing procedures to ensure the documentation in the health record meets the standards of the Department of Veterans Affairs and other accrediting and licensing agencies.

b. The Chief of Staff or designee has oversight responsibility for health record timeliness, accuracy, and completion.

c. Care Line/Service Chiefs are responsible for establishing and maintaining professional documentation standards for their respective employees.

d. The attending physician is responsible for the accuracy of the health record for the patients under his/her care.

e. Only professionally trained staff and supervised students in clinical training programs, which have been approved by the Director of the VA Southern Nevada Healthcare System, may make entries in health records.

f. The Chief, Health Information Management Section and/or the Chief of Staff, or their designees are responsible for determining if an individual has the necessary training and ability to make entries in the medical record.

**5. REFERENCES:** VHA Handbook 1907.1; Joint Commission; Medical Record Management, 9<sup>th</sup> Edition; Current Medical Staff Bylaws; MCM 136-18, Approved Abbreviation List, and other accrediting and regulatory agency standards.

**6. RESCISSIONS:** MCM 136-14, Medical Record Charting Guidelines, dated February 2010.

**7. RECERTIFICATION:** December 2013



Concur/Do Not Concur

Ramu Komanduri, MD  
Chief of Staff

Concur/Do Not Concur

Maria R. Andrews, MS, FACHE  
Associate Director

Concur/Do Not Concur

Shirley L. Caldwell-Butts, MSN, RN  
AD Patient Care Services/Nurse Executive

Approved/Disapproved

John B. Bright  
Director

## **HAZARD COMMUNICATION PROGRAM**

**1. PURPOSE:** To establish a policy to assure that the safe handling of hazardous materials through proper labeling, Material Safety Data Sheet (MSDS) availability and use, and employee training.

**2. POLICY:**

a. It is the policy of the Department of Veterans Affairs and this Medical Center to promote and adhere to Federal OSHA Regulation 29 CFR 1910.1200, Hazard Communication Standard and VHA Directive 98-011, Management of Hazardous Chemicals.

b. Employees shall be trained on the safe handling and use of all hazardous chemicals prior to use of the hazardous chemical or chemical containing product.

c. All containers of hazardous chemicals shall be properly labeled with contents and hazard warning information.

d. This policy applies only to the sections in which hazardous chemicals are used.

**3. ACTION:**

a. Procedures:

(1) Hazardous Chemicals Inventory: A physical inventory of hazardous chemicals in all physical forms – liquids, solids, gases, vapors, fumes, and mists – whether they are “contained” or not in the work area shall be conducted. This inventory shall be checked against the MSDS’s in the area for completeness. Additions and deletions shall be made as appropriate to produce an updated chemical inventory. A copy of this current chemical inventory should be maintained in each area. The inventory is to be kept updated as each new chemical, product or substance is received or deleted.

(2) Material Safety Data Sheets (MSDS’s): Each section shall obtain the most current copy of the specific MSDS for each chemical or hazardous material used in your respective areas.

(3) Labeling: All containers of hazardous chemicals received on station, or those which smaller quantities of chemical are transferred to, shall be labeled. The labels must be in legible English and display the following information:

- (a) Chemical identity
- (b) Appropriate hazard warning

(c) Name and address of manufacturer (original container only).

(4) Training:

(a) The Industrial Hygienist will act as consultant to Care Line/Service Chiefs and supervisors in the development of Hazard Communication training for all employees using hazardous chemicals.

(b) Care Line/Service Chiefs will review and update Section's Hazard Communication Program annually and provide all employees working with hazardous chemical substances with information and training on the chemicals used in their work area. Training will be given initially (before the employee comes into contact with hazardous chemicals), on an annual basis, and whenever a new hazardous chemical is brought into the work area. Training topics shall include, at a minimum:

1) The existence and requirements of 29 CFR 1910.1200 and an overview of this program.

2) The location and availability of this written program, the MSDS's for chemicals used in the work area and the chemical inventory for the specific area.

3) Labeling requirements.

4) Where hazardous chemicals are present in their work areas.

5) Methods/observations used to detect the presence or release of the hazardous chemicals in their work areas (odor, etc.)

6) The physical and health hazards of the hazardous chemicals in their work areas to include signs and symptoms of exposure and target organs.

7) Methods of protection (safe work practices, personal protection equipment, emergency procedures).

8) Prohibited work practices (i.e., mixing or altering chemicals).

9) An explanation of MSDS's and labels, and how to obtain and use information.

(5) Miscellaneous:

(a) In the event of non-routine tasks in which employees have potential exposure to hazardous chemicals, the Care Line/Service Chief will assure that employees are properly trained in use of hazardous chemicals before initiating the task.

(b) Contractors working on site will be required to have MSDS's for hazardous substances readily available to VA staff, on all shifts.

(c) Contractors will be expected to inform the Chief, Facility Management Service or project engineer at this facility in regard to any hazardous chemicals, which they bring onto the site.

(6) Disposal of Hazardous Waste Material:

(a) Disposal of hazardous waste material will adhere to Environmental Protection Agency (EPA) and other regulatory guidelines for tracking and manifesting of hazardous waste. More detailed guidelines are provided in Medical Center Memorandum (MCM) 138-22 (previously MCM 02-100), Hazardous Materials and Waste Management Policy.

(b) Contact the GEMS Coordinator, at extension 3197, with any questions relating to hazardous waste disposal.

b. Definitions:

(1) **Hazardous Chemical:** A hazardous chemical is any chemical which presents a physical hazard or a health hazard to an individual.

(2) **Health hazards** mean that a chemical or chemical product has statistical evidence, based on at least one study conducted with established scientific principles that acute or chronic health effects may occur in exposed employees. The term health hazard includes chemicals which are carcinogens, toxic or highly toxic agents, reproductive toxins, irritants, corrosives, sensitizers, hepatotoxins, nephrotoxins, neurotoxins, agents having an effect on the hematopoietic system, and agents which damage the lungs, skin, eyes, or mucous membranes.

(3) **Physical hazards** mean a chemical or chemical product or substance for which there is scientific valid evidence that it is a combustible liquid, a compressed gas, explosive, flammable, or organic peroxide, an oxidizer, pyrophoric, unstable (reactive) or water reactive.

(4) **Material Safety Data Sheet (MSDS):** The MSDS is a document, which describes the physical and chemical properties of products, their physical and health hazards, and precautions for safe handling and use.

(5) **Labels:** Labels must be on each container of chemicals. Original containers must be labeled, tagged, or marked with the identity of the hazardous chemical contained therein, and the name and address of the manufacturer and have appropriate hazard warnings. The hazard warning can be words, pictures, or symbols, which provide an immediate understanding of the primary health and/or physical hazard(s) of the

material. Labels must be legible, in English, and prominently displayed. Transfer containers, i.e., containers which are used on station to house smaller quantities and are not in original containers, shall be labeled, tagged, or marked with the identity of the hazardous chemicals contained therein and have the appropriate hazard warnings.

#### **4. RESPONSIBILITIES:**

a. The Associate Director, as Chairperson of the Medical Center Environment of Care Council, has the overall management responsibility for oversight of the program.

b. The GEMS Coordinator maintains a master file of original MSDS's, accompanied by a master list of hazardous chemicals.

c. The Industrial Hygienist or designee coordinates the development and maintenance of the Hazard Communication Program to assure its effectiveness and will:

(1) Act as a consultant to all sections in the identification and management of hazardous and potentially hazardous chemicals.

(2) Provide a copy of the Standard 29 CFR 1910.1200 to all sections using hazardous chemicals.

(3) Assure MSDS's meet the requirement of 29 CFR 1910.1200, including being in English.

(4) Monitor the compliance of the Hazard Communication Program by conducting surveys and employee interviews annually.

d. Logistics will maintain a master list of MSDS's for hazardous chemicals in use at the Medical Center that are procured and distributed by Supply, Processing & Distribution (SPD). These MSDS's shall be made available upon request.

e. The Care Line/Service Chief will:

(1) Prepare and maintain a hazardous chemical inventory and ensure the information is readily available to employees, the Industrial Hygienist, and the Employee Health Clinician.

(2) Provide their employees who handle hazardous chemicals with an initial training, annual refresher training, anytime a new hazardous substance is introduced into the work area and maintain a record of this training.

(3) Provide an annual hazardous chemical inventory update by January 1<sup>st</sup> of each year to the GEMS Coordinator. The hazardous chemical inventory will include the name of the substance, the area the substance is used in, manufacturer and the total

quantity of the substance on hand. The hazardous chemical inventory will be updated on a continuing basis.

f. The Supervisor will:

(1) Be responsible for assuring that the safety precautions recommended on the MSDS's are followed and that the required protective clothing is furnished and used.

(2) Provide a labeled hazardous materials binder readily accessible to all employees, on all work shifts, containing the following: a copy of 29 CFR 1910.1200, an up-to-date alphabetically filed MSDS for each hazardous chemical used by the section in that area, an updated hazardous chemical inventory and a current copy of the facility Medical Center Memorandum 04-06, "Hazard Communication Program".

(3) Ensure that labels on hazardous chemical containers are present and not defaced.

(4) Ensure that chemicals utilized in containers other than the original are properly labeled with hazard warning labels to prevent misuse of any chemicals.

(5) Provide Material Safety Data Sheets (MSDS's) which are the most current copy available. MSDS's will be updated on a continuing basis, as new chemicals are evaluated and brought in the facility.

g. Employees are responsible for attending training sessions and following established safe working procedures, utilizing required protective equipment and reporting problems through the supervisory chain.

## **5. REFERENCES:**

OSHA 29 CFR 1910.1200, Hazard Communication Standard  
VA Handbook 7700.1, Occupational Safety and Health Program  
VHA Industrial Hygiene Guidebook, Chapter 10, Hazard Communication.

**6. RESCISSION:** PC-10-03, Hazard Communication Program, dated February 2010.

**7. RECERTIFICATION:** April 2013

Concur/Do Not Concur

Concur/Do Not Concur

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Chief of Staff

Shirley L. Caldwell-Butts, MSN, RN  
AD Patient Care/Nurse Executive

Concur / Do Not Concur

Approved / Disapproved

Deborah Dort, MD  
Acting Associate Director

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Director

## **OPTOMETRY SECTION STANDARD OPERATING POLICY**

### **RESIDENT COUNSELING, REMEDIATION AND DISMISSAL**

**1. PURPOSE:** To define policy, procedures and responsibilities that address counseling, remediation and dismissal of noncareer, postgraduate residents.

**2. APPLICABILITY:** This standard operating procedure (SOP) applies to all post graduate residents in Ocular Disease at the VA Southern Nevada Healthcare System's Optometry Section. It is the policy of the VA Southern Nevada Healthcare System (VASNHS) to provide a fair, equitable, and timely forum for internal review and resolution of disputes on issues regarding deficiencies in performance, suitability or conduct of postgraduate residents arising during the academic year and term of appointment.

**3. PROCESSES AND RESPONSIBILITIES:**

a. Director has the overall responsibility of ensuring that all noncareer, postgraduate residents in Ocular Disease are provided with and follow the policy guidelines in accordance with established directives.

b. Chief, Optometry Section is responsible for the overall delivery of care at VASNHS Eye Clinic and ensures that the attending staff and residents provide quality care. The Chief, Optometry Section has the ultimate responsibility for the coordination of the Optometry Section and the review and revision of this SOP and is consulted on any recommendation for dismissal of an optometry resident.

c. Program Coordinator is responsible for the quality of the overall affiliated education training program at VASNHS Eye Clinic and ensuring that the program is in compliance with the policies of the respective accrediting and/or certifying bodies, and for assuring coordination of activities among all programs and the quality of educational experiences provided within the section. The Program Coordinator addresses issues, provides counseling and remediation and makes recommendations for dismissal of a postgraduate resident.

d. The Director of Residency Programs at the academic affiliate is responsible for the administration of the program at the various affiliated sites. The Director of Residency Programs is consulted on any recommendation for dismissal of a postgraduate resident.

**1. Counseling and Remediation:**

Residents who develop deficiencies in any area of patient care as identified by the Program Coordinator or Attending Staff must participate in a corrective

program designed by the Program Coordinator to address these deficiencies including, but not limited to, the following:

(1) Counseling: The Program Coordinator, in consultation with the Attending Staff (when applicable), will meet with the resident within 48 hours to discuss the identified area(s) of deficiency and how this may affect patient care. The Program Coordinator or Attending Staff will monitor the resident in the area(s) identified as deficient to insure that corrective action has been effected.

(2) Remediation: When a resident has been counseled regarding an area or area of patient care identified as being deficient, the Program Coordinator or Attending Staff will monitor the progress and performance of the resident in weekly intervals. If the identified deficiencies remain, the Program Coordinator will be responsible for designing an individualized program that addresses fundamental concepts and the proper procedures necessary to bring the resident's performance to an acceptable level to ensure quality patient care and safety.

2. Dismissal:

(1) When it is determined that a postgraduate resident should be separated for deficiencies in performance, suitability or conduct that could not be successfully addressed with counseling and remediation, the Program Coordinator will prepare a separation recommendation and will send it through the Chief of the Section, Chief of Staff and the Director of Residency Programs for review and comment and then to the Director for a decision. The recommendation must be supported by a thorough documentation of the resident's deficiencies. If the decision is to separate, the separation will be effected within 15 days of approval.

(2) The Director may modify the provisions of paragraph (1) as he/she determines necessary.

(3) Under normal conditions, the appointment of the postgraduate resident will terminate upon completion of the approved term of service.

4. **REFERENCES AND RELATED DOCUMENTS:**

VASNHS, MCM 02-04-87, "VA Grievance Procedure"  
VASNHS, MCM 11-04-09, "Supervision of Postgraduate Residents"  
VHA Handbook 1400.1, Resident Supervision, current version  
VA Handbook 5021, Part IV, Chapter 2  
M-8, part II, chapter 1

APPROVED BY: \_\_\_\_\_

Geoffrey F. Chiara, O.D.  
Chief, Optometry Section



**Time and Attendance for Part-Time Physicians,  
Dentists, Optometrists, and Podiatrists**

1. **PURPOSE:** To provide policy for effecting regular and adjustable work hours for part-time physicians and to ensure accuracy of time and attendance records. Significant changes have been made to this policy to describe new requirements and procedures for utilization of adjustable work hours.
  
2. **POLICY:** It is the policy of this health care system to ensure accurate accounting of time and attendance for part-time physicians in accordance with regulation. Part-time physicians who are not on a regular part-time schedule will be placed on adjustable work hours.
  
3. **ACTION:**
  - a. Definitions:
    - (1) **Adjustable Work Hours:** Adjustable work hours is a program established to accommodate varying VA patient care needs and part-time VA physicians who have VA or non-VA patient care, research, or educational responsibilities that make adherence to the same regularly scheduled tour of duty every pay period difficult. Adjustable tours are appropriate, for example for part-time physicians at active affiliated facilities with extensive patient care, research, and educational responsibilities who frequently encounter emergencies or other unanticipated obligations that require them to deviate from their scheduled tour of duty. Adjustable work hours provide a means for minimizing this problem.
    - (2) **Administrative Workweek:** The administrative workweek includes Sunday through the following Saturday.
    - (3) **Annual Service Level Expectation:** The number of hours in a service year part-time physicians on either a fixed tour of duty or adjustable work hours are expected to be present during the service year.
    - (4) **Biweekly Work Requirement:** For part-time physicians on adjustable work hours, the total number of hours an employee is scheduled to work during the pay period or to otherwise account for through the use of approved leave. The work requirements of part-time physicians on adjustable work hours are dependent upon VA patient care and other work requirements. All or a portion of the biweekly requirement may be set as a tour of duty (specific hours that the employee must be on duty). However, all of the hours in the biweekly work requirement can be variable if such an arrangement meets VA's needs. These physicians need not be scheduled for

duty every biweekly pay period if VA duty is not required. The biweekly work requirement may remain stable throughout the life of the Memorandum of Service Level Expectations, or may be adjusted by the supervisor on a pay period to pay period basis.

(5) Memorandum of Service Level Expectations, VA Form (VAF) 0880a: VAF 0880a is a written memorandum of understanding between VA and the part-time physician on either a fixed tour of duty or adjustable work hours that specifies an expected level of service during a service year (see Attachment A and C).

(6) Present: To be considered present and to have time count toward the annual work requirement, a part-time physician on adjustable work hours must be engaged in VA clinical, administrative, research, or educational activities as defined.

(7) Service Year: The one-year period covered by a signed VA Memorandum of Service Level Expectations. The agreed level of service shall be commenced on the first day of a pay period.

(8) Tour of Duty: Since the biweekly work requirement and schedule of part-time physicians on adjustable work hours may vary from pay period to pay period, they do not have a tour of duty, per se. However, a tour of duty will be noted in the Electronic Time and Attendance record reflecting the average number of hours to be worked per pay period as stipulated on the Memorandum of Service Level Expectations. The tour of duty forms the basis on which the employee will be paid while the Memorandum of Service Level Expectations is in effect.

b. Determination of Regular or Adjustable Tours:

(1) Physicians may be appointed on a part-time basis. However, part-time appointments are only appropriate in situations where the physician's duties and responsibilities are to be performed at a VA facility, regardless of whether the tour is fixed or adjustable. In situations where the physician's presences at a VA facility is not required (e.g., on-call), other types of appointments or a mix of appointments may be more appropriate. (e.g., intermittent or fee-basis).

(2) Part-time appointments normally imply regularly scheduled tours of duty that do not significantly change from one pay period to another. This schedule may be changed or adjusted during the pay period to accommodate unforeseen needs, if such change is properly approved. All part-time physicians placed on fixed tour of duty must sign a Memorandum of Service Level Expectations, VAF 0880a. (See Attachment C)

(3) When it is perceived to be of benefit to VA patients, part-time physicians can be assigned to adjustable work hours. Part-time physicians should be placed on adjustable work schedules if they have VA or non-VA patient care, research or education responsibilities that make adherence to regularly scheduled tours of duty impractical.

(a) All part-time physicians placed on adjustable work hours must sign a Memorandum of Service Level Expectations, VAF 0880a (including part-time physicians already on adjustable work hours). Under the Memorandum, VA and the part-time physician reach an annual service level expectation based on anticipated VA patient care or other work requirements and physician availability.

Each part-time physician on adjustable work hours is to be paid the same amount each biweekly pay period. VA supervisors establish biweekly work requirements and schedules for their employees based on recurring or known patient care and other VA needs. The biweekly work requirement and/or schedule may be changed with the supervisor's written approval (which may be in electronic format, e.g., e-mail, etc.). However, if VA duty is not required, the biweekly work requirements of physicians on adjustable work schedules are to be so annotated.

(4) VAF 0880a does not constitute an employment contract. It does not obligate VA to provide a physician with the level of employment outlined in the Memorandum, nor does it obligate a physician to provide the expected level of service. However, whenever possible, either VA or the employee should give the other advance notice whenever any VAF 0880a is to be terminated. Terminations should coincide with the end of a pay period.

(a) VAF 0880a contains an expected level of commitment and estimates the amount of time a physician is expected to dedicate to patient care, administrative, research, and educational activities. These activities are defined in paragraph 3.d. below and a worksheet to assist in allocating such time is provided in Attachment B (VAF 0880b).

(b) VAF 0880a is to be prepared by the employee's service, recommended for approval by the Chief of Staff, and approved by the Director. The agreed level of service shall be commenced on the first day of a pay period after approval by the Director. Copies of the approved memorandum are to be provided to the part-time physician, the physician's supervisor, the Compliance Officer (for monitoring and auditing of part-time physician time and attendance) and to Payroll Section to be filed in the employee's payroll folder. Human Resources Management staff will enter the Memorandum of Service Level Expectations for part-time physicians in Veterans Health Information Systems and Technology Architecture (VistA) and will then file the original signed form in the employee's Official Personnel Folder in Human Resources Management Service (HRMS).

(c) The amount of service may not exceed 1820 hours in a service year (seven eighths of full-time employment). The total expected service on VAF 0880a may not be modified, but if an adjustment is required, the existing Memorandum of Service Level Expectations must be terminated and reconciled by HRMS. Accordingly, a new VAF 0880a must be established.

(d) When termination of VAF 0880a by VA or physician is necessary, advance notice should be given by either party, when possible. The termination of VAF 0880a should coincide with the end of a pay period. VA or the

physician may terminate VAF 0880a at any time. Such terminations shall be in writing and copies provided to the part-time physician, the physician's supervisor, the Compliance Officer and to Payroll Section to be filed in the employee's payroll folder. The original signed termination document will be forwarded to HRMS. HRMS staff will terminate the Memorandum of Service Level Expectations for part-time physicians in VistA and file the document in the employee's Official Personnel Folder. VA supervisors shall promptly terminate VAF 0880a whenever it no longer forms the appropriate basis for compensating the physician.

When VA terminates a VAF 0880a prior to the expiration period, the employee's services should be reviewed to determine whether a fixed work schedule, another type of VA appointment, or termination from employment is appropriate.

(e) VAF 0880a automatically terminates on its expiration date. It also terminates if a physician leaves VA employment for any reason, transfers to another VA facility, moves to an excluded position (e.g., movement to a part-time position with a fixed schedule or conversion to full-time, intermittent, fee basis or without compensation employment) or signs a new VAF 0880a.

(f) When VAF 0880a expires or is terminated, it must be reconciled in accordance with the following procedures:

(1) When a memorandum expires or is terminated, the salary and benefits paid are to be reconciled against the amount of work performed during the term of VAF 0880a. HRMS shall determine the number of hours the employee should have worked between the beginning and expiration or termination of VAF 0880a and then determine the number of hours the employee worked during this period, and compute any applicable overpayment or underpayment. Based on information received from HRMS, the Payroll Office will take the necessary steps for underpayment or overpayment. In the case of an overpayment, a Bill of Collection will be issued to the employee. The overpayment liability may not be waived.

(2) In addition to the determination of whether an underpayment or overpayment occurred, HRMS must also determine whether an adjustment to the part-time physician's leave balances must also be made. HRMS will notify the Payroll Office to take necessary actions to adjust leave balances when needed.

c. Recording of Time and Attendance for Part-Time Physicians on Adjustable Work Hours:

(1) All part-time physicians placed on adjustable work hours will record their time and attendance by using automated procedures in VistA through the use of the Electronic Subsidiary Record (ESR).

(2) Supervisors will establish a biweekly work requirement for employees on adjustable work hours and this requirement will be documented in writing using VAF 0880b (Attachment B). All or a portion of the biweekly requirement may be set as a tour of duty (specific hours that the employee must be on duty). However, all of the hours in the biweekly work requirement can be variable if such an arrangement meets VA's needs. Periodically, supervisors are to assess the need for the employee's services and make appropriate adjustments in the biweekly work requirement as necessary. If there is a need to adjust an employee's biweekly work requirement, the approved change will be documented in writing by the supervisor. Whenever possible, adjustments to an employee's biweekly work requirement should be approved in advance. However, in emergent situations, the supervisor can approve such changes on a retroactive basis.

In all cases, the supervisor's approval of a change in the biweekly work requirement will be documented in writing.

(3) Employees are to record their time and attendance on a daily basis in the ESR.

(4) Supervisors are to verify and document that the biweekly work requirement has been met or accounted for by an appropriate leave charge, or that there has been an approved change to the biweekly work requirement. After verification, the supervisor will approve the ESR.

d. Delineation of Time: All part-time physicians, whether on regular or adjustable tours, and service chiefs will complete Attachment E - Delineation of Time and Certification Form, certifying the amount of time spent on patient care, education, research, and administrative duties. This form must be completed and signed at time of hire and will be included in the pre-employment package provided by the Medical Staff Office. This form should be updated as often as necessary to ensure accuracy. The form will be kept at the service level and must be made available upon request by the Compliance Officer, Chief of Staff, or outside entity in case of an audit. The statutory missions of VHA include patient care, research and education. Supporting these broad VHA goals can entail a variety of different work activities, while they contribute to increasing the quality of care provided to veteran patients. At times these official VA functions may be performed off-site from the VA, and still make important contributions to VA care. Whether patient care, research, academic, or administrative in nature, any off-site VA work must be directly related to the VA mission. The list below includes examples of on-site and off-site work, but is not all-inclusive.

(1) On-Site: (on VA grounds)

(a) Clinical: Clinical duties involve providing and/or supervising patient services at VA, clinical teaching at VA related to the care of VA patients, providing patient care at an outpatient clinic, or participating in interdisciplinary patient care conferences at VA. For example, patient evaluation, invasive procedures,

consultation, attending rounds, journal club, follow-up calls, clinical documentation, care coordination, or care planning conferences.

(b) **Administrative:** Administrative duties involve activities such as attending meetings at VA regarding program development, enhancement of clinical or teaching services, continuing medical education, patient care and medical staff issues (e.g., Medication Management and Infection Control Committees, Medical Executive Board, etc.).

(c) **Research:** Research activities include such things as conducting either funded or unfunded approved VA research activities in assigned VA lab space and attending meetings at VA related to research activities (e.g. Research and Development Committee).

(d) **Education:** Educational activities are limited to the hours spent by VA clinical staff preparing and delivering formal presentations or lectures. This excludes supervision of residents on the wards and training of nurses on the wards. Any hours clinicians spend learning about a topic (grand rounds, on the ward, or other site) is part of ongoing clinical skills maintenance or mandatory review and should be counted under clinical time rather than education.

(2) **Off-Site:** (not on VA grounds but performing approved work which is directly related to maintaining academic status, in turn, bringing advantage of academic leadership in respective fields to VA patients)

(a) **Clinical:** This includes providing services for VA patients at a non-VA location (e.g., a VA physician uses the affiliate catheterization lab to treat VA patients with no charge to VA); participating in interdisciplinary patient care conferences at an affiliate to discuss VA patients (e.g., approved VA representation at clinical conferences such as a Tumor Board); teaching related to the care of VA patients (e.g., Grand Rounds); approved attendance at Medical Executive Committee meetings; public service or other professional activities when the activity is considered to be of substantial benefit to VA in accomplishing its general mission or one of its specific functions; or providing services regarding a VA patient from another site (e.g., reading x-rays from home or entering patient notes via remote computer log-on). NOTE: Health care professionals cannot receive any compensation from other sources for activities carried out when they are in a duty status; they must be in a leave status or outside their VA tour of duty.

(b) **Administrative:** This includes approved attendance at lectures, conferences, or off-site meetings related to VA duties (e.g., national or VISN committees or meetings); activities required to maintain academic status (appropriately shared with the affiliate in the case of part-time employees); approved VA representation at meetings at affiliates regarding curriculum development or resident selection; or other administrative issues related to VA activities for which employees are not compensated by the affiliate.

(c) Research: Conducting off-site funded research activities with written waiver from VACO (e.g., research space not available at VAMC); developing a letter of intent; VA representation on a joint IRB; or, if approved, non-funded research related to VA's mission. NOTE: Time allocated for non-funded research will be at the discretion of the supervisor and approved by the COS or Director.

(d) Education: This involves such things as providing orientation or training to house staff or other students at the affiliate regarding information related to VA and its mission.

e. These above examples do not describe all situations that can properly constitute VA work, but provide illustrations of the types of activities that can count as VA work. Consideration needs to be given to the overall situation and context of the work situation. For part-time employees, accurate documentation of VA work for timekeeping purposes is essential.

f. Certification Verifying Receipt, Understanding and Compliance: All part-time physicians are to be advised of VA time and attendance procedures and will certify in writing that they understand such procedures. This certification is to be filed in the employee's Official Personnel Folder. Attachment D is to be used for this certification.

#### **4. RESPONSIBILITIES:**

a. The Chief of Staff has the following responsibilities:

(1) Determining that the adjustable work hours are essential for meeting patient care needs.

(2) Making recommendations to the Director for approval of adjustable work hours for part-time physicians whose duties meet the above criteria.

(3) Ensuring all part-time physicians and clinical Care Line/ Service Chiefs sign Attachment E, Delineation of Time and Certification Form, certifying the amount of time spent on patient care, education, research, and administrative duties.

(4) Ensuring all newly hired part-time physicians sign receipt, understanding and compliance with this policy (Attachment D). This certification form is part of the hiring packet

for newly hired physicians and is coordinated through the Medical Staff Office. The Medical Staff Office will forward the original signed certification to Human Resources Management Service to be filed in the Official Personnel Folder.

b. Clinical service chiefs are responsible for the following:

(1) Ensuring all part-time physicians are aware of their timekeeper's name, location, phone number and e-mail address.

(2) Ensuring part-time physicians are aware of procedures regarding verification of time and attendance.

(3) Reviewing and updating regularly to reflect changes, Attachment E - Delineation of Time and Certification Form with each part-time physician, and certifying the amount of time spent on patient care, education, research, and administrative duties is accurate.

(4) The day-to-day administration of adjustable work hours;

(5) Accounting for deficient time by an appropriate leave charge; and

(6) Assuring adequate coverage to provide necessary services.

(7) After part-time physicians on adjustable work schedules have properly recorded and certified their time and attendance in the ESR, service chiefs (or designated supervisor) will approve the ESR after they verify and document that the biweekly work requirements have been met or accounted for by an appropriate leave charge.

c. Part-time physicians are responsible for the following:

(1) Signing and dating a copy of the VASNHS certifying receipt, understanding and compliance of this policy (Attachment D).

(2) Reviewing and updating regularly to reflect changes, Attachment E - Delineation of Time and Certification Form with their respective clinical service chief and signing the form which annotates amount of time spent on patient care, education, research, and administrative duties.

(3) Fulfilling their total work obligation by duty performance or obtaining leave approval.

(4) Promptly submitting a properly executed SF-71, either electronic or paper to the unit timekeeper; Since everyone has access to VISTA all leave requests should be entered electronically.

(5) Obtaining supervisory approval in advance of attending off-site meetings, conferences, and lectures related to VA duties.

(6) If on an adjustable tour, recording their time and attendance on a daily basis in the ESR.

d. The employee's timekeeper is responsible for the following:



(1) Posting the time and attendance reports daily for those part-time physicians on regular and flexible tours.

(2) Assuring any duty performed in excess of the scheduled bi-weekly tour for part-time physicians on a regular tour is approved by the Chief of Staff.

e. Human Resources Management Service is responsible for:

(1) Ensuring all signed certification forms (Attachment D) for newly hired physicians are filed in the physician's Official Personnel Folder. These signed forms will be forwarded to Human Resources Management Service from the Medical Staff Office.

(2) Ensuring all physicians who change from full-time or intermittent status to part-time status sign receipt, understanding and compliance of this policy (Attachment D) and that the signed certification form is filed in the physician's Official Personnel Folder.

f. The Compliance Officer is responsible for ensuring monthly physical and electronic monitoring of part-time physicians and reporting audit results to the Chief of Staff, the Director, and the VISN.

5. **REFERENCES:** VA Handbook 5011, Part II, Chapter 3

6. **RESCISSION:** Medical Center Memorandum 02-08-154 dated October 2008

7. **RECERTIFICATION:** February 2013

Concur/Do No Concur

Concur/Do Not Concur

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Director

## **Infection Prevention and Control Plan**

### **1. PURPOSE:**

a. The purpose of surveillance, prevention and control of infections program is to identify and reduce the risks of acquiring and transmitting infections among patients, employees, contract service workers, volunteers, students, and visitors. The program covers a broad range of processes and activities, both in direct patient care and in patient care support, that are coordinated and carried out by the organization. This program also links with external organization support systems to reduce the risks from the environment, including food and water source.

b. The scope of the program is facility wide and also includes surveillance of the VA Southern Nevada Healthcare System (VASNHS) at the Community Based Outreach Center (CBOC) in Henderson and Pahrump; Business Center, Central Clinic, East Clinic, Community Based Outreach Center for Homeless Veterans (MASH), North Clinic, Northwest Clinic, Southwest Clinic, West Clinic, Psychosocial Rehabilitative Recovery Center, and the Vet's Center. The MOFH Infection Control Plan is addressed in OI 44-5. Patients seen are from age 18-100+ years.

### **2. POLICY:**

a. To assure that all patients, employees, contract workers, visitors, volunteers, and students are provided the maximum protection from infections. Recommendations for infection prevention and control are based on standards of recognized professional and external agencies such as the Centers for Disease Control and Prevention (CDC), Association for Practitioners in Infection Control and Epidemiology (APIC), The Joint Commission (TJC), Occupational Safety and Health Administration (OSHA), and Department of Veterans Affairs (VA) Directives.

b. All individuals assigned to the VASNHS - Las Vegas are responsible for the prevention and control of transmission of infection. Infection Control is not a department but an organization-wide commitment.

c. This MCM refers to all VASNHS Ambulatory Care settings not associated with the Mike O'Callaghan Federal Hospital unless noted within the paragraph or subsection.

### **3. ACTION:**

a. Actions taken to help prevent or help reduce the risk of healthcare acquired infections (formerly known as nosocomial infections) in patients, employees, and visitors are:

(1) Sinks are readily available throughout the facility for handwashing. Handwashing is the number one way to help prevent the spread of infection. Alcohol based hand sanitizer may be used if there is no visible debris on the hands.

(2) Exam gloves are located in every exam room and other patient care areas.

(3) Provide Flu Vaccine to all patients, employees, and volunteers on an annual basis.

(4) Mandatory initial TB testing / evaluation of all employees and volunteers. Annual testing / evaluation of those with the potential to share air space with a TB patient. Those with a history of a positive TB test, will complete a questionnaire addressing the signs and symptoms of TB.

(5) Offer Hepatitis B Vaccine to all employees.

(6) Having readily available - Personal protection equipment for possible exposure to bloodborne pathogens, which consists of gloves, masks, eye protection, gowns, and Cardiopulmonary Resuscitation (CPR) masks. These items are strategically located throughout the facilities.

(7) Biohazard spill kits are available for blood or body fluid spills if housekeeping is not readily available. These are located in personal protection equipment cabinets.

(8) Provide the Pneumovax to all Veterans and employees age 65 and older and to those that are in a high-risk group.

(9) Patients with a suspected airborne disease will don a mask and be transferred to a negative pressure room as soon as possible. There are two negative pressure rooms at the MOFH on 3B (the VA unit). Additionally, there are two negative pressure rooms on 3A and the Obstetrics (OB) Unit, that could be utilized in an emergency. The Post Anesthesia Care Unit (PACU), Step-down Unit (SDU), and Intensive Care Unit (ICU) each have one.

(10) Environmental Services (housekeeping) performs daily cleaning throughout the facilities.

(11) Patients suspected of TB or other respiratory transmitted diseases are instructed to wear a mask.

(12) Employees with a communicable disease or condition are requested to stay home until they have recovered or are no longer infectious. Employees should report these illnesses to the Occupational Health Nurse. Also, if the employee

comes into contact with someone with a contagious illness and he/she is susceptible, they should report it so an evaluation can be made.

(13) Employees that are exposed to a communicable disease while on duty will be evaluated and treated on a case by case basis according to the organism encountered. Occupational Health provider will make the determination according to CDC recommendations.

(14) Supply, Processing, and Distribution (SPD) sterilizes instruments and other reusable items that are used for invasive procedures. Chemical and biological monitoring is performed to ensure that sterility was attained.

(15) Indwelling medical devices are removed from patients as soon as condition permits.

(16) Known or suspected healthcare acquired infections are reported to the Infection Control Practitioner. Also, communicable illnesses are reported to her/him.

(17) An employee exposure to bloodborne pathogens is treated as an emergency.

(18) Only cleaning agents that were approved by the infection control committee shall be used.

(19) Pest control is performed on a regular basis and is contracted. If a pest control problem arises prior to the next scheduled visit, the contracted company will come on call.

(20) Resheathing of contaminated needles and syringes is prohibited unless a device or a one handed technique is utilized.

(21) Sharps containers that are secured to the wall and locked in place are strategically placed throughout the facility so as to decrease the number of needlestick exposures. These containers are designed in such a way to keep contaminated items out of reach. Free standing containers may be utilized in limited access areas such as Ambulatory Procedures, Phlebotomy, and SPD.

(22) The consumption of food and drink, applying lip balm, or handling contact lens in an area where there is a possibility of patient contact or bloodborne pathogens is prohibited.

(23) Finger tip rubbers are used to turn pages in charts, etc. instead of licking fingers to do so.

(24) Patient care items are not stored under sinks.

(25) Medication refrigerator temperatures are monitored with temperature sensors according to MCM 138-14.

(26) Patient care items and equipment are cleaned, disinfected, and/or sterilized according to their classification. Patient care items are disinfected prior to being sent to the Biomedical Department. Disinfectant wipes are available in every exam and procedure room.

(28) When there is evidence that there may be an outbreak of an infectious disease, an outbreak study will be conducted according to guidelines set forth by the Association for Practitioners in Infection Control and Epidemiology. Once identified, action will be taken to control the outbreak. The primary components of the initial investigation include the following:

- (a) Confirming the presence of an outbreak
- (b) Alerting key partners about the investigation
- (c) Performing a literature review
- (d) Establishing a preliminary case definition
- (e) Developing a methodology for case finding
- (f) Preparing an initial line list and epidemic curve
- (g) Observing and reviewing potentially implicated patient care activities
- (h) Considering whether environmental sampling should be done
- (i) Implementing initial control measures

The primary components of the follow-up investigation include the following:

- (a) Refining the case definition
- (b) Continuing case finding and surveillance
- (c) Reviewing regularly control measures
- (d) Considering whether an analytic study should be performed
- (e) Communicate the findings by writing a report.

(29) Certain communicable diseases are reported to the Health Department, according to law, which is done by the Infection Control Practitioner.

(30) All departments are ultimately responsible for their rotation of stock, quality control, checking for expired items, and maintenance of appropriate stock levels.

(31) Standard and Transmission Based Precautions are used throughout the facility. See attachment.

(32) Patients with the flu or other upper respiratory infections are asked to keep their mouths and nose covered with tissues or a mask is offered.

(33) Clean linen is kept covered at all times and is kept separate from dirty linen.

(34) Syringes, angiocaths, and lancets with a safety mechanism and needleless IV systems are used so as to reduce the incidence of sharps injuries.

(35) Items that are contaminated are kept separate from clean items.

(36) Biohazardous waste receptacles are strategically located throughout the facility.

(37) Certain antibiotics and their usage are monitored.

(38) Patients that are infected with Hepatitis C are offered the Hepatitis A and B vaccines in order to prevent further injury to the liver.

(39) Respiratory Hygiene Stations, which contain tissues, masks, and alcohol based hand sanitizer are located at the entrance to clinics.

b. The VA Southern Nevada Healthcare System uses a coordinated process to reduce the risks of endemic and epidemic healthcare acquired infections in patients and health care workers.

This process is based on sound epidemiological principles and research. It addresses issues that are high risk and epidemiologically important to the VASNHS such as:

- (1) Surgical site or other procedure infections
- (2) Device-related infections
- (3) Drug resistant microorganisms
- (4) Communicable diseases
- (5) Bacteremias

(6) Suspicion of Employee bloodborne pathogen exposures or incidents, are reported to the Occupational Health Nurse and Infection Control Practitioner.

c. Surveillance is the data collection, processing, and analysis function of the infection prevention and control program, which is carried out for the purpose of reducing the risk of healthcare acquired infections for patients, workers, and visitors. It is carried out for the purpose of identifying problem areas, providing analytical basis for the formulation of effective intervention strategies, and analyzing the effectiveness of interventions that have been instituted. Data may be collected from a number of sources. Generally, the following are routinely examined for indications of healthcare acquired infections:

- (1) Microbiology data
- (2) Medical records - progress notes
- (3) Graphic records
- (4) Radiographic reports
- (5) Medication records
- (6) Interviews
- (7) Autopsy reports

d. Case findings and demographically important healthcare acquired infections are reported to the infection prevention and control committee.

e. The Centers for Disease Control and Prevention (CDC) definitions for healthcare acquired infections shall be utilized.

f. The infection prevention and control process is integrated with the organization-wide performance improvement process. Data about healthcare acquired infection risks, trends, and rates stimulate ongoing study to improve prevention and control activities and reduce healthcare acquired infection rates to the lowest possible levels.

g. If there should be a sudden influx of infectious patients, the Infection Prevention and Control Practitioner will notify the Southern Nevada Health District, Epidemiology Section. If it were an overwhelming number of patients, then the patients would be directed to go to the Mike O'Callaghan Federal Hospital Emergency Room or to a local hospital or Quick-Care.

h. There are certain contagious infectious diseases that are at higher risk of being transmitted at the clinics than others. Colds and flu have the highest risk of being transmitted.

i. With the threat of bioterrorism, as a weapon of mass destruction, there is the risk of other diseases such as:

- (1) Smallpox
- (2) Anthrax
- (3) Plague
- (4) Tularemia
- (5) Botulism
- (6) Brucellosis
- (7) Q Fever
- (8) Viral Hemorrhagic Fevers

j. If there are any internal or external disasters, the Emergency Management Plan will be initiated.

k. For any patient procedure that requires an injection or incision, aseptic technique shall be followed.

- (1) If there is a need for hair removal, then disposable clippers or depilatories shall be used.
- (2) The area will first be prepped with an appropriate antiseptic.
- (3) For incisions, a sterile field using sterile draping shall be attained.
  - (a) The provider will wear a mask and sterile gloves.
  - (b) Antimicrobial prophylaxis is indicated only in certain procedures.
- (4) Educate your patients about surgical site infections and how to prevent them with good proper hand hygiene. Instruct them to notify their provider if they have any of the signs and symptoms of a wound infection.

j. Single use disposable items are not reprocessed.



#### 4. **RESPONSIBILITIES:**

- a. The Director has the overall responsibility for the implementation of this memorandum.
- b. The Associate Director has the responsibility of supporting the efforts of all administrative services in implementing this memorandum.
- c. The Chief of Staff has the responsibility of providing support to all clinical services in implementing this memorandum.

d. **Infection Prevention and Control Committee:** The multidisciplinary Infection Prevention and Control Committee is responsible for the continuous monitoring of the Infection Prevention and Control Program. In the interest of early and complete reporting and prevention, authority is given to the Infection Prevention and Control Chairperson and Infection Prevention and Control Practitioner to institute any culture and sensitivity testing, isolation procedures, and any other precautions or actions deemed necessary to prevent further transmission of infection, such as in an outbreak. When these actions are taken, the patient's primary physician shall be notified. The Infection Prevention and Control Committee, through its chairperson or physician members, has the authority to institute appropriate control measures or studies when there is reasonable consideration of danger to any patient or personnel.

The committee will establish and execute policies to prevent the acquisition and cross contamination of healthcare acquired infections. Committee members shall meet no less than quarterly. Written meeting minutes are sent to the Chief of Staff and Director for signatures and then are sent to the [Medical Executive Board](#) and [Executive Leadership Board](#).

e. **Infection Prevention and Control Chairperson:** The Chairperson is a physician or dentist with knowledge or interest in epidemiology and infectious diseases. He/she conducts Infection Prevention and Control Committee meetings, and is responsible for direction and advice to the Infection Prevention and Control Practitioner. The Chairperson has delegated authority from the medical center director and the Infection Prevention and Control Committee to institute emergency infection control measures and studies to investigate a suspected or apparent problem when indicated.

f. **Infection Prevention and Control Practitioner (ICP):** The ICP is a registered nurse with a certification in infection prevention and control. He/she serves as a principal member and co-chair of the Infection Prevention and Control Committee, responsible for coordinating, implementing, supervising, and evaluating standards of care relating to infection prevention and control; compiles and analyzes surveillance of infections in patients and personnel. To obtain maximum benefit from the role of the nurse, he/she is given authority and freedom to function in all departments of the facility as well as having access to all records. Develops and participates in inservice education programs. Provides input for orientation to new employees and an annual update.

Assures reporting of communicable diseases to the public health department. Is available as a consultant to the Air Force Infection Control Officer at the Mike O'Callaghan Federal Hospital. Assumes responsibility for self-education by reviewing current literature, attending workshops, seminars, and formal courses. He/she acts as a reference person for all departments and employees. Consults on the purchase of supplies and equipment. Networks with ICPs from other healthcare facilities (other Vas, contract nursing homes, and community hospitals) to assist in the continuum of care and to notify them of any healthcare acquired infections that this facility detects during follow-up.

g. Care Line/Service Chiefs have the responsibility of implementing this memorandum. They need to maintain an effective infection prevention and control program within their services and utilize the Infection Prevention and Control Practitioner or committee when needed. Their new employees must attend orientation and the mandatory annual updates. Policies and procedures are reviewed and updated every three years or sooner if needed. Care Line/Service Chiefs ensure that their employees see Occupational Health [personnel](#) when requested.

h. Employees, Volunteers, Students, and Consultants: It is the responsibility of all of these personnel to know and abide by the Infection Prevention and Control Program. All new employees must attend orientation and mandatory annual updates. Compliance with established infection prevention and control protocol is the responsibility of each individual. Each employee is responsible for reporting real or suspected infections to the Infection Prevention and Control Practitioner.

## **5. REFERENCES:**

Association for Practitioners in Infection Control and Epidemiology Text of Infection Control and Epidemiology, 3<sup>rd</sup> Edition; 2009  
The Joint Commission Accreditation Manual, current edition  
Hospital Infections Third Edition, Bennett and Brachman  
OSHA Bloodborne Pathogen Standard, 29 CFR 1910.1030, Revised 2001  
CDC Tuberculosis Prevention Guideline for Healthcare Facilities 2005 MMWR Vol 54  
M-1, Part I, Chapter 1, Section 1.84, par 1; chapter 26;  
M-2, Part III, chapter 3, M-3, Part III, chapter 2

**6. RESCISSION:** MCM IC-10-01, Infection Prevention and Control Plan, dated March 2010

**7. RECERTIFICATION:** September 2013

Concur/Do Not Concur

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Attachments (4):

- A. Standard Precautions
- B. Standard Precautions, Table I
- C. Standard Precautions, Table II
- D. Standard Precaution, Table AA

## Standard Precautions

Standard Precautions synthesize the major features of UP (Blood and Body Fluid Precautions) (27, 28) (designed to reduce the risk of transmission of bloodborne pathogens) and BSI (29, 30) (designed to reduce the risk of transmission of pathogens from moist body substances) and applies them to all patients receiving care in hospitals, regardless of their diagnosis or presumed infection status. Standard Precautions apply to (1) blood; (2) all body fluids, secretions, and excretions except sweat, regardless of whether or not they contain visible blood; (3) nonintact skin; and, (4) mucous membranes. Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals.

## Transmission-Based Precautions

Transmission-Based Precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission in hospitals.

There are three types of Transmission-Based Precautions:

Airborne Precautions, Droplet Precautions, and Contact Precautions. They may be combined for diseases that have multiple routes of transmission. When used either singularly or in combination, they are to be used in addition to Standard Precautions.

Airborne Precautions are designed to reduce the risk of airborne transmission of infectious agents. Airborne transmission occurs by dissemination of either airborne droplet nuclei (small-particle residue {5  $\mu$ m or smaller in size} of evaporated droplets that may remain suspended in the air for long periods of time) or dust particles containing the infectious agent. Microorganisms carried in this manner can be dispersed widely by air currents and may become inhaled by or deposited on a susceptible host within the same room or over a longer distance from the source patient, depending on environmental factors; therefore, special air handling and ventilation are required to prevent airborne transmission. Airborne Precautions apply to patients known or suspected to be infected with epidemiologically important pathogens that can be transmitted by the airborne route.

Droplet Precautions are designed to reduce the risk of droplet transmission of infectious agents. Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5  $\mu$ m in sizes) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets are generated from the source person primarily during coughing, sneezing, or talking and during the performance of certain procedures such as suctioning and bronchoscopy. Transmission

via large-particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only short distances, usually 3 ft or less, through the air. Because droplets do not remain suspended in the air, special air handling and ventilation are not required to prevent droplet transmission. Droplet Precautions apply to any patient known or suspected to be infected with epidemiologically important pathogens that can be transmitted by infectious droplets.

Contact Precautions are designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Direct-contact transmission involves skin-to-skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person, such as occurs when personnel turn patients, bathe patients, or perform other patient-care activities that require physical contact. Direct-contact transmission also can occur between two patients (eg, by hand contact), with one serving as the source of infectious microorganisms and the other as a susceptible host. Indirect-contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the patient's environment. Contact Precautions apply to specified patients known or suspected to be infected or colonized (presence of microorganism in or on patient but without clinical signs and symptoms of infection) with epidemiologically important microorganisms that can be transmitted by direct or indirect contact.

A synopsis of the types of precautions and the patients requiring the precautions is listed in [Table 1](#).

**Empiric Use of Airborne, Droplet, or Contact Precautions.** In many instances, the risk of nosocomial transmission of infection may be highest before a definitive diagnosis can be made and before precautions based on that diagnosis can be implemented. The routine use of Standard Precautions for all patients should reduce greatly this risk for conditions other than those requiring Airborne, Droplet, or Contact Precautions. While it is not possible to prospectively identify all patients needing these enhanced precautions, certain clinical syndromes and conditions carry a sufficiently high risk to warrant the empiric addition of enhanced precautions while a more definitive diagnosis is pursued. A listing of such conditions and the recommended precautions beyond Standard Precautions is presented in [Table 2](#). The organisms listed under the column "Potential Pathogens" are not intended to represent the complete or even most likely diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out. Infection control professionals are encouraged to modify or adapt this table according to local conditions. To ensure that appropriate empiric precautions are implemented always, hospitals must have systems in place to evaluate patients routinely according to these criteria as part of their preadmission and admission care.

## IMMUNOCOMPROMISED PATIENTS

Immunocompromised patients vary in their susceptibility to nosocomial infections, depending on the severity and duration of immunosuppression. They generally are at increased risk for bacterial, fungal, parasitic, and viral infections from both endogenous and exogenous sources. The use of Standard Precautions for all patients and Transmission-Based Precautions for specified patients, as recommended in this guideline, should reduce the acquisition by these patients of institutionally acquired bacteria from other patients and environments. It is beyond the scope of this guideline to address the various measures that may be used for immunocompromised patients to delay or prevent acquisition of potential pathogens during temporary periods of neutropenia. Rather, the primary objective of this guideline is to prevent transmission of pathogens from infected or colonized patients in hospitals. Users of this guideline, however, are referred to the "Guideline for Prevention of Nosocomial Pneumonia" (95, 96) for the HICPAC recommendations for prevention of nosocomial aspergillosis and Legionnaires' disease in immunocompromised patients.

### Recommendations

The recommendations presented below are categorized as follows:

**Category IA.** Strongly recommended for all hospitals and strongly supported by well-designed experimental or epidemiologic studies. **Category IB.** Strongly recommended for all hospitals and reviewed as effective by experts in the field and a consensus of HICPAC based on strong rationale and suggestive evidence, even though definitive scientific studies have not been done.

**Category II.** Suggested for implementation in many hospitals. Recommendations may be supported by suggestive clinical or epidemiologic studies, a strong theoretical rationale, or definitive studies applicable to some, but not all, hospitals. No recommendation; unresolved issue. Practices for which insufficient evidence or consensus regarding efficacy exists. The recommendations are limited to the topic of isolation precautions. Therefore, they must be supplemented by hospital policies and procedures for other aspects of infection and environmental control, occupational health, administrative and legal issues, and other issues beyond the scope of this guideline.

## I. Administrative Controls

### Education

Develop a system to ensure that hospital patients, personnel, and visitors are educated about use of precautions and their responsibility for adherence to them. Category IB

### Adherence to Precautions

Periodically evaluate adherence to precautions, and use findings to direct improvements. Category IB

## **II. Standard Precautions**

Use Standard Precautions, or the equivalent, for the care of all patients. Category IB

### Handwashing

(1) Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites. Category IB

(2) Use an antimicrobial soap for routine handwashing, in a healthcare facility. Category IB

(3) Use a waterless antiseptic agent if there is no visible debris on the hands. Category IB (See Contact Precautions for additional recommendations on using antimicrobial and antiseptic agents.)

### Gloves

Wear gloves (clean, nonsterile gloves are adequate) when touching blood, body fluids, secretions, excretions, and contaminated items. Put on clean gloves just before touching mucous membranes and nonintact skin. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms.

Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another patient, and wash hands immediately to avoid transfer of microorganisms to other patients or environments. Category IB

### Mask, Eye Protection, Face Shield

Wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions. Category IB

### Gown

Wear a gown (a clean, nonsterile gown is adequate) to protect skin and to prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions. Select a gown that is appropriate for the activity and amount of fluid likely to be encountered. Remove a soiled gown as promptly as possible and wash hands to avoid transfer of microorganisms to other patients or environments. Category IB

### Patient-Care Equipment

Handle used patient-care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and

environments. Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and reprocessed appropriately. Ensure that single-use items are discarded properly. Category IB

#### Environmental Control

Ensure that the hospital has adequate procedures for the routine care, cleaning, and disinfection of environmental surfaces, beds, bed rails, bedside equipment, and other frequently touched surfaces and ensure that these procedures are being followed. Category IB

#### Linen

Handle, transport, and process used linen soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures and contamination of clothing and that avoids transfer of microorganisms to other patients and environments. Category IB

#### Occupational Health and Bloodborne Pathogens

Take care to prevent injuries when using needles, scalpels, and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments; and when disposing of used needles. Never recap used needles, or otherwise manipulate them using both hands, or use any other technique that involves directing the point of a needle toward any part of the body; rather, use either a one-handed "scoop" technique or a mechanical device designed for holding the needle sheath. Do not remove used needles from disposable syringes by hand, and do not bend, break, or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpel blades, and other sharp items in appropriate puncture-resistant containers, which are located as close as practical to the area in which the items were used, and place reusable syringes and needles in a puncture-resistant container for transport to the reprocessing area. Category IB (2) Use mouthpieces, resuscitation bags, or other ventilation devices as an alternative to mouth-to-mouth resuscitation methods in areas where the need for resuscitation is predictable. Category IB

#### Patient Placement

Place a patient who contaminates the environment or who does not (or cannot be expected to) assist in maintaining appropriate hygiene or environmental control in a private room. If a private room is not available, consult with infection control professionals regarding patient placement or other alternatives. Category IB

### **III. Airborne Precautions**

In addition to Standard Precautions, use Airborne Precautions, or the equivalent, for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small-particle residue {5  $\mu$ m or smaller in size} of evaporated droplets containing microorganisms that remain suspended in the air and that can be dispersed widely by air currents within a room or over a long distance). Category IB



#### Patient Placement

Place the patient in a private room that has (1) monitored negative air pressure in relation to the surrounding area, (2) 6 to 12 air changes per hour, and (3) appropriate discharge of air outdoors or monitored high-efficiency filtration of room air before the air is circulated to other areas in the hospital. (23) Keep the room door closed and the patient in the room. When a private room is not available, place the patient in a room with a patient who has active infection with the same microorganism, unless otherwise recommended, (23) but with no other infection. When a private room is not available and cohorting is not desirable, consultation with infection control professionals is advised before patient placement. Category IB

#### Respiratory Protection

Wear respiratory protection when entering the room of a patient with known or suspected infectious pulmonary tuberculosis. (23, 81) Susceptible persons should not enter the room of patients known or suspected to have measles or (rubeola) or varicella (chickenpox) if other immune caregivers are available. If susceptible persons must enter the room of a patient known or suspected to have measles (rubeola) or varicella, they should wear respiratory protection. (81) Persons immune to measles (rubeola) or varicella need not wear respiratory protection. Category IB

#### Patient Transport

Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize patient dispersal of droplet nuclei by placing a surgical mask on the patient, if possible. Category IB

#### Additional Precautions for Preventing Transmission of Tuberculosis

Consult CDC "Guidelines for Preventing the Transmission of Tuberculosis in Health-Care Transmission of Facilities" (23) for additional prevention strategies.

### **IV. Droplet Precautions**

In addition to Standard Precautions, use Droplet Precautions, or the equivalent for a patient known or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets {larger than 5  $\mu$ m in size} that can be generated by the patient during coughing, sneezing, talking, or the performance of procedures). Category IB

#### Patient Placement

Place the patient in a private room. When a private room is not available, place the patient in a room with a patient(s) who has active infection with the same microorganism but with no other infection (cohorting). When a private room is not available and cohorting is not achievable, maintain spatial separation of at least 3 ft between the

infected patient and other patients and visitors. Special air handling and ventilation are not necessary, and the door may remain open. Category IB

#### Mask

In addition to standard precautions, wear a mask when working within 3 ft of the patient. (Logistically, some hospitals may want to implement the wearing of a mask to enter the room.) Category IB

#### Patient Transport

Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize patient dispersal of droplets by masking the patient, if possible. Category IB

### **V. Contact Precautions**

In addition to Standard Precautions, use Contact Precautions, or the equivalent, for specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient-care activities that require touching the patient's dry skin) or indirect contact (touching) with environmental surfaces or patient-care items in the patient's environment. Category IB

#### Patient Placement

Place the patient in a private room. When a private room is not available, place the patient in a room with a patient(s) who has active infection with the same microorganism but with no other infection (cohorting). When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. Consultation with infection control professionals is advised before patient placement. Category IB

#### Gloves and Handwashing

In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, nonsterile gloves are adequate) when entering the room. During the course of providing care for a patient, change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material and wound drainage). Remove gloves before leaving the patient's environment and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent. (72, 94)

After glove removal and handwashing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the patient's room to avoid transfer of microorganisms to other patients or environments. Category IB

#### Gown

In addition to wearing a gown as outlined under Standard Precautions, wear a gown (a clean, nonsterile gown is adequate) when entering the room if you anticipate that your clothing will have substantial contact with the patient, environmental surfaces, or items in

the patient's room, or if the patient is incontinent or has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing. Remove the gown before leaving the patient's environment. After gown removal, ensure that clothing does not contact potentially contaminated environmental surfaces to avoid transfer of microorganisms to other patients or environments. Category IB

#### Patient Transport

Limit the movement and transport of the patient from the room to essential purposes only. If the patient is transported out of the room, ensure that precautions are maintained to minimize the risk of transmission of microorganisms to other patients and contamination of environmental surfaces or equipment. Category IB

#### Patient-Care Equipment

When possible, dedicate the use of noncritical patient-care equipment to a single patient (or cohort of patients infected or colonized with the pathogen requiring precautions) to avoid sharing between patients. If use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another patient. Category IB

#### Additional Precautions for Preventing the Spread of Vancomycin Resistance

Consult the HICPAC report on preventing the spread of vancomycin resistance for additional prevention strategies. (94

**TABLE 1**  
**SYNOPSIS OF TYPES OF PRECAUTIONS AND PATIENTS REQUIRING THE PRECAUTIONS \***

=====

### **Standard Precautions**

Use Standard Precautions for the care of all patients

### **Airborne Precautions**

In addition to Standard Precautions, use Airborne Precautions for patients known or suspected to have serious illnesses transmitted by airborne droplet nuclei. Examples of such illnesses include:

Measles  
 Varicella (including disseminated zoster) +  
 Tuberculosis ++

### **Droplet Precautions**

In addition to Standard Precautions, use Droplet Precautions for patients known or suspected to have serious illnesses transmitted by large particle droplets. Examples of such illnesses include:

Invasive *Haemophilus influenzae* type b disease, including meningitis, pneumonia, epiglottitis, and sepsis

Invasive *Neisseria meningitidis* disease, including meningitis, pneumonia, and sepsis

Other serious bacterial respiratory infections spread by droplet transmission, including:

Diphtheria (pharyngeal)  
 Mycoplasma pneumonia  
 Pertussis  
 Pneumonic plague  
 Streptococcal pharyngitis, pneumonia, or scarlet fever in infants and young children

Serious viral infections spread by droplet transmission, including:

Adenovirus +  
 Influenza  
 Mumps  
 Parvovirus B19  
 Rubella

### **Contact Precautions:**

In addition to Standard Precautions, use Contact Precautions for patients known or suspected to have serious illnesses easily transmitted by direct patient contact or by contact with items in the patient's environment. Examples of such illnesses include:

Gastrointestinal, respiratory, skin, or wound infections or colonization with multidrug-resistant bacteria judged by the infection control program, based on current state, regional, or national recommendations, to be of special clinical and epidemiologic significance

Enteric infections with a low infectious dose or prolonged environmental survival, including:

Clostridium difficile

For diapered or incontinent patients: enterohemorrhagic Escherichia coli O157:H7, Shigella, hepatitis A, or rotavirus

Respiratory syncytial virus, parainfluenza virus, or enteroviral infections in infants and young children

Skin infections that are highly contagious or that may occur on dry skin, including:

Diphtheria (cutaneous)

Herpes simplex virus (neonatal or mucocutaneous)

Impetigo

Major (noncontained) abscesses, cellulitis, or decubiti

Pediculosis

Scabies

Staphylococcal furunculosis in infants and young children

Zoster (disseminated or in the immunocompromised host) +

Viral/hemorrhagic conjunctivitis

Viral hemorrhagic infections (Ebola, Lassa, or Marburg) \*

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-----  
\* See Appendix A for a complete listing of infections requiring precautions, including appropriate footnotes.

+ Certain infections require more than one type of precaution.

++ See CDC "Guidelines for Preventing the Transmission of Tuberculosis in Health-Care Facilities." (23)

=====  
=====

**TABLE 2**  
**CLINICAL SYNDROMES OR CONDITIONS WARRANTING ADDITIONAL**  
**EMPIRIC PRECAUTIONS TO PREVENT TRANSMISSION OF**  
**EPIDEMIOLOGICALLY IMPORTANT PATHOGENS PENDING**  
**CONFIRMATION OF DIAGNOSIS \***

| =====   |                                   |
|---|-----------------------------------|
| =====   |                                   |
| Clinical Syndrome or Condition +<br>Precautions   | Empiric<br>Potential Pathogens ++ |
| -----   |                                   |
| -----   |                                   |
| <b>Diarrhea</b>   |                                   |
| Acute diarrhea with a likely infectious cause in an<br>Contact<br>incontinent or diapered patient   | Enteric Pathogens &               |
| Diarrhea in an adult with a history of recent<br>Contact<br>antibiotic use  | Clostridium difficile             |
| Meningitis<br>Droplet   | Neisseria meningitidis            |
| <b>Rash or exanthems, generalized, etiology unknown</b>   |                                   |
| Petechial/ecchymotic with fever<br>Droplet  | Neisseria meningitidis            |
| Vesicular<br>Airborne and<br>contact  | Varicella                         |
| Maculopapular with coryza and fever<br>Airborne   | Rubeola (measles)                 |
| <b>Respiratory infections:</b>  |                                   |
| Cough/fever/upper lobe pulmonary infiltrate<br>Airborne<br>in an HIV-negative patient or a patient at low<br>risk for HIV infection                 | Mycobacterium tuberculosis        |
| Cough/fever/pulmonary infiltrate in any lung<br>Airborne<br>location in an HIV-infected patient or a patient<br>at high risk for HIV infection (23) | Mycobacterium tuberculosis        |

|  |                      |
|--|----------------------|
| Paroxysmal or severe persistent cough during<br>Droplet<br>periods of pertussis activity | Bordetella pertussis |
|--|----------------------|

|   |   |
|---|---|
| Respiratory infections, particularly bronchiolitis<br>Contact<br>and croup, in infants and young children | Respiratory syncytial or<br>parainfluenza virus |
|---|---|

### Risk of multidrug-resistant microorganisms

|  |  |
|--|--|
| History of infection or colonization with<br>Contact<br>multidrug-resistant organisms @<br>Skin, wound, or urinary tract infection in a patient<br>Contact<br>with a recent hospital or nursing home stay in a<br>facility where multidrug-resistant organisms are prevalent | Resistant bacteria<br><br><br><br>Resistant bacteria |
|--|--|

#### Skin or Wound Infection

|   |                        |
|---|------------------------|
| Abscess or draining wound that cannot be covered<br>Contact | Staphylococcus aureus, |
|---|------------------------|

Group A

streptococcus

-----  
-----  
\* Infection control professionals are encouraged to modify or adapt this table according to local conditions. To ensure that appropriate empiric precautions are implemented always, hospitals must have systems in place to evaluate patients routinely according to these criteria as part of their preadmission and admission care.

+ Patients with the syndromes or conditions listed below may present with atypical signs or symptoms (eg, pertussis in neonates and adults may not have paroxysmal or severe cough). The clinician's index of suspicion should be guided by the prevalence of specific conditions in the community, as well as clinical judgment.

++ The organisms listed under the column "Potential Pathogens" are not intended to represent the complete, or even most likely, diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out.

& These pathogens include enterohemorrhagic Escherichia coli O157:H7, Shigella, hepatitis A, and rotavirus.

@ Resistant bacteria judged by the infection control program, based on current state, regional, or national recommendations, to be of special clinical or epidemiological significance.

Table AA

## APPENDIX A

## Type and Duration of Precautions Needed for Selected Infections and Conditions

| Infection/Condition  |     | Precautions |       |
|--|-----|-------------|-------|
| Type *   |     | Duration    |       |
| +  |     |             |       |
| -----  |     |             |       |
| -----  |     |             |       |
| Abscess  |     |             |       |
| Draining, major (1)  | C   |             | DI    |
| Draining, minor or limited (2)   | S   |             |       |
| Acquired immunodeficiency syndrome (3)                                   | S   |             |       |
| Actinomycosis  | S   |             |       |
| Adenovirus infection, in infants and young children                      | D,C |             | DI    |
| Amebiasis  | S   |             |       |
| Anthrax  |     |             |       |
| Cutaneous  | S   |             |       |
| Pulmonary  | S   |             |       |
| Antibiotic-associated colitis (see Clostridium difficile)                |     |             |       |
| Arthropodborne viral encephalitides (eastern, western,                   |     |             |       |
| Venezuelan equine encephalomyelitis; St. Louis, California encephalitis) |     | S (4)       |       |
| Arthropodborne viral fevers (dengue, yellow fever, Colorado tick fever)  |     | S (4)       |       |
| Ascariasis   | S   |             |       |
| Aspergillosis  | S   |             |       |
| Babesiosis   | S   |             |       |
| Blastomycosis, North American, cutaneous or pulmonary                    | S   |             |       |
| Botulism   | S   |             |       |
| Bronchiolitis (see respiratory infections in infants and young children) |     |             |       |
| Brucellosis (undulant, Malta, Mediterranean fever)                       | S   |             |       |
| Campylobacter gastroenteritis (see gastroenteritis)                      |     |             |       |
| Candidiasis, all forms including mucocutaneous                           | S   |             |       |
| Cat-scratch fever (benign inoculation lymphoreticulosis)                 | S   |             |       |
| Cellulitis, uncontrolled drainage  | C   |             | DI    |
| Chancroid (soft chancre)   | S   |             |       |
| Chickenpox (varicella; see F (5) for varicella exposure)                 | A,C |             | F (5) |
| Chlamydia trachomatis  |     |             |       |
| Conjunctivitis   | S   |             |       |



|                               |   |
|-------------------------------|---|
| Genital                       | S |
| Respiratory                   | S |
| Cholera (see gastroenteritis) |   |

## Precautions

| Infection/Condition   | Type * | Duration |
|---|--------|----------|
| Closed-cavity infection   |        |          |
| Draining, limited or minor  | S      |          |
| Not draining  | S      |          |
| Clostridium   |        |          |
| C botulinum   | S      |          |
| C difficile   | C      | DI       |
| C perfringens   |        |          |
|   |        |          |
| Food poisoning  | S      |          |
| Gas gangrene  | S      |          |
| Coccidioidomycosis (valley fever)                                     |        |          |
| Draining lesions  | S      |          |
| Pneumonia   | S      |          |
| Colorado tick fever   | S      |          |
| Congenital rubella  | C      | F (6)    |
| Conjunctivitis  |        |          |
| Acute bacterial   | S      |          |
| Chlamydia   | S      |          |
| Gonococcal  | S      |          |
| Acute viral (acute hemorrhagic)                                       | C      | DI       |
| Coxsackievirus disease (see enteroviral infection)                    |        |          |
| Creutzfeldt-Jakob disease   | S (7)  |          |
| Croup (see respiratory infections in infants and young children)      |        |          |
| Cryptococcosis  | S      |          |
| Cryptosporidiosis (see gastroenteritis)                               |        |          |
| Cysticercosis   | S      |          |
| Cytomegalovirus infection, neonatal or immunosuppressed               | S      |          |
| Decubitus ulcer, infected   |        |          |
| Major (1)   | C      | DI       |
| Minor or limited (2)  | S      |          |
| Dengue  | S (4)  |          |
| Diarrhea, acute -- infective etiology suspected (see gastroenteritis) |        |          |
| Diphtheria  |        |          |
| Cutaneous   | C      | CN (8)   |
| Pharyngeal  | D      | CN (8)   |
| Ebola viral hemorrhagic fever   | C (9)  | DI       |

| Attachment D (continued)  |               |                 |
|---|---------------|-----------------|
| Echinococcosis (hydatidosis)  | S             |                 |
| <u>Infection/Condition</u>  | <u>Type *</u> | <u>Duration</u> |
| Echovirus (see enteroviral infection)   |               |                 |
| Encephalitis or encephalomyelitis (see specific etiologic agents)   |               |                 |
| Endometritis  | S             |                 |
| Enterobiasis (pinworm disease, oxyuriasis)  | S             |                 |
| Enterococcus species (see multidrug-resistant organisms if epidemiologically significant or vancomycin resistant) |               |                 |
| Enterocolitis, Clostridium difficile  | C             | DI              |
| Enteroviral infections  |               |                 |
| Adults  | S             |                 |
| Infants and young children  | C             | DI              |
| Epiglottitis, due to Haemophilus influenzae   | D             | U (24 hrs)      |
| Epstein-Barr virus infection, including infectious mononucleosis  | S             |                 |
| Erythema infectiosum (also see Parvovirus B19)  | S             |                 |
| Escherichia coli gastroenteritis (see gastroenteritis)  |               |                 |
| Food poisoning  |               |                 |
| Botulism  | S             |                 |
| Clostridium perfringens or welchii  | S             |                 |
| Staphylococcal  | S             |                 |
| Furunculosis -- staphylococcal  |               |                 |
| Infants and young children  | C             | DI              |
| Gangrene (gas gangrene)   | S             |                 |
| Gastroenteritis   |               |                 |
| Campylobacter species   | S (10)        |                 |
| Cholera   | S (10)        |                 |
| Clostridium difficile   | C             | DI              |
| Cryptosporidium species   | S (10)        |                 |
| Escherichia coli  |               |                 |
| Enterohemorrhagic O157:H7   | S (10)        |                 |
| Diapered or incontinent   | C             | DI              |
| Other species   | S (10)        |                 |
| Giardia lamblia   | S (10)        |                 |
| Rotavirus   | S (10)        |                 |
| Diapered or incontinent   | C             | DI              |
| Salmonella species including S typhi  | S (10)        |                 |
| Shigella species  | S (10)        |                 |

|  |               |                 |
|--|---------------|-----------------|
| Diapered or incontinent  | C             | DI              |
| Vibrio parahaemolyticus  | S (10)        |                 |
| <b>Attachment D (continued)</b>  |               |                 |
| <u>Infection/Condition</u>   | <u>Type *</u> | <u>Duration</u> |
| Viral (if not covered elsewhere)   | S (10)        |                 |
| Yersinia enterocolitica  | S (10)        |                 |
| German measles (rubella)   | D             | F (22)          |
| Giardiasis (see gastroenteritis)   |               |                 |
| Gonococcal ophthalmia neonatorum (gonorrheal ophthalmia,<br>acute conjunctivitis of newborn) | S             |                 |
| Gonorrhea  | S             |                 |
| Granuloma inguinale (donovanosis, granuloma venereum)  | S             |                 |
| Guillain-Barre syndrome  | S             |                 |
| Hand, foot, and mouth disease (see enteroviral infection)                                    |               |                 |
| Hantavirus pulmonary syndrome  | S             |                 |
| Helicobacter pylori  | S             |                 |
| Hemorrhagic fevers (for example, Lassa and Ebola)  | C (9)         | DI              |
| Hepatitis, viral   |               |                 |
| Type A   | S             |                 |
| Diapered or incontinent patients   | C             | F (11)          |
| Type B -- HBsAg positive   | S             |                 |
| Type C and other unspecified non-A, non-B  | S             |                 |
| Type E   | S             |                 |
| Herpangina (see enteroviral infection)   |               |                 |
| Herpes simplex (Herpesvirus hominis)   |               |                 |
| Encephalitis   | S             |                 |
| Neonatal (12) (see F (12) for neonatal exposure)   | C             | DI              |
| Mucocutaneous, disseminated or primary, severe   | C             | DI              |
| Mucocutaneous, recurrent (skin, oral, genital)   | S             |                 |
| Herpes zoster (varicella-zoster)   |               |                 |
| Localized in immunocompromised patient, or disseminated<br>(13)                              | A,C           | DI              |
| Localized in normal patient  | S (13)        |                 |
| Histoplasmosis   | S             |                 |
| HIV (see human immunodeficiency virus)   | S             |                 |
| Hookworm disease (ancylostomiasis, uncinariasis)   | S             |                 |
| Human immunodeficiency virus (HIV) infection (3)   | S             |                 |
| Impetigo<br>hrs)   | C             | U (24)          |

|  |               |                 |
|--|---------------|-----------------|
| Infectious mononucleosis   | S             |                 |
| Influenza  | D (14)        | DI              |
| Kawasaki syndrome  | S             |                 |
| <b>Infection/Condition</b>   | <b>Type *</b> | <b>Duration</b> |
| Lassa fever  | C (9)         | DI              |
| <b>Attachment D (continued)</b>  |               |                 |
| Legionnaires' disease  | S             |                 |
| Leprosy  | S             |                 |
| Leptospirosis  | S             |                 |
| Lice (pediculosis)   | C             | U (24)          |
| Listeriosis  | S             |                 |
| Lyme disease   | S             |                 |
| Lymphocytic choriomeningitis   | S             |                 |
| Lymphogranuloma venereum   | S             |                 |
| Malaria  | S (4)         |                 |
| Marburg virus disease  | C (9)         | DI              |
| Measles (rubeola), all presentations   | A             | DI              |
| Melioidosis, all forms   | S             |                 |
| Meningitis   | S             |                 |
| Aseptic (nonbacterial or viral meningitis {also see enteroviral infections}) |               |                 |
| Bacterial, gram-negative enteric, in neonates                                | S             |                 |
| Fungal   | S             |                 |
| Haemophilus influenzae, known or suspected<br>hrs)                           | D             | U (24)          |
| Listeria monocytogenes   | S             |                 |
| Neisseria meningitidis (meningococcal) known or suspected<br>hrs)            | D             | U (24)          |
| Pneumococcal   | S             |                 |
| Tuberculosis (15)  | S             |                 |
| Other diagnosed bacterial  | S             |                 |
| Meningococcal pneumonia<br>hrs)  | D             | U (24)          |
| Meningococcemia (meningococcal sepsis)<br>hrs)                               | D             | U (24)          |
| Molluscum contagiosum  | S             |                 |
| Mucormycosis   | S             |                 |
| Multidrug-resistant organisms, infection or colonization (16)                |               |                 |
| Gastrointestinal   | C             | CN              |
| Respiratory  | C             | CN              |

|   |               |                 |
|---|---------------|-----------------|
| Pneumococcal  | S             |                 |
| Skin, wound, or burn  | C             | CN              |
| Mumps (infectious parotitis)  | D             | F (17)          |
| Mycobacteria, nontuberculosis (atypical)  |               |                 |
| Pulmonary   | S             |                 |
| Wound   | S             |                 |
|   |               |                 |
| <b>Infection/Condition</b>  | <b>Type *</b> | <b>Duration</b> |
| Mycoplasma pneumonia  | D             | DI              |
| Necrotizing enterocolitis   | S             |                 |
| <b>Attachment D (continued)</b>   |               |                 |
| Nocardiosis, draining lesions or other presentations  | S             |                 |
| Norwalk agent gastroenteritis (see viral gastroenteritis)                                       |               |                 |
| Orf   | S             |                 |
| Parainfluenza virus infection, respiratory in infants and young children                        | C             | DI              |
| Parvovirus B19  | D             | F (18)          |
| Pediculosis (lice)  | C             | U (24 hrs)      |
| Pertussis (whooping cough)  | D             | F (19)          |
| Pinworm infection   | S             |                 |
| Plague  |               |                 |
| Bubonic   | S             |                 |
| Pneumonic   | D             | U (72 hrs)      |
| Pleurodynia (see enteroviral infection)   |               |                 |
| Pneumonia   |               |                 |
| Adenovirus  | D,C           | DI              |
| Bacterial not listed elsewhere (including gram-negative bacterial)                              | S             |                 |
| Burkholderia cepacia in cystic fibrosis (CF) patients, including respiratory tract colonization | S (20)        |                 |
| Chlamydia   | S             |                 |
| Fungal  | S             |                 |
| Haemophilus influenzae  |               |                 |
| Adults  | S             |                 |
| Infants and children (any age)  | D             | U               |
| (24 hrs)  |               |                 |
| Legionella  | S             |                 |
| Meningococcal   | D             | U               |
| (24 hrs)  |               |                 |

|  |               |                 |
|--|---------------|-----------------|
| Multidrug-resistant bacterial (see multidrug-resistant organisms)                                  |               |                 |
| Mycoplasma (primary atypical pneumonia)  | D             | DI              |
| Pneumococcal   |               |                 |
| Multidrug-resistant (see multidrug-resistant organisms)  |               |                 |
| Pneumocystis carinii   | S (21)        |                 |
| Pseudomonas cepacia (see Burkholderia cepacia)   | S (20)        |                 |
| Staphylococcus aureus  | S             |                 |
| Streptococcus, Group A   |               |                 |
|  |               |                 |
| Adults   | S             |                 |
| Infants and young children (hrs)   | D             | U (24)          |
| Viral  |               |                 |
| <b>Infection/Condition</b>   | <b>Type *</b> | <b>Duration</b> |
| Adults   | S             |                 |
| Infants and young children (see respiratory infectious disease, acute)                             |               |                 |
| <b>Attachment D (continued)</b>  |               |                 |
| Poliomyelitis  | S             |                 |
| Psittacosis (ornithosis)   | S             |                 |
| Q fever  | S             |                 |
| Rabies   | S             |                 |
| Rat-bite fever (Streptobacillus moniliformis disease, Spirillum minus disease)                     | S             |                 |
| Relapsing fever  | S             |                 |
| Resistant bacterial infection or colonization (see multidrug-resistant organisms)                  |               |                 |
| Respiratory infectious disease, acute (if not covered elsewhere)                                   |               |                 |
| Adults   | S             |                 |
| Infants and young children (3)   | C             | DI              |
| Respiratory syncytial virus infection, in infants and young children, and immunocompromised adults | C             | DI              |
| Reye's syndrome  | S             |                 |
| Rheumatic fever  | S             |                 |
| Rickettsial fevers, tickborne (Rocky Mountain spotted fever, tickborne typhus fever)               | S             |                 |
| Rickettsialpox (vesicular rickettsiosis)   | S             |                 |
| Ringworm (dermatophytosis, dermatomycosis, tinea)  | S             |                 |
| Ritter's disease (staphylococcal scalded skin syndrome)  | S             |                 |
| Rocky Mountain spotted fever   | S             |                 |
| Roseola infantum (exanthem subitum)  | S             |                 |

|   |               |                 |
|---|---------------|-----------------|
| Rotavirus infection (see gastroenteritis)                         |               |                 |
| Rubella (German measles; also see congenital rubella)             | D             | F (22)          |
| Salmonellosis (see gastroenteritis)                               |               |                 |
| Scabies<br>hrs)   | C             | U (24)          |
| Scalded skin syndrome, staphylococcal (Ritter's disease)          | S             |                 |
| Schistosomiasis (bilharziasis)                                    | S             |                 |
| Shigellosis (see gastroenteritis)                                 |               |                 |
| Sporotrichosis  | S             |                 |
| Spirillum minus disease (rat-bite fever)                          | S             |                 |
| Staphylococcal disease (S aureus)                                 | S             |                 |
| Skin, wound, or burn  |               |                 |
| Major (1)   | C             | DI              |
| Minor or limited (2)  | S             |                 |
| Enterocolitis   | S (10)        |                 |
| Multidrug-resistant (see multidrug-resistant organisms)           |               |                 |
| <b>Infection/Condition</b>  | <b>Type *</b> | <b>Duration</b> |
| Pneumonia   | S             |                 |
| Scalded skin syndrome   | S             |                 |
| Toxic shock syndrome  | S             |                 |
| <b>Attachment D (continued)</b>                                   |               |                 |
| Streptobacillus moniliformis disease (rat-bite fever)             | S             |                 |
| Streptococcal disease (group A streptococcus)                     |               |                 |
| Skin, wound, or burn  |               |                 |
| Major (1)<br>hrs)   | C             | U (24)          |
| Minor or limited (2)  | S             |                 |
| Endometritis (puerperal sepsis)                                   | S             |                 |
| Pharyngitis in infants and young children<br>hrs)                 | D             | U (24)          |
| Pneumonia in infants and young children<br>hrs)                   | D             | U (24)          |
| Scarlet fever in infants and young children<br>hrs)               | D             | U (24)          |
| Streptococcal disease (group B streptococcus), neonatal           | S             |                 |
| Streptococcal disease (not group A or B) unless covered elsewhere | S             |                 |
| Multidrug-resistant (see multidrug-resistant organisms)           |               |                 |
| Strongyloidiasis  | S             |                 |
| Syphilis  |               |                 |



|  |               |                 |
|--|---------------|-----------------|
| Skin and mucous membrane, including congenital, primary, secondary                   | S             |                 |
| Latent (tertiary) and seropositivity without lesions                                 | S             |                 |
| Tapeworm disease   |               |                 |
| Hymenolepis nana   | S             |                 |
| Taenia solium (pork)   | S             |                 |
| Other  | S             |                 |
| Tetanus  | S             |                 |
| Tinea (fungus infection dermatophytosis, dermatomycosis, ringworm)                   | S             |                 |
| Toxoplasmosis  | S             |                 |
| Toxic shock syndrome (staphylococcal disease)  | S             |                 |
| Trachoma, acute  | S             |                 |
| Trench mouth (Vincent's angina)  | S             |                 |
| Trichinosis  | S             |                 |
| Trichomoniasis   | S             |                 |
| Trichuriasis (whipworm disease)  | S             |                 |
| Tuberculosis   |               |                 |
| Extrapulmonary, draining lesion (including scrofula)                                 | S             |                 |
| Extrapulmonary, meningitis (15)  | S             |                 |
| Pulmonary, confirmed or suspected or laryngeal disease                               | A             | F (23)          |
| Skin-test positive with no evidence of current pulmonary disease                     | S             |                 |
| <b>Infection/Condition</b>   | <b>Type *</b> | <b>Duration</b> |
| Tularemia  |               |                 |
| Draining lesion  | S             |                 |
| Pulmonary  | S             |                 |
| Typhoid (Salmonella typhi) fever (see gastroenteritis)                               |               |                 |
| <b>Attachment D (continued)</b>  |               |                 |
| Typhus, endemic and epidemic   | S             |                 |
| Urinary tract infection (including pyelonephritis), with or without urinary catheter |               |                 |
| S  |               |                 |
| Varicella (chickenpox)   | A,C           | F (5)           |
| Vibrio parahaemolyticus (see gastroenteritis)  |               |                 |
| Vincent's angina (trench mouth)  | S             |                 |
| Viral diseases   |               |                 |
| Respiratory (if not covered elsewhere)   |               |                 |
| Adults   | S             |                 |
| Infants and young children (see respiratory infectious disease, acute)               |               |                 |
| Whooping cough (pertussis)   | D             | F (19)          |
| Wound infections   |               |                 |
| Major (1)  | C             | DI              |

|   |        |    |
|---|--------|----|
| Minor or limited (2)  | S      |    |
| Yersinia enterocolitica gastroenteritis (see gastroenteritis) |        |    |
| Localized in immunocompromised patient, disseminated (13)     | A,C    | DI |
| Localized in normal patient                                   | S (13) |    |
| Zygomycosis (phycomycosis, mucormycosis)                      | S      |    |
| Zoster (varicella-zoster)                                     |        |    |

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Abbreviations: type of precautions: A, Airborne; C, Contact; D, Droplet; S, Standard; when A, C, and D are specified, also use S.  
+ Duration of precautions: CN, until off antibiotics and culture-negative; DH, duration of hospitalization; DI duration of illness (with wound lesions, DI means until they stop draining); U, until time specified in hours (hrs) after initiation of effective therapy; F, see footnote number.

- (1) No dressing or dressing does not contain drainage adequately.
- (2) Dressing covers and contains drainage adequately.
- (3) Also see syndromes of conditions listed in Table 2.
- (4) Install screens in windows and doors in endemic areas.
- (5) Maintain precautions until all lesions are crusted. The average incubation period for varicella is 10 to 16 days, with a range of 10 to 21 days. After exposure, use varicella zoster immune globin (VZIG) when appropriate, and discharge susceptible patients if possible. Place exposed susceptible patients on Airborne Precautions beginning 10 days after exposure and continuing until 21 days after last exposure (up to 28 days if VZIG has been given). Susceptible persons should not enter the room of patients on precautions if other immune caregivers are available.
- (6) Place infant on precautions during any admission until 1 year of age, unless nasopharyngeal and urine cultures are negative for virus after age 3 months.
- (7) Additional special precautions are necessary for handling and decontamination of blood, body fluids and tissues, and contaminated items from patients with confirmed or suspected disease. See latest College of American Pathologists (Northfield, Illinois) guidelines or other references.
- (8) Until two cultures taken at least 24 hours apart are negative.
- (9) Call state health department and CDC for specific advice about management of a suspected case. During the 1995 Ebola outbreak in Zaire, interim recommendations were published. (97) Pending a comprehensive review of the epidemiologic data from the

outbreak and evaluation of the interim recommendations, the 1988 guidelines for management of patients with suspected viral hemorrhagic infections (16) will be reviewed and updated if indicated.

(10) Use Contact Precautions for diapered or incontinent children <6 years of age for duration of illness.

(11) Maintain precautions in infants and children <3 years of age for duration of hospitalization; in children 3 to 14 years of age, until 2 weeks after onset of symptoms; and in others, until 1 week after onset of symptoms.

(12) For infants delivered vaginally or by C-section and if mother has active infection and membranes have been ruptured for more than 4 to 6 hours. (13) Persons susceptible to varicella are also at risk for developing varicella when exposed to patients with herpes zoster lesions; therefore, susceptibles should not enter the room if other immune caregivers are available.

(13) Persons susceptible to Varicella are also at risk for developing Varicella when exposed to patients with herpes zoster lesions; therefore, susceptibles should not enter the room if other immune caregivers are available.

(14) The "Guideline for Prevention of Nosocomial Pneumonia" (95,96) recommends surveillance, vaccination, antiviral agents, and use of private rooms with negative air pressure as much as feasible for patients for whom influenza is suspected or diagnosed.

Many hospitals encounter logistic difficulties and physical plant limitations when admitting multiple patients with suspected influenza during community outbreaks. If sufficient private rooms are unavailable, consider cohorting patients or, at the very least, avoid room sharing with high-risk patients. See "Guideline for Prevention of Nosocomial Pneumonia" (95,96) for additional prevention and control strategies.

(15) Patient should be examined for evidence of current (active) pulmonary tuberculosis. If evidence exists, additional precautions are necessary (see tuberculosis).

(16) Resistant bacteria judged by the infection control program, based on current state, regional, or national recommendations, to be of special clinical and epidemiologic significance.

(17) For 9 days after onset of swelling.

(18) Maintain precautions for duration of hospitalization when chronic disease occurs in an immunodeficient patient. For patients with transient aplastic crisis or red-cell crisis, maintain precautions for 7 days.

(19) Maintain precautions until 5 days after patient is placed on effective therapy.

(20) Avoid cohorting or placement in the same room with a CF patient who is not infected or colonized with B cepacia. Persons with CF who visit or provide care and are not infected or colonized with B cepacia may elect to wear a mask when within 3 ft of a colonized or infected patient.

(21) Avoid placement in the same room with an immunocompromised patient.

(22) Until 7 days after onset of rash.

(23) Discontinue precautions only when TB patient is on effective therapy, is improving clinically, and has three consecutive negative sputum smears collected on different days, or TB is ruled out. Also see CDC "Guidelines for Preventing the Transmission of Tuberculosis in Health-Care Facilities." (23)

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### **HIV CONSENT POLICY**

1. **PURPOSE:** To establish infection control policies, treatment protocol, and test ordering protocol for HIV patients.
2. **POLICY:** In order to provide for optimal protection to the patient and staff and to maintain confidentiality for the patient, the following measures will be observed. It is VHA policy that HIV testing be a part of routine medical care: that providers routinely provide HIV testing to all Veterans (if they consent); and that those Veterans who test positive for HIV infection are referred for state-of-the-art HIV treatment, prevention of complications, and care of related conditions, including mental health needs, as soon as possible after diagnosis.
3. **ACTION:** As the nation's largest single provider of HIV care, it is important that the VA be a leader in the integration of HIV into clinical care. Treatment of patients with HIV infection falls within the mission of the VA Southern Nevada Healthcare System (VASNHS) and projections indicate there will be increased numbers. Health care workers at this VASNHS must adopt the attitude that all patients are presumed to be possibly infected; therefore standard precautions need to be employed.
  - a. All provisions of the Privacy Act will be strictly observed. Nevada State law regarding HIV test reporting is followed. VASNHS reports to the Southern Nevada Health District (SNHD) only; not to any legal authorities. A signed consent for release of information must precede disclosure to other than VA physicians.
  - b. Charts are not marked on the front with any distinctive or descriptive signs.  
A diagnosis of HIV is recorded on the problem sheet in the chart.
  - c. Results of any testing is released only to authorized personnel, as outlined in VA Circular 10-88-151, Section 121, Confidentiality of Medical Records.
  - d. Standard blood and body fluid precautions are enforced.
  - e. All applicable service policies and procedures are enforced.
  - f. Casual contact has not been shown to be a route for spread of the infection.
  - g. Upon their request, patients can be tested for HIV seropositivity.
  - h. Voluntary informed consent must be obtained prior to testing.

i. Following needlestick injuries to employees, the Occupational Health Physician will request the laboratory to do an HIV (Elisa) test on both the employee and patient.

All positive Elisa tests are confirmed by the Western Blot test. The test, if negative, needs to be repeated at the appropriate time intervals (baseline, 6 weeks, 3 months, 6 months, and one year). Post-exposure prophylaxis is offered to employees with high risk needlestick injuries. This is determined on a case by case basis.

j. Health care providers must provide education about risk reduction and access to condoms. This is a key component of VHA's program to prevent HIV, HCV, and other sexually transmitted diseases. Both male latex and the female polyurethane condoms are currently available on the VHA National Formulary and are classified as a medical supply (VA CLASS XA900). Male and female Veterans can be prescribed any type of condom, as best suits their individual prevention needs (Access to Condoms As HIV Prevention IL 10-2001-012. URL: <http://vaww.hiv.va.gov/vahiv?page=prtop08-va-03>).

k. HIV testing in VA is regulated by federal law and corresponding VA regulations that require informed consent and pre- and post-test counseling. Guidelines for HIV Testing in VA regulations and policies do not limit or define which VA health care professionals can perform HIV counseling and testing. Providers who obtain consent should be familiar with these VA policies.

l. The CDC's Revised recommendations for HIV testing include the following:

(1) HIV screening for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines

(2) HIV testing of people at high risk for HIV infection at least once a year

(a) Injection drug users

(b) Sexual partner of an injection drug user

(c) Persons who exchange sex for money or drugs

(d) Sexual partner of an HIV infected individual

(e) Men who have sex with men

(f) Heterosexual persons who have had or whose sexual partners have had more than one sexual partner since their most recent HIV test

(3) Prevention counseling should be performed with HIV diagnostic testing or as part of HIV screening programs in health-care settings

(4) Include HIV screening in the routine panel of pre-natal screening tests for all pregnant women, unless the patient declines

(5) Repeat screening in the third trimester in certain jurisdictions with elevated rates of HIV infection among pregnant women.

#### **4. RESPONSIBILITIES:**

a. All providers must see that pre- and post-test counseling is done and properly recorded. They must obtain voluntary informed consent and must provide patients with written educational materials about HIV testing prior to or at the time consent is obtained.

b. All employees will guard the confidentiality of records of patients who are positive or undergoing testing.

c. Supervisors will ensure that employees do not engage in discriminatory conduct and that they follow proper procedures.

d. The Director has overall responsibility for implementation of this memorandum.

e. The Associate Director has the responsibility of supporting the efforts of all administrative services in implementing this policy.

f. The Chief of Staff has the responsibility of providing support to all clinical services in implementing this policy.

g. Laboratory Director will ensure procedures are in place for the timely performance of initial HIV testing and reflex confirmatory testing and that the results are posted into CPRS in a timely fashion. He/she will ensure that the Infection Control Practitioner is notified of any positive HIV test results.

h. Infection Control Practitioner will report all positive HIV test reports to the Southern Nevada Health District.

#### **5. REFERENCES:**

a. OSHA Bloodborne Pathogen Standard 29CFR 1910.1030, Federal Register Federal Register: January 18, 2001 (Volume 66, Number 12), pp. 5317-5325.

b. Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome. MMWR Supplement 1999 Dec 10; 48(RR-13).

c. CDC's Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-care Settings. MMWR 2006; 55 (No. RR-14 : 1 – 18)

d. VHA Directive 2009-036: Testing For Human Immunodeficiency Virus in Veteran's Health Administration Facilities August 14, 2009  
[http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2056](http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2056)

e. VHA Handbook 1004.01 Informed Consent for Clinical Treatments and Procedures, August 14, 2009  
[http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2055](http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2055)

6. **RESCISSION:** MCM-IC-10-03, "HIV Infection Control Policy, dated March 2010.

7. **RECERTIFICATION:** April 2013

Concur/Do Not Concur

Ramu Komanduri, M.D.  
Chief of Staff

Concur/Do Not Concur

Shirley L. Caldwell-Butts, MSN, RN  
AD Patient Care/Nurse Executive

Concur/Do Not Concur

Deborah Dort, MD  
Acting Associate Director

Approved/Disapproved

John B. Bright  
Director



## **Patient Safety Program**

**1. PURPOSE:** To establish policy, assign responsibility, and set procedures for the Veterans Affairs Southern Nevada Healthcare System (VASNHS) Patient Safety Program.

**2. POLICY:**

a. The Veterans Affairs Southern Nevada Healthcare System (VASNHS) will maintain an integrated, patient-centered, evidence-based Patient Safety Program (PSP) that supports and promotes the organization's mission, vision, and values. The PSP elements are consistent with the goals of the Veterans Healthcare Administration (VHA), the Veterans Affairs National Center for Patient Safety (NCPS), and the Veterans Integrated Services Network (VISN), and reflect strategies that contribute to the development, implementation, maintenance, and improvement of patient safety processes. Key objectives are to promote respect for the dignity of patients served by assuring a safe care environment, improve patient and organizational outcomes through reduced mortality rates, adverse events, and conditions that result in injury and harm, and to ensure psychological support to patients, families, and staff members who have been involved in healthcare error(s). This is accomplished through the identification and analysis of risks that cause or contribute to, or have the potential to cause or contribute to preventable patient injury or impairment, and the implementation of efficient safety-focused processes and preventive measures. Recognizing that effective medical/healthcare error reduction requires an integrated and coordinated approach, this policy relates specifically to a systematic system-wide program that is designed to minimize physical injury, accidents, and undue psychological stress for patients during patient care appointments, clinic visits, and hospital stays.

b. VASNHS leadership assumes a role in establishing a culture of safety that minimizes hazardous risks and patient harm by focusing on processes of care. VASNHS leaders are responsible for fostering an environment through personal example, emphasizing patient safety as an organizational priority, educating clinical and non-clinical staff about commitment to the reduction of medical errors, supporting proactive reduction in medical/healthcare errors, and integrating patient safety priorities into the new design and redesign of all relevant organizational processes, functions, and services. The organization supports a culture of safety that encourages a blameless system of recognizing, reporting, and analyzing risks, errors, and near misses.

**3. ACTION:**

a. Definitions:

(1) Mild to Moderate Adverse Outcome: Any set of circumstances that do not achieve the desired outcome and result in a mild to moderate physical or psychological adverse patient outcome.

(2) Adverse Event: Untoward incidents, therapeutic misadventures, iatrogenic injuries, or other undesirable occurrences directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic, or other VHA facility.

(3) Sentinel Event: An unexpected occurrence involving death, serious physical or psychological injury, or the risk thereof. Serious injury specifically includes the loss of limb or function. “Risk thereof” includes any process variation for which a recurrence would carry a significant chance of serious adverse outcomes.

(4) Close Call or Near Miss: Any event or process variation that could have resulted in an adverse event however did not, either by chance or through timely intervention.

(5) Root Cause Analysis (RCA): Comprehensive, systematic, and multidisciplinary process for investigating causes and/or contributing factors associated with adverse events.

(6) Proactive Risk Assessment: A method of evaluating a product or process to identify system vulnerabilities and their associated corrective actions before an adverse event occurs. Proactive Risk Assessment models include Healthcare Failure Mode and Effects Analysis (HFMEA).

b. Procedures:

(1) VASNHS patient safety staff will identify program priorities and implement patient safety initiatives based on analysis of internal data, standards from external regulatory and accrediting bodies, and findings from ongoing risk assessments. VASNHS patient safety staff will conduct annual surveys to assess the facility’s culture of patient safety and examine the patient safety program effectiveness to include the staffs’ willingness to report errors.

(2) VASNHS leaders and managers will foster leadership/management styles that promote staffs’ participation in patient safety initiatives to include proactive risk analysis and participation in RCAs, demonstrates value and respect for staffs’ contributions to patient safety, supports open communication about patient safety practices and processes and error disclosure, and incorporates accountability and responsibility for patient safety into staffs’ competencies.

(3) VASNHS leadership will provide oversight for patient safety improvement initiatives through the designation of a multidisciplinary Patient Safety Committee (PSC), which will be chaired by the Patient Safety Program Manager. The PSC will develop and/or evaluate patient safety policies and procedures, implement a facility patient safety plan, design tools to assess and monitor patient safety processes, and report patient safety improvement strategies and associated outcomes.

(4) VASNHS clinicians and organizational leaders will ensure that disclosure is a routine part of the response to adverse events and that disclosing adverse events to patients and their families is accomplished with skill, tact, and within the legal limits that support patient privacy.

#### **4. RESPONSIBILITY:**

a. The Facility Director has overall responsibility for the Patient Safety Program. The Director shall appoint a Patient Safety Committee responsible for monitoring and reporting program compliance and for recommendations for program changes.

b. The Chief of Staff and Associate Director will implement procedures that ensure compliance under their span of control.

c. Care Line and Service Chiefs will ensure their employees are knowledgeable about and comply with patient safety policy, procedures, and reporting guidelines.

d. Patient Safety Manager is responsible for:

(1) Patient safety program administration and supervision; system-wide safety awareness.

(2) Committee leadership and oversight.

(3) Directing RCAs and HFMEAs, and initiating reports to internal and external entities.

(4) Disseminating up-to-date patient safety data throughout the organization, with routine, periodic, and required annual reports to leadership.

(5) Communicating alerts and advisories published by the National Center for Patient Safety, Food and Drug Administration, and Veteran Health Administration, and Central Office.

e. Patient Safety Staff are responsible for:

(1) Under general guidance from the Patient Safety Manager development of relevant, evidence-based patient safety initiatives and processes.

(2) Active leadership/participation on the Patient Safety Committee and other committees and workgroups that impact patient safety.

(3) Promoting a culture of patient safety and safety awareness; ensuring patient safety program elements are integrated into organizational processes through applicable patient safety policies, education programs, fairs, focused campaigns including and not limited to the Institute for Healthcare Improvement Protecting 5 Million Lives from Harm, and other relatable events.

(4) Disseminating up-to-date patient safety data throughout the organization through multiple forums/avenues that include monthly staff meetings, electronic messaging, reports, and websites.

(5) Implementing and evaluating patient safety indicators and processes, monitoring compliance, developing improvement strategies, and systematically reporting strategies and outcomes.

(6) Educating staff, patients, and family about patient safety programs, policies, initiatives, patient safety goals, best practices, and reporting mechanisms.

(7) Responding to alerts and advisories published by the National Center Patient for Safety, Joint Commission, Food and Drug Administration, and Veteran Healthcare Administration, and Veterans Affairs Central Office.

(8) Reviewing, analyzing, and acting on adverse events, close calls, patient incidents, patient safety concerns, and aggregate findings to identify underlying causes and implement changes to reduce the likelihood of recurrence; utilizing VHA prioritization method: the Safety Assessment Code (SAC) to assist in determining whether to initiate a review; collecting and analyzing data to evaluate care processes for opportunities to reduce risks; initiating corrective actions with a focus on processes and systems to reduce risks; documenting and reporting findings, interventions, and outcomes.

(9) Conducting a minimum of four individual RCAs, one Proactive Risk Assessment, and four aggregated reviews per year, and data entry using the Web-spot software application.

(10) Participating in surveys by Joint Commission, Office of Inspector General, Systematic Ongoing Assessment and Review Strategy, and College of American Pathologists laboratory accrediting agency; prioritizes patient safety initiatives based on findings.

(11) Utilizing Institute for Healthcare Improvement Trigger Tool methodology to identify indicators to the possibility of adverse events, with a focus on harm caused by medical treatment, regardless of whether the harm is associated with error or considered preventable.

f. VASNHS staff is responsible for:

- (1) Complying with patient safety policies and procedures.
- (2) Participating in orientation and education programs that promote safe patient care environments.
- (3) Reducing variation in patient care and devising strategies to avoid reliance on memory through use of protocols, checklists, and standardization of work processes.
- (4) Methodically evaluating and reporting the safety vulnerabilities of current patient care technology and care delivery systems.
- (5) Appropriately reporting patient incidents, patient safety concerns, and adverse events to include close calls.

**5. REFERENCES:**

HCPRO Patient Safety Officer's Handbook dated 2008  
 Joint Commission Comprehensive Accreditation Manual for Ambulatory Care,  
 current edition VHA National Patient Safety Improvement Handbook 1051/1  
 dated May 23, 2008

**6. RESCISSION:** Medical Center Memorandum PS-10-02 titled Patient Safety and Risk Management Program, and dated March 2010.

**7. RECERTIFICATION:** August 2013

Concur / Do not Concur

Concur / Do not Concur

Ramanujam Komanduri, MD  
 Chief of Staff

Shirley L. Caldwell-Butts, MSN, RN  
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Concur / Do not Concur

Approved / Disapproved

Maria R. Andrews, MS, FACHE  
 Associate Director

John B. Bright  
 Director

## HAND HYGIENE

1. **PURPOSE:** This policy provides guidance for establishing the basic requirement for hand hygiene at the VA Southern Nevada Healthcare System (VASNHS).

2. **POLICY:** It is the policy of VASNHS that all employees abide by the Veterans Health Administration (VHA), Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), and the National Center for Patient Safety (NCPS) guidelines for hand hygiene. Hand hygiene is the single most effective method to prevent cross contamination and reduce the acquisition of infection.

3. **ACTION:**

a. All healthcare workers in direct patient contact areas, i.e., inpatient rooms, outpatient clinics, etc., as well as those who may have direct patient contact in other settings, such as radiology technicians, phlebotomists, etc., are required to:

(1) Use an alcohol-based hand rub or antimicrobial soap and water to routinely decontaminate their hands before and after having direct contact with a patient.

(a) If hands are not visibly soiled, an alcohol-based hand rub needs to be used for routinely decontaminating hands; manufacturers' instructions need to be followed when using these products. Apply to dry hands; using a sufficient amount to keep all areas wet throughout the preparation procedure. An amount of the product (about dime sized) should be placed on the palm of one hand and rubbed together, touching all surfaces of both hands and wrists, under the nails, and jewelry until it has evaporated. A paper towel should not be used.

(b) When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, such as after contact with excretions, mucous membranes, non-intact skin, or wound dressings, hands need to be washed with soap and water. If there is visible debris on the hands then antimicrobial soap and water should be used. **Note:** Proper hand hygiene techniques are illustrated in Figures II.1 and II.2 of the WHO Guidelines on Hand Hygiene in Health Care, available at: [http://whqlibdo.who.int/publications/2009/9789241597906\\_eng.pdf](http://whqlibdo.who.int/publications/2009/9789241597906_eng.pdf)

1) Wet hands thoroughly with water.

2) Dispense one pump of soap into hands.

3) Wash hands up to and including the wrists using friction with special attention to areas between fingers, under nails and jewelry.

- 4) Hand washing should be for about 15 seconds, making sure that all surfaces of both hands and wrists have been washed.
- 5) Rinse hands under running water.
- 6) Dry hands with a paper towel.
- 7) Use a paper towel to turn off the faucet and to open the door to the patient's room.

(2) All clinical staff will wash hands with soap and water whenever hands are visibly soiled or contaminated:

- (a) After contact with a potential source of microorganism such as bodily fluids, excretions, mucous membranes, non-intact skin, and wound dressing.
- (b) After exposure to potential spore-forming pathogens, such as *Clostridium difficile*.
- (c) Before and after each patient contact
- (d) Before and meals
- (e) After use of the toilet
- (f) After smoking
- (g) Before and after handling patient care items
- (h) After coughing or sneezing
- (i) When hands are visibly soiled
- (j) After handling dirty linen
- (k) After handling trash/garbage

- (l) After handling bedpans, urinals, catheters
  - (m) Before preparing food
  - (n) After changing diapers
  - (o) After handling specimens
  - (p) After handling inanimate objects that are likely to be contaminated
- (3) Use an alcohol-based hand rub or antimicrobial soap and water:
- (a) Before inserting or handling any invasive device for patient care, whether or not gloves are used.
  - (b) Before donning sterile gloves and after removing sterile or non-sterile gloves (allow the hand rub to dry completely before donning sterile gloves).
  - (c) If moving from a contaminated body site to another body site during care of the same patient.
  - (d) Before handling medication.
  - (e) After contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient.
- (4) Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin is anticipated. Gloves must be removed after caring for a patient. If gloves become visibly soiled, or if performing patient care on a contaminated site, remove or change gloves before moving to another body site on the same patient, a device, or the environment. The same pair of gloves is not to be worn for the care of more than one patient; gloves are not to be washed, they are to be disposed of appropriately. Complete appropriate hand hygiene thereafter. **Note:** The correct procedure for donning and removing gloves is illustrated in the WHO Guidelines on Hand Hygiene in Health Care, available at [http://whqlibdoc.who.int/publications/2009/9789241597906\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf)



b. Artificial fingernails of any type (acrylic, sculptured, silk wraps, overlays, tips, or nail extenders) and nail jewelry will not be worn by healthcare personnel whose duties involve direct patient care, whether non-supervisory or supervisory, and whether it is regular contact or occasional contact, because they harbor larger numbers of organisms and have been implicated in outbreaks of infection. Nail polish, if worn, should not be chipped. Nails must be no longer than 1/4 inch beyond the end of the nail bed.

c. All facility staff will wash hands with soap and water before eating and after using the toilet.

d. Appropriate supplies are provided, to include the following:

(1) An alcohol-based hand rub is readily available at the point of patient care, e.g., at the entrance to each patient room or at the bedside, as well as other locations such as clinics, emergency rooms, Community Living Centers (CLC's), Post-Anesthesia Care Units (PACU's), etc. **Note:** Alcohol-based hand rubs may present an abuse risk in certain patient care areas, such as inpatient psychiatric or mental health residential rehabilitation treatment programs. Local clinicians and facility leaders need to use discretion in their use of alcohol-based products in these areas.

(2) Antimicrobial soap must be available in all patient care areas where soap is provided (i.e., at all sinks with a soap dispenser).

(3) Appropriate labeling: VHA facilities that supply both antimicrobial and non-antimicrobial soap must clearly and unambiguously label the dispensers to ensure that all users know which dispenser is providing antimicrobial soap and which dispenser is providing non-antimicrobial soap.

(4) Pocket-sized containers of alcohol-based rub must be available to all health care workers. **Note:** This does not imply a requirement for all health care workers to carry pocket-sized alcohol hand rubs.

(5) Appropriate hand lotions or creams to minimize irritant contact dermatitis must be readily available. **Note:** Products designed for health care applications that do not reduce the effectiveness of other hand hygiene products, such as antimicrobial compounds, e.g., as "CHG compliant." Hand lotions or creams must be compatible with gloves being used in the facility.

e. Soap is not added to partially-empty dispensers. Soap will be dispensed from disposable bladders or other containers that prevent old and new soap from mixing.

f. Care is taken in installing and storing alcohol-based hand rubs consistent with fire safety requirements.

(1) Alcohol-based hand rub dispensers must not be located over, or adjacent to, ignition sources (including electrical receptacles and switches).

(2) Corridors must have at least 6 feet of clear width with hand rub dispensers spaced at least 4 feet apart.

(3) Alcohol-based hand rub dispensers may not be installed in carpeted corridors unless the corridor is sprinkler protected.

(4) Dispensers may not project more than 6 inches into corridor egress width. **Note:** Consideration will be given to installing dispensers at a height that ensures that they can be used by staff, patients and visitors who are in wheelchairs.

(5) Supplies of alcohol-based hand rub products must be stored in cabinets or areas approved for flammable materials consistent with applicable regulations and standards.

g. Improving hand hygiene is an institutional priority and administrative and financial support is provided, as appropriate.

(1) Financial support includes providing adequate supplies of alcohol hand rubs, antimicrobial soaps, gloves (regular and sterile), and lotion.

(2) Input needs to be solicited from employees regarding the feel, fragrance, and skin tolerance of products, such as soap, alcohol hand rub, hand lotions, and gloves and this information needs to be used to inform local and national purchasing decision makers.

h. Information or educational materials on hand hygiene provisions are provided to all health care workers. VHA “Infection Don’t Pass it On” campaign, led by the VHA Office of Public Health and Environmental Hazards and VHA National Center for Patient Safety, provides relevant materials on its website at <http://www.publichealth.va.gov/InfectionDontPassItOn/> and [http://vaww.ncps.med.va.gov/Guidelines/Hand\\_Hygiene/index.html](http://vaww.ncps.med.va.gov/Guidelines/Hand_Hygiene/index.html)

i. Monitoring health care worker’s adherence to required hand hygiene will be conducted, and the health care workers will be provided information regarding their performance.

j. The facility environment Management Service staff refers to guidance on hand hygiene and related practices in the Environmental Services Procedure Guide. <http://vaww.vhaco.va.gov/dushom/eps/2005EMS/whnjs.htm>

#### **4. RESPONSIBILITIES:**

- a. The Director has the overall responsibility for the implementation of this memorandum.
- b. The Associate Director has the responsibility of supporting the efforts of all administrative services in implementing this plan.
- c. The Chief of Staff has the responsibility of providing support to all clinical services in implementing this memorandum.
- d. Supervisors and managers are responsible for ensuring that all of their employees comply with this memorandum. They will assign someone to monitor and report compliance with proper hand hygiene on a monthly basis, which in turn will be reported to the Infection Prevention and Control Coordinator.
- e. The Infection Control Coordinator and Infection Control Committee are responsible for updates and revisions to this memorandum.
- f. All employees are required to comply with this memorandum.

## 5. **REFERENCES:**

- a. Centers for Disease Control and Prevention web site with Guideline for Hand Hygiene in Health-Care Settings and related materials. Available at <http://www.cdc.gov/handhygiene/>.
- b. Joint Commission 2010 National Patient Safety Goals. Available at: <http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/>
- c. American Society for Health Care Engineering web site on the safe use alcohol-based hand rub, at: <http://www.ashe.org/ashe/codes/handrub/index.html>
- d. World Health Organization Guidelines on Hand Hygiene in Health Care, 2009. Available at: [http://whqlibdoc.who.int/publications/2009/9789241597906\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf)
- e. World Health Organization Hand Hygiene Tools and Materials, Available at: <http://www.who.int/gpsc/5may/tools/en/index.html>
- f. FDA Retail Food Protection: Employee Health and Personal Hygiene Handbook, Available at: <http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/IndustryandRegulatoryAssistanceandTrainingResources/ucm113827.htm>; See especially the section on “Employee Health and Highly Susceptible Populations,” Available at: <http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/IndustryandRegulatoryAssistanceandTrainingResources/ucm184170.htm#susc>

g. VHA Environmental Services Procedure Guide, available at:  
<http://vaww.vhaco.va.gov/dushom/eps/2005EMS/whnjs.htm>

h. VHA Handbook 1109.04, Food Service Management Program, available at:  
<http://vaww1.va.gov/vhapublications/index.cfm>

i. CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007, available at:  
<http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>

6. **RESCISSION:** Medical Center Memorandum IC-10-09, “Hand Hygiene”, dated March 2010.

7. **RECERTIFICATION:** February 2014

Concur / Do not Concur

Concur / Do not Concur

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## **Laser Safety Program**

1. **PURPOSE:** To establish a Laser Safety Program for the protection of staff, patients, visitors and educational trainees. In addition, the Laser Safety Program assures compliance with the American National Standard Institute publication regarding the safe use of lasers in health care facilities. The Joint Commission requires strict adherence to the American National Standard Institute guidelines whenever lasers are used in a treatment regimen. These guidelines include, but are not limited to, standards for hazard evaluation, training programs, medical surveillance of health care personnel, and calibration.

2. **POLICY:** It is the policy of the VA Southern Nevada Healthcare System (VASNHS) to establish a safe and responsible use of laser technology and provide guidelines as described herein.

3. **ACTION:**

a. Definitions are described and listed below as a reference:

(1) **Laser:** A device which produces an intense and coherent directional beam of light by stimulating electronic or molecular transitions of energy. The word “laser” is actually an acronym for Light Amplification by the Stimulated Emission of Radiation.

(2) **Laser-Controlled Area:** Any room or area of rooms that houses a variable focus laser where the occupants and activities of those within are subject to the Laser Safety Program requirements due to the presence of an operating laser in that work space.

(3) **Laser Personnel:** Department of Veterans Affairs employees who work with or operate lasers, or whose duties require them to work in or otherwise be present in a laser-controlled area.

(4) **Incidental Personnel:** Department of Veterans Affairs employees whose duties make it possible, but unlikely that they will be exposed to laser radiation.

(5) **Maximum Permissible Exposure:** The theoretical level of laser radiation which has been established by the American National Standard Institute to which a person may be exposed without hazardous effects or adverse biological changes in human tissues.

(6) **Variable Focus Laser:** Any laser designated for therapeutic purposes with a treatment focal point that can be changed from one distance to another.

(7) Fixed Focus Laser: Any laser designated for therapeutic purposes with a treatment focal point that is predetermined and does not exceed 10 centimeters.

b. Only appropriately credential and privileged clinicians will perform therapeutic laser procedures for eligible VA beneficiaries.

c. General:

(1) Lasers will be used in accordance with the Laser Safety Program by authorized personnel who are conducting Food and Drug Administration approved procedures while following all applicable safety policies described within this memorandum.

(2) Lasers, laser accessories, and laser keys will be stored in areas designated by the Laser Safety Officer.

(3) Lasers and laser accessories will be positioned for use in such a way as to minimize the possibility of personal injury (e.g., falls), inadvertent beam activation, or equipment damage.

d. Credentialing and Privileging: Only staff with privileges recommended by the Executive Committee of the Medical Staff (ECMS) and approved by the Medical Center Director in accordance with VHA guidelines will utilize the lasers within the VASNHS.

e. Training:

(1) The Laser Safety Officer will maintain permanent training documentation files to include records of participation safety training and information sessions, laser courses attended, laser cases performed, laser videos viewed, and laser seminars or workshops in which a Medical Center employee was involved.

(2) Reference material, operator manuals, and updated information from the manufacturer of the (ACC) laser instrument will be provided for the review and use by all laser personnel in a timely manner.

f. Medical Surveillance of Laser Personnel: Employees who work in a laser room with a variable focus laser will not be allowed to enter the laser-controlled area unless they have proper documentation of their visual status to include ocular health history, corrected visual acuity in each eye, and tests for macular function and contrast sensitivity every two years.

g. Outer Door Warning System: All entrance/exit doorways to laser-controlled area will be clearly designated on the outside with a laser light danger sign which specifies the class and wavelength of the laser instrument within. In addition, the

door will be locked during all laser procedures to assure no inadvertent exposure to staff, patients, or visitors in the Medical Center. Appropriate security measures will be observed at all times. Appropriate signage and use of partitions will be used when fixed focus lasers are in use.

h. Eye Protection:

(1) Protective eyewear will be made available and will be clearly marked to illustrate the specific type and wavelength in the room for which eye protection is provided, and warning of the same device will be required.

(2) The operator of a laser that is equipped with a filter cap/shutter of an appropriate optical density is adequately protected against beam injury to his or her eyes. Protective glasses are required for all other laser personnel at all times when in the laser-controlled area.

(3) Patients whose eyes are being intentionally exposed to laser radiation require no protection.

i. High-voltage considerations:

(1) A qualified electrician will check the integrity of electrical cords and plugs prior to operation.

(2) Laser personnel will assure that the floor is kept dry at all times in the laser-controlled area.

(3) The use of extension cords with the laser instrument is expressly forbidden.

(4) The laser operator foot pedal will remain on a dry floor with the protective housing intact.

4. **RESPONSIBILITY:**

a. The Medical Center Director is responsible for assuring that lasers are used in accordance with all applicable standards, policies, regulations, and procedures.

b. The Chief of Staff will assure the safe, responsible, and efficacious use of laser technology through the establishment of and adherence to the Laser Safety Program described herein.

c. The Chief of Optometry Service is responsible to update or recertify this policy.

d. The Laser Safety Officer: The Chief of the Optometry Service is appointed the Laser Safety Officer for this facility. The Laser Safety Officer in conjunction with the Executive Committee of the Medical Staff will recommend laser privileges in accordance with the standards set forth in this document as well as appropriate Department of Veterans Affairs regulations. The Laser Safety Officer to complete quarterly reports regarding relevant activities such as laser usage, maintenance, outcome studies, adverse incidents, modifications to room and/or equipment, and other topics as they relate to safe operation of lasers.

5. **REFERENCES:**

*L'esperance, FA, Jr.: Ophthalmic Lasers*, vols. 1 and 2, 3<sup>rd</sup> ed. CV Mosby, St. Louis, 1989.

*American National Standard for the Safe Use of Lasers in Health Care Facilities*. American National Standards Institute Publications Z136.3-1988, 1430 Broadway, New York, New York.

*Novus Argon Laser Operator Manual*. Coherent Medical Group, 3270 Bayshore Road, Palo Alto, California.

*Novus 2000 ND: YAG Laser Operator Manual*. Coherent Medical Group, 3270 Bayshore Road, Palo Alto, California.

Joint Commission on Accreditation of Healthcare Organizations, *Accreditation Manual for Ambulatory Care*, recent edition.

6. **RESCISSION:** Medical Center Memorandum 112-10-01, dated February 2010.

7. **RECERTIFICATION:** April 2013

Concur / Do Not Concur

Concur / Do Not Concur

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### **Issuance of Optical Aids**

1. **PURPOSE:** Purpose of this memorandum is to provide information for ordering and issuing eyeglasses and/or contact lenses to eligible Veterans.

2. **POLICY:** It is the policy of VA Southern Nevada Healthcare System to establish guidelines for the issuing of eyeglasses.

- a. Prescriptions for eyeglasses and repairs will be filled by the optical supply source currently under VA Contract. Prescriptions for eyeglasses with one or more non-contract items, contact lenses and low vision aids on hearing aid eyeglasses may be obtained locally through a non-contract source.
- b. Eligibility for eyeglasses and contact lenses will be established prior to Veteran undergoing an eye examination when the examination is done solely to issue a prescription for optical aids pursuant to VHA HANDBOOK 1173.12, VHA Directive 1173, and Title 38 U.S.C., and Code of Federal Regulations, (CFR) 17.149.
- c. Veterans found to be in need of eyeglasses but not eligible for VA purchase (VHA handbook 1173.12, PL 104-262), may be eligible for prescription only by the examining Optometrist. Such prescriptions will be annotated with a disclaimer, "Not to be filled at VA Expense."
- d. Lenses, tints, prisms and other visual aids not available under contract may be authorized only upon written approval by the Optometrist on a per patient basis.
- e. Prescriptions for eyeglasses with tinted lenses will be filled for eligible Veterans with post cataract surgery, chronic uveitis, severe corneal disease, etc. "Sunglasses" will not be provided solely for comfort or without the medical justification documented and signed by the Optometrist.
- f. Replacement of eyeglasses may be authorized for eligible Veterans when necessitated by fair wear and tear, change in prescription or loss or breakage due to circumstances beyond the control of the Veteran. Replacement of lenses will be considered only for Veterans who have received eyeglasses at VA expense when the frames are in usable condition.

**NOTE:** Replacement of lost eyeglasses will be determined by the Optometrist based on medical need on a case-by-case basis.

- g. Spare eyeglasses may be authorized for Veterans with continuing eligibility when there is a compelling medical circumstance requiring a second pair. (See VHA HANDBOOK 1173.12, page 3, 7a).

h. Contact lenses may be provided to eligible Veterans with a diagnosis of monocular aphakia or binocular aphakia, severe astigmatism, pathologic myopia, keratoconus, and aniseikonia or ocular/vision glasses for correction of a specific eye condition. This must be clearly documented by the prescribing optometrist only when contact lenses are superior to eyeglasses in improving or protecting the beneficiary's visual or medical function.

i. The prescribing optometrist will not exceed two re-orders per patient in any twelve months period due misuse, abuse, or willful damage.

### **3. ACTION:**

a. The patient's Primary Care Physician will consult his/her patient to Optometry for an examination. A working VAF 10-2914 will be completed and forwarded to the Health Technician:

(1) Eye Clinic personnel will complete all appropriate blocks for patient identification, prescription, frame information, measurements and any special ordering instructions.

(2) Once the order is completed and verified, the Health Technician transcribes the ordering information into the electronic VAF 10-2914 in CPRS to await electronic authorization by the prescribing doctor. Once the prescribing doctor has electronically signed the prescription, it is automatically forwarded to the VA Regional Fabrication Laboratory to make the glasses.

(3) The VA Regional Fabrication Laboratory will mail the eyeglasses directly to the Veteran. Should the Veteran feel the prescription is not correct they are encouraged to contact the Eye Clinic and request that the prescription be checked. All redo orders will be sent to the VA Regional Fabrication Laboratory listing the corrections needed. Re-do orders will be handled in the same manner as new orders.

### **4. RESPONSIBILITY:**

a. Optometry: For determining medical need for the optical aid and composing the correct recommended prescription.

b. Health Technician: will measure, fit, adjust and perform necessary adjustments as needed.

c. Prosthetic Service: To determine eligibility (per VHA HANDBOOKS 1173.1 & 1173.12), and to initiate procurement action through appropriate source.

### **5. REFERENCES:**

6.     **RESCISSION:** Medical Center Memorandum 112-10-02, dated February 2010.

7.     **RECERTIFICATION:** April 2013

Concur / Do Not Concur

Concur / Do Not Concur

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### **PROPER DESTRUCTION OF MEDICATION**

1. **PURPOSE:** To establish a policy for the disposition of outdated, returned or deteriorated drugs which cannot be reissued.
2. **POLICY:** Pharmaceutical products must be disposed of according to applicable VA, local, state, and federal requirements. This is required to ensure product accountability and protection of people and the environment.
3. **ACTION:**
  - a. Patients will be instructed to destroy medications by utilizing community resources and drop off points. Refer to MCM 119-03, Medication Return Policy, for procedures for medications returned by patients.
  - b. All outdated, returned, or deteriorated medication in treatment areas will be returned to Pharmacy for disposition as soon as possible. Medications cannot be stored outside of Pharmacy or designated drug storage areas at any time.
  - c. Only Licensed Nursing Personnel, Licensed Independent Practitioners, Pharmacists, and Pharmacy Technicians may accept or handle medications returned for destruction. Under no circumstances will any other staff accept or handle any medications for destruction.
  - d. All drug storage areas will be inspected by pharmacy monthly and outdated and deteriorated drugs removed and returned to the pharmacy for destruction.
  - e. Only Registered Nurses or Pharmacists may remove outdated or deteriorated controlled substances from clinic stock. The RN or Pharmacist will complete VA Form 10-2321 "Controlled Substance Order" by entering "believed to be" followed by the drug name, strength, and quantity and return the form and drug to a Pharmacy employee to forward to the Pharmacy Vault. The removal of drug from clinic stock will be documented on VA Form 10-2320 or in automated dispensing system software for treatment areas with this technology.
  - f. Partially used injectable controlled substances, i.e., morphine, meperidine, and testosterone may be flushed down the sink at the nursing unit by a registered nurse when witnessed by an authorized nursing employee. This wastage will be documented on VA Form 10-2320 using two entries or similarly documented in automated dispensing system software for those treatment areas with this technology. The first entry will be the dose given, and the second entry will be the amount wasted. The second entry documenting wastage will include the signatures of the registered nurse and an authorized nursing employee on VA Form 10-2320 or equivalent documentation in the automated dispensing system.
  - g. Antineoplastic waste generated by Pharmacy Service will be placed in a "Chemotherapy Waste" container by the Infusion Pharmacist or Technician. The Infusion

Nurse will place antineoplastic waste remaining after chemotherapy administration in a “Chemotherapy Waste” container.

The Pharmacy IV Room and Nursing Infusion Room will each contain a chemo-bulk waste receptacle and a chemo-sharps container. Both containers are leak-proof plastic and are designated “Chemotherapy Waste”. Protective clothing and absorbent towels used in the preparation and administration of chemotherapy are placed inside the liner of the yellow chemo-bulk receptacle. The chemo-sharps container is for syringes, needles, glass bottles, vials, IV bags and transfer or infusion sets. Full containers will be stored in the designated area for pick up by the contracted licensed disposal service.

h. Controlled substances returned to the Pharmacy and determined not suitable for reissue, including excess and outdated controlled substances, will be segregated from the regular stock. The items will be entered into the controlled substance package by a pharmacy service supervisor or designee. The item will be counted by a pharmacy supervisor or designee and the vault personnel requesting the destruction. The item will be signed and sealed in the presence of both parties and clear cellophane tape will be applied over the signatures and seal. Two copies of the destruction form will be printed and signed by both parties. One will be attached to the bag and the other will be placed in the binder marked drugs awaiting destruction.

i. Each controlled substance will be packed on-site, documented, processed and either returned to the manufacturer for credit or destroyed by a contracted pharmaceutical waste management company. A DEA Form 222 (Order Form) is prepared for all schedule II controlled substances and a Schedule Drug Inventory Report is completed for all other controlled substances that can be returned to the manufacturer for credit by the contractor. A DEA Form 41 (Registrants Inventory of Drugs Surrendered) is prepared for all controlled products that will be destroyed by the contracted pharmaceutical waste management service.

j. All other non-controlled substance tablets, capsules, liquids, ointments, creams and suppositories will be packed on-site, documented, processed, and disposed of by a contracted pharmaceutical waste management service. A Return Drug Report containing estimated value will be completed if any of the drugs are eligible for return to the manufacturer. All non-returnable products will be properly disposed of by the contracted pharmaceutical waste management service. The Inventory Management Technician will maintain these records.

k. The pharmaceutical waste management company will provide signed copies of DEA Forms 222, and 41 to the Controlled Substance Technician to ensure accountability of controlled substances picked up by the contracted pharmaceutical waste management service.

l. The pharmacy technicians in charge of inventory management and controlled substances will ensure that outdated or pharmaceuticals unsuitable for dispensing are removed from working stock and picked up by the contracted pharmaceutical waste management service.

**4. RESPONSIBILITIES:**

a. All Care Line/Service Chiefs are responsible for the contents of this Memorandum and ensuring that employees follow procedures outlined in this Memorandum.

b. Chief, Facilities Management will be responsible for properly disposing of hazardous pharmaceutical waste.

**5. REFERENCES:**

VA Handbook 1108.1 dated October 4, 2004  
VA Handbook 1108.05 dated May 30, 2006  
FDA CPG 7132.09

**6. RESCISSION:** Medical Center Memorandum 08-07-17, "Proper Destruction of Medication" dated August 2007, is hereby rescinded and replaced by Medical Center Memorandum 119-10-11 entitled, "Proper Destruction of Medication".

**7. RECERTIFICATION:** May 2013

Concur/Do Not Concur

Concur/Do Not Concur

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## **COMPUTERIZED PATIENT RECORD SYSTEM ENTRY**

1. **PURPOSE:** The purpose of this Medical Center Memorandum is to define a consistent process for entering all electronic orders and notes into the Computerized Patient Record System (CPRS).
2. **POLICY:** It is the policy of the Department of Veteran Affairs and the VA Southern Nevada Healthcare System to provide appropriate and timely care for our Veterans through the use of consistent and accurate entry in the patient's electronic medical record. The consistent and accurate use of CPRS ensures the patient's medical record is current, accurate, and readily available regardless of the patient's location. It also provides a method to track, follow-up, and document that we provide comprehensive, longitudinal, and high quality healthcare in a customer-oriented environment.
3. **ACTION:** The following policy and procedures are established to provide guidelines for this process:
  - a. VA Southern Nevada Healthcare System mandates the use of CPRS by providers for patient care management in the outpatient setting. This is a condition of employment for all providers.
  - b. Progress Notes and Orders:
    - (1) Providers must enter all progress notes and all orders for medication (except schedule II controlled substances, and approved non-formulary or other consult initiated medication orders), laboratory studies, radiology requests, consults, and procedures directly into CPRS. Progress notes can be dictated with the approval of the Chief, Health Information Management Section. Prescriptions for schedule II controlled substances must be written on VA Form 10-2577F. The only exemptions to provider order entry are:
      - (a) Off-tour telephone inpatient orders. Registered Nurses may accept and enter into CPRS, telephone orders for inpatients, after normal duty hours, when a provider is not readily accessible to CPRS.
      - (b) Verbal orders are only to be used in emergent conditions. The ordering provider must sign orders promptly.
    - (2) Dictated progress notes must be reviewed, edited, and signed in a timely manner.
    - (3) The provider should electronically sign all outstanding notes and orders of the medical record immediately upon completion.

(4) Use of a progress note with extensive, standardized verbiage (boilerplate) is discouraged. If used, the provider must ensure all documentation appearing in the note is accurate and reflective of the visit and plan of care. Omitting essential information and/or leaving erroneous information (including unaddressed prompts) in the note is considered falsification of the medical record and has ethical and legal implications.

(5) Automation of the progress notes is encouraged. This includes the use of templates and drop down menus, which enable the provider to select common verbiage associated with clinic visits. Omitting essential information and/or leaving erroneous information (including unaddressed prompts) in the note is considered falsification of the medical record and has ethical and legal implications.

(6) Cutting and pasting information from one part of the electronic record to another part is discouraged unless it is important that the information be repeated.

c. Consults/Procedures:

(1) The provider must electronically enter all orders and required information for consults and/or procedures.

(2) Preliminary work-ups as defined by specialty criteria must be completed before sending a patient for a consult/procedure appointment.

(3) Each specialty area will have a designated employee who will be responsible for regular review of pending consults/procedures to ensure a streamlined process. Actions taken may include acceptance/cancel/forward/schedule/complete/discontinue and/or add comments as appropriate. Regular review of pending consults/procedures will ensure no consult/procedure request is missed and avoid any duplicate requests.

(4) Medical clerks will make appointments for requested consults/procedures according to the process defined in each consulting area.

(5) Providers initiating stat consults/procedures are responsible for contacting and receiving approval from the appropriate specialist. If a stat consult/procedure is requested and the approving specialist is not available, the provider must contact his/her care line chief to arrange for immediate action. Failure to contact the appropriate specialist or the care line chief to arrange for the consultation or procedure to be done immediately is evidence that the consult/procedure does not need to be "stat".

(6) Patients will not automatically be re-scheduled for a consult/procedure after a no-show. Clinical judgment should be used to determine whether to re-book an appointment or procedure. If the clinician decides not to re-book



an appointment, the consult/procedure service should “close out” the consult with an annotation that the patient was a “no show” (e.g. “Patient did not show for his appointment. Please reconsult if clinically indicated.”). The ordering provider will receive a view alert.

(7) Consultant providers will electronically enter and address all consult/procedure requests by utilizing the appropriate electronic note titles to properly complete/update the consult/procedure request. The ordering provider will receive a view alert.

d. Laboratory: The provider must electronically enter all laboratory orders.

e. Imaging:

(1) The provider must electronically enter all imaging orders and must include a “history and reason” for the request.

(2) Preliminary work-ups as defined by imaging criteria must be completed before sending a patient for an imaging request.

f. Pharmacy:

(1) The provider must electronically enter all pharmacy orders. It is the responsibility of the provider to review dosages, schedules, refills, and all aspects of the order. Exceptions to this rule are:

(a) Schedule II controlled substances requests must be written on VA Form 10-2577F.

(b) Registered Nurse may accept and enter into CPRS telephone orders for after hour inpatient needs when a provider is not readily accessible to CPRS. The ordering provider must sign orders promptly.

(c) Verbal orders are only to be used in emergent conditions. The ordering provider must sign orders promptly.

(2) The provider must electronically enter all non-formulary requests (initial or renewal). All required portions of the request must be completed to ensure complete and proper processing of the request.

(3) Pharmaceutical agents should be ordered in accordance with current Pharmacy process, procedures, and protocols.

g. View Alerts (Notifications)

(1) The provider is responsible to regularly review his/her view alerts to keep informed of his/her patients' activities or to set a surrogate to receive alerts in his/her absence.

(2) View alerts can be customized to reduce the number of view alerts received; however, mandatory alerts (i.e. critical values, abnormal results, etc) cannot be removed through customizing and must be reviewed by the provider on a regular basis.

h. Computer System Failure: In the event of a computer system failure, each care line or service must have a contingency plan to continue patient care.

#### 4. **RESPONSIBILITIES:**

a. It is the responsibility of the Medical Center Director to provide appropriate access to all levels of care.

b. It is the responsibility of the clinical service supervisors and/or designees to oversee the process of ordering, tracking, and completing electronic orders and progress notes to promote continuity of patient care.

c. It is the responsibility of clinical staff members to utilize CPRS appropriately for all documentation and order placement as well as to ensure preliminary tests are completed prior to a consult/procedure/imaging appointment.

d. It is the responsibility of the staff who are assigned by their clinical service supervisors to receive or deny consult and procedure requests. They are responsible for reviewing new consult requests to their assigned specialty area utilizing VA view alerts (notifications), applying appropriate specialty criteria, and communicating their decision to the ordering provider.

e. It is the responsibility of the clerical and administrative staff to process requests and make clinic appointments according to the time frames indicated by requesting clinicians.

f. It is the responsibility of the service chief and/or designees to monitor the consult/tracking process as a function of appropriateness and continuity of care.

g. It is the responsibility of Chief, Health Information Management to approve dictation of progress notes by individual providers and to ensure dictated progress notes are connected to the appropriate visit.

#### 5. **REFERENCES:**

JCAHO Ambulatory Care (current edition)

EDMS 166245 Memorandum dated January 30, 2002

MCM 02-04-120 dated January 2004, Medical Record Committee

MCM 02-04-132 dated March 2004, Medical Record Charting Guidelines  
MCM 02-04-148 dated April 2004, Health Records  
MCM 02-05-134 dated Nov. 2005, Electronic Signatures/ Computer Based  
Medical Records

6. **RESCISSION:** MCM 11-07-02, Computerized Patient Record System Entry,  
dated August 2007.

7. **RECERTIFICATION:** August 2013

Concur/Do Not Concur

Concur/Do Not Concur

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### **Supervision of Postgraduate Residents**

1. **PURPOSE:** The purpose of this memorandum is to delineate the requirements for the appropriate supervision of postgraduate residents in medicine, dentistry, optometry, and podiatry as they acquire skills and for documenting and monitoring the degree of this supervision at the VA Southern Nevada Healthcare System (VASNHS).

2. **POLICY:** It is the policy of the VASNHS to provide adequate and appropriate postgraduate medical education to residents in all patient care services including, but not limited to inpatient care, outpatient care, emergency care, and the performance and interpretation of diagnostic/therapeutic procedures.

3. **ACTION:** The following process defines the supervision, documentation and monitoring of postgraduate residents:

a. Definitions:

(1) **Graduate Medical Education (GME):** Process by which clinical and didactic experiences are provided to residents enabling them to acquire those skills, knowledge, and attitudes that are important in the care of patients. The purpose of GME is to provide an organized and integrated educational program providing guidance and supervision of the resident, to facilitate the resident's professional and personal development, and to provide safe and appropriate care for patients.

(2) **Residents:** Individuals who are engaged in a graduate training program in medicine (which includes all specialties like internal medicine, surgery, psychiatry, etc.) dentistry podiatry or optometry and who participate in patient care under the direction of supervising practitioners. The Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) must accredit the programs. The term includes individuals in their first year of training often referred to as "interns" and individuals in approved subspecialty graduate medical education programs who also have been referred to as fellows by some sponsoring institutions.

(3) **Chief Resident:** The Chief Resident is an individual who is considered senior in the training program and who may or may not be a licensed independent practitioner. Chief residents are designated by the Residency Program Director and may assume advanced administrative responsibilities necessary for the operation of the residency program. Chief residents fall into one of two categories:

(a) **Chief Resident – In Training:** Chief residents who are currently enrolled in an accredited residency program, but who have not completed the full academic program leading to board eligibility. These chief residents are not independent and cannot be privileged to work in the discipline for which they are being trained. This model is common in surgery programs. Chief residents are designated by

the Residency Program Director and may assume advanced administrative responsibilities necessary for the operation of the residency program.

(b) Chief Resident – Post Training: chief residents, who have completed an accredited residency program, but engage in an additional year of training and responsibility. These chief residents are board-eligible or board-certified and are able to be privileged in the discipline of their completed specialty-training program. These chief residents are frequently licensed independent practitioners. This model is common in internal medicine programs.

(4) Supervising Practitioner: Licensed, independent physicians, dentists, podiatrists and optometrists, regardless of the type of appointment, who have been formally credentialed and privileged at the VASNHS and Mike O’Callaghan Federal Hospital (MOFH). The supervising practitioner must be approved by the sponsoring entity in order to supervise residents. In some training settings, other health care professionals with documented qualifications and appropriate academic appointments (i.e., psychologists, audiologists), may function as supervising practitioners for selected training experiences. Supervising practitioners can provide care and supervision only for those clinical activities for which they have clinical privileges. The term is synonymous with the term attending or faculty.

(5) VA Designated Education Officer (DEO) is the single designated VA employee who has oversight responsibility for all clinical training at the VASNHS. The title for this education leader is the Associate Chief of Staff for Education (ACOS/E). The ACOS/E is a designated education leader with expertise in GME and health professions education.

(6) Designated Institutional Official (DIO) is an individual employed by the sponsoring entity who has the authority and responsibility for the oversight and administration of trainees in discipline-specific programs. The DIO is responsible for ensuring compliance with ACGME and/or AOA institutional requirements.

(7) Residency Program Director is the educational leader with full authority and responsibility for the administration of a single residency program in a specialty or subspecialty. The Residency Program Director is responsible for full compliance with standards of accrediting and certifying bodies.

(8) VA Residency Program Coordinator: In accordance with accrediting and certifying body requirements, appropriately-credentialed local VA clinicians are appointed as such for each residency training program and are responsible for the management and monitoring of training program activities at the VA site.

(9) Supervision: An intervention provided by a supervising practitioner to a resident. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the resident while

monitoring the quality of professional services delivered. Supervision is exercised through observation, consultation, directing the learning of the resident, and role modeling. Documentation of supervision must be entered into the medical record by the supervising practitioner or reflected within the resident progress note or other appropriate entries in the medical record (e.g., procedure reports, consultations, discharge summaries). Pathology and radiology reports must be verified by a supervising practitioner.

b.        Graduated Levels Of Responsibility:

(1)        As part of their training program, residents earn progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervising practitioner present, or to act in a teaching capacity is based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the supervising practitioner as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. In general, however, residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, residents are allowed to certify and re-certify certain treatment plans (e.g., Physical Therapy, Speech Therapy) as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising practitioner over and above standard setting-specific documentation requirements.

(2)        The Residency Program Director defines the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform. The Residency Program Director makes this list of graduated levels of responsibility available to other appropriate staff. Annually, at the time of promotion, or more frequently as appropriate, this document, along with a list of residents assigned to each year or level of training, is provided to the relevant VA Residency Program Coordinator, service chief, ACOS/E and COS. The Residency Program Director must include a specific statement identifying the evidence on which such an assignment is made and any exceptions for individual residents, as applicable.

c.        Documentation of Supervision of Residents:

(1)        Supervising Practitioner Involvement: The medical record must clearly demonstrate the involvement of the supervising practitioner in each type of resident-patient encounter described.

(2)        Supervision Documentation: Documentation of supervision must be entered into the medical record by the supervising practitioner or reflected within the resident progress note or other appropriate entries in the medical record (e.g., procedure reports, consultations, discharge summaries). Pathology and radiology reports must be verified by a supervising practitioner.

(a) Types of allowable documentation are:

1) Progress note or other entry into the medical record by the supervising.

2) Addendum to the resident progress note by the supervising practitioner within seventy-two (72) hours of resident completing/signing the note.

3) Co-signature of the progress note or other medical record entry by the supervising practitioner within 72 hours of resident completing/signing the note. NOTE: Supervising practitioner's co-signature signifies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry. Use of "additional signer" or "identified signer" options in CPRS is not an acceptable form of documenting resident supervision (See VHA Handbook 1907.1).

4) Resident progress note or other medical record entry documenting the name of the supervising practitioner with whom the case was discussed, a summary of the discussion, and a statement of the supervising practitioner's oversight responsibility with respect to the assessment or diagnosis and/or the plan for evaluation and/or treatment. Statements such as the following are acceptable to demonstrate the supervising practitioner's oversight responsibility: I have seen and discussed the patient with my supervising practitioner, Dr. "X" and Dr. "X" agrees with my assessment and plan. I have discussed the patient with my supervising practitioner, Dr. "X" and Dr. "X" agrees with my assessment and plan. The supervising practitioner of record for this patient care encounter is Dr. "X".

(b) The type of allowable documentation varies according to the clinical setting and kind of patient encounter. In all cases, the responsible supervising practitioner must be clearly identifiable in the documentation of the patient encounter or report of reviews of patient material (e.g., pathology or imaging reports). An independent note or addendum by the supervising practitioner is required for inpatient admissions, pre-operative assessment, and extended care admissions. The frequency of documentation of involvement of the supervising practitioner depends upon the setting and the patient's condition. The timeframe for signing or co-signing the progress notes, consultations, and reports is delineated in local facility policy or local medical staff bylaws.

(3) Patient Settings:

(a) Inpatient Care:

1) Inpatient Admission: For patients admitted to an inpatient service of the medical center, the supervising practitioner must physically meet,

examine, and evaluate the patient within 24 hours of admission including weekends and holidays. Documentation of the supervising practitioner's findings and recommendations regarding the treatment plan must be in the form of an independent progress note or an addendum to the resident note, which must be entered by the end of the calendar day following admission. If the specific requirements of the pre-operative notes are included, the admission note (or addendum) may also serve as the pre-operative note.

2) Night Float Admissions: For patients admitted to an inpatient service of the medical center, a "night float" resident occasionally provides care before the patient is transferred to an inpatient ward team. In these cases, the supervising practitioner must physically meet and examine the patient within 24 hours of admission by the night float to the inpatient service, irrespective of the time the ward team assumes responsibility for the patient. In addition, the supervising practitioner for night float admissions must be clearly designated by local policy. Documentation is either in the form of an independent progress note or an addendum to the resident's note.

3) Continuing Care of Inpatients: Supervising practitioners are expected to be personally involved in the ongoing care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the resident. Any of the four types of documentation referenced is acceptable.

4) Discharge from Inpatient Status: The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from an inpatient service of the medical center is appropriate and based on the specific circumstances of the patient's diagnoses and therapeutic regimen; this may include physical activity, medications, diet, functional status, and follow-up plans. Evidence of this assurance must be documented by the supervising practitioner's countersignature of the discharge summary or discharge note.

5) Transfer from One Inpatient Service to Another, or Transfer to a Different Level of Care (Inter-service or Inter-ward Transfer): The supervising practitioner, in consultation with the resident, ensures that the transfer of the patient from one inpatient service to another or transfer to a different level of care is appropriate and based on the specific circumstances of the patient's diagnoses and condition. The supervising practitioner from the transferring service must be involved in the decision to transfer the patient. The supervising practitioner from the receiving service must treat the patient as a new admission and must write an independent note or an addendum to the resident's transfer acceptance note. This provision covers transfers into and out of intensive care units or transfers to extended care. The only exception is whenever the same supervising practitioner is responsible for the patient across different levels of care.

6) Inpatient Consultations: A supervising practitioner is responsible for clinical consultations from each specialty service. When residents are



involved in consultation services, the supervising practitioner is responsible for supervision of these residents. Any of the four types of documentation referenced is acceptable.

7) Intensive Care Units (ICU), including Medical, and Surgical ICUs: For patients admitted to, or transferred into, an ICU of the medical center, the supervising practitioner must physically meet, examine, and evaluate the patient as soon as possible, but no later than 24 hours after admission or transfer, including weekends and holidays. An admission note or addendum to the resident's admission note is required within 1 day of admission. Because of the unstable nature of patients in ICUs, frequent evidence of involvement of the supervising practitioner is expected. Supervising practitioner involvement is expected on a daily or more frequent basis and may be documented using any of the four types of documentation referenced.

(b) Outpatient Clinic:

1) Physical Presence: The supervising practitioner must be physically present in the clinic area during clinic hours.

2) New Outpatient Encounters: New patients to a facility require a higher level of supervising practitioner documentation than other outpatients. Each new patient needs to be seen by or discussed with the supervising practitioner. Documentation of the supervising practitioner's findings and recommendations regarding the treatment plan must be in the form of an independent progress note or an addendum to the resident note. Supervising practitioner's co-signature of the resident's note is not sufficient documentation of resident supervision.

3) Outpatient Consultations: A supervising practitioner is responsible for clinical consultations from each outpatient clinic to another supervising practitioner within the local facility. When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents. Any of the four types of documentation referenced is acceptable.

4) Continuing Care in the Outpatient Setting: The supervising practitioner must be identifiable for each resident's patient care encounter. Return patients must be seen by, or discussed with, the supervising practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate. Any of the four types of documentation referenced is acceptable.

5) Discharge from Outpatient Clinic: The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from clinic is appropriate. Any of the four types of documentation referenced is acceptable.

(c) Extended Care (Nursing Homes):

1) New Extended Care Admissions: Each new patient admitted to an extended care facility must be seen by the responsible supervising practitioner within 72 hours of admission. Documentation of the supervising practitioner's findings and recommendations regarding the treatment plan must be in the form of an independent progress note or an addendum to the resident note.

2) Continuing Care in the Extended Care Setting: The supervising practitioner must be identifiable for each resident's patient care encounter. Extended care patients must be seen by, or discussed with, the supervising practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate. Any of the four types of documentation referenced in is acceptable.

(d) Emergency Department:

1) Physical Presence: The supervising practitioner for the emergency department must be physically present in the emergency department.

2) Emergency Department Visits: Each new patient to the emergency department must be seen by or discussed with the supervising practitioner. Documentation of the supervising practitioner's findings and recommendations regarding the treatment plan must be in the form of an independent progress note or an addendum to the resident note.

3) Discharge from the Emergency Department: The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from the emergency department is appropriate. Any of the four types of documentation referenced is acceptable.

4) Emergency Department Consultations: A supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the consulting service-supervising practitioner is responsible for supervision of these residents.

Residents from a consulting service are expected to contact their supervising practitioners while the patient is still in the emergency department in order to discuss the case and to develop and recommend a plan of management. The emergency room practitioner is responsible for the disposition of the patient. Any of the four types of documentation referenced is acceptable. The emergency room practitioner is not the supervisor of the consulting resident, but is the responsible practitioner for the patient.

(e) Operating Room (OR) Procedures: Supervising practitioners must provide appropriate supervision for the patient's evaluation, management decisions, and procedures. Determination of the level of supervision is a function of the level of responsibility assigned to the individual resident involved and the complexity of the procedure.

1) Pre-procedure Note: The pre-procedure supervising practitioner note requirement applies to OR and same day (ambulatory) surgical procedures; it does not apply to routine bedside procedures and clinic procedures such as skin biopsy, central and peripheral lines, lumbar punctures, centeses, incision and drainage, etc. For all elective or scheduled surgical procedures, a supervising practitioner must evaluate the patient and write a pre-procedural note or an addendum to the resident's pre-procedure note describing the findings, diagnosis, plan for treatment, and/or choice of specific procedure to be done. This pre-procedural evaluation and note may be done up to 30 days in advance of the surgical procedure. All applicable JCAHO standards concerning documentation must be met. A pre-procedure note may also serve as the admission note if it is written within 1 calendar day of admission by the supervising practitioner with responsibility for continuing care of the inpatient, and if the note meets criteria for both admission and pre-operative notes. Use of appropriate note titles in CPRS is encouraged. Other services involved in the patient's operative care (e.g., Anesthesiology) must write their own pre-procedure notes (such as for the administration of anesthesia) as required by JCAHO, but such documentation does not replace the pre-operative documentation required by the surgery supervising practitioner.

2) Informed Consent. Informed consent must be obtained as detailed in VHA Handbook 1004.1.

3) Veterans Health Information Systems and Technology Architecture (VistA) Surgical Package. Staff involvement in procedures as defined in the VistA Surgical Package must be documented in the computerized surgical log (a part of the VistA Surgical Package) and reported to VA Central office via the Surgical Quarterly Report consistent with the following scale:

a) Level A: Attending Doing the Operation. The staff practitioner performs the case, but may be assisted by a resident.

b) Level B: Attending in OR, Scrubbed. The supervising practitioner is physically present in the operative or procedural room and directly involved in the procedure. The resident performs major portions of the procedure.

c) Level C: Attending in OR, Not Scrubbed. The supervising practitioner is physically present in the operative or procedural room. The supervising practitioner observes and provides direction. The resident performs the procedure.

d) Level D: Attending in OR Suite, Immediately Available: The supervising practitioner is physically present in the operative or procedural suite and immediately available for resident supervision or consultation as needed.

e) Level E: Emergency Care: Immediate care is necessary to preserve life or prevent serious impairment. The supervising practitioner has been contacted.

f) Level F: Non-OR Procedure: Routine bedside and clinic procedure done in the OR. The supervising practitioner is identified.

(f) Non-OR Procedures:

1) Routine Bedside and Clinic Procedures: Routine bedside and clinic procedures include: skin biopsies, central and peripheral lines, lumbar punctures, centeses, and incision and drainage. Supervision for these activities is dependent on the setting in which they occur. Documentation standards must follow the setting-specific guidelines.

2) Non-routine, Non-bedside Diagnostic, or Therapeutic Procedures: Non-routine, non-bedside, diagnostic, or therapeutic procedures (e.g., endoscopy, cardiac catheterization, invasive radiology, chemotherapy, radiation therapy) are procedures that require a high level of expertise in their performance and interpretation. Although gaining experience in doing such procedures is an integral part of the education of the resident, such procedures may be done only by residents with the required knowledge, skill, and judgment and under an appropriate level of supervision by a supervising practitioner. Supervising practitioners are responsible for authorizing the performance of such procedures and must be physically present in the procedural area. Supervision for these procedures takes into account the complexity and inherent risk of the procedure, the experience of the resident, and assigned graduated levels of responsibility. Documentation standards must follow the setting-specific guidelines. Documentation of the degree of supervising practitioner involvement is encouraged. Any of the four types of documentation referenced is acceptable. With respect to chemotherapy and radiation therapy, the supervising practitioner must be present during the treatment planning (i.e., choice of modality and regimen), dosage or dosimetry determinations, and writing of chemotherapy or radiation therapy orders. Neither the supervising practitioner nor the resident need to be present during the administration of either chemotherapy or radiation therapy since therapy delivery is a function of associated health personnel.

d. Emergency Situations: An emergency is defined as a situation where immediate care is necessary to preserve the life of or to prevent serious impairment of the health of a patient. In such situations, any resident, assisted by medical center personnel, is (consistent with the informed consent provisions of VHA Handbook 1004.1) permitted to do everything possible to save the life of a patient or to save a patient from serious

harm. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible. The resident must document the nature of that discussion in the patient's record.

e. Evaluation of Residents, Supervising Practitioners and Training Sites:

(1) Evaluations of Residents.

(a) Each resident must be evaluated according to accrediting and certifying body requirements on patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Evaluations occur as indicated by the accrediting or certifying body, or at least semiannually, and are communicated to each resident in a timely manner. Evaluations must be accessible to the resident at the end of the resident's rotation or every 6 months, whichever is more frequent. Written evaluations must be discussed with the resident.

(b) When a resident's performance or conduct is judged to be detrimental to patient care, evaluation of the resident, in mutual consultation with the faculty, must be done. Residents may be dismissed from VA assignment in accordance with VA Handbook 5021, Part VI, paragraph 18, which includes a requirement to notify the Residency Program Director of the affiliated participating institution of a proposed dismissal of a resident in an integrated program.

(2) Evaluation of Supervising Practitioner and Training Site. Each resident rotating through a VA facility must be given the opportunity to complete confidential written evaluations of the supervising practitioner(s) and the VA training site(s). Evaluations must be conducted in accordance with the standards of the appropriate accrediting and/or certifying bodies. Evaluations need to conform to program-specific requirements. Academic evaluations are the confidential property of the residency program and Residency Program Director.

(3) Storage and Use of Evaluations. Secure storage of evaluations of residents, supervisors, and training sites is the responsibility of the Residency Program Director. The evaluations are aggregated and analyzed in compliance with accrediting and certifying body standards. The evaluations must be communicated to the responsible VHA service chief and/or VA Residency Program Coordinator in a manner and timetable agreeable to both.

f. Monitoring:

(1) The goal of monitoring resident supervision is to foster a system-wide environment of peer learning and collaboration among VHA managers, supervising practitioners, and residents. The monitoring process involves the use of existing information, the production of a series of evaluative reports, the accompanying process of public review of key findings, and discussion of policy implications.

(2) The basic foundation for resident supervision ultimately resides in the integrity and good judgment of professionals (supervising practitioners and residents) working collaboratively in well-designed health care delivery systems. Accordingly, monitoring of resident supervision is a shared responsibility of national, VISN, and local facility leaders.

(3) The key objectives of the resident supervision monitoring process are to continuously improve and enhance:

- (a) The quality and safety of patient care involving residents.
- (b) VHA's educational environment and culture of learning.
- (c) The documentation of resident supervision.
- (d) The systems of care involving residents.

(4) The monitoring of resident supervision is a medical record review process, and a quality management activity. Documents and data arising from this monitoring are confidential and protected under Title 38 United States Code (U.S.C.) 5705, and its revised implementing regulations.

#### **4. RESPONSIBILITIES:**

a. The Director is responsible for establishing local policy to fulfill the requirements of VHA Handbook 1400.1, and the applicable accrediting and certifying body requirements. The medical center Director appoints or assigns the duties of the DEO to the appropriate local education leader. The Director, with input from DEO and the COS must report annually to the VISN Director, or designee, the status of resident training programs in facility. This reporting must take place through the AR RTP (RCN 10-0906) process. (1) The VA medical center Director is responsible for ensuring that a local monitoring process exists for resident supervision. The monitoring process must include the following:

(1) Creation of a local policy entitled "Monitoring of Resident Supervision". This policy must define the procedures that are to be followed for the monitoring of resident supervision. The policy must include procedures for monitoring the following elements:

- (a) Inpatient care involving residents.
- (b) Outpatient care involving residents.
- (c) Procedural care involving residents.

- (d) Emergency care involving residents.
  - (e) Consultative care involving residents.
  - (f) Surgical care involving residents including a review of the appropriateness of Levels E and F each instance of surgical care performed at levels E and F (as coded in the VistA surgical package) must be reviewed.
- (2) Review of quality improvement data (protected by 38 U.S.C. 5705 and its revised implementing regulations and current VA policy):
- (a) Results of medical record reviews and other locally-derived quality management data concerning patient care involving residents.
  - (b) Incident reports and tort claims involving residents.
  - (c) Risk events including adverse events and “near misses” involving residents.
  - (d) Patient complaints involving residents.
  - (e) Review of externally-derived quality management data such as External Peer Review Program (EPRP) data.
  - (f) Review of reports by accrediting and certifying bodies.
- (3) Review of residents’ comments related to their VA experience, if available.
- (4) Identification of opportunities for improvement in resident supervision and creation of action plans.
- b. The Chief of Staff (COS) is responsible for assessing the quality of residency training at the VASNHS and the quality of care provided by supervising practitioners and residents. The ACOS/E may assist the COS in fulfilling these requirements.
- c. The DEO or ACOS/E is responsible for ensuring that:
- (1) A facility resident supervision policy is in place.
  - (2) Graduated level of responsibility is established in each specialty and/or subspecialty.
  - (3) Facility monitoring and reporting requirements regarding training issues and resident supervision are met.

(4) A process is established for monitoring resident supervision the results in identification of areas for improvement and facility action plans.

d. The Resident Program Director is responsible for the overall education and training program in a given discipline. This person defines the level of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform. The list of graduated levels of responsibility is made available to other appropriate staff. Annually, at the time of promotion or more frequently as appropriate, this document along with a list of residents assigned to each year or level of training is provided to the relevant VA Residency Program Coordinator, service chief and COS. A specific statement must be included identifying the evidence on which such an assignment is made and any exceptions for individual residents, as applicable. This individual is customarily at the affiliated institution. Secure storage of evaluations of residents, supervisors, and training sites is the responsibility of the Residency Program Director. The evaluations are aggregated and analyzed in compliance with accrediting and certifying body standards. The evaluations must be communicated to the responsible VHA service chief and/or VA Residency Program Coordinator in a manner and timetable agreeable to both.

e. Residency Program Coordinator for each residency-training program is responsible for ensuring that supervising practitioners are appropriately fulfilling their responsibilities to provide supervision to residents and that ongoing evaluation of supervisors, residents and the VA site are conducted. They will ensure that residents' function within their assigned graduated level of responsibility; and is responsible for:

(1) Assessing resident supervision within the program via a systematic review process.

(2) Structuring training programs consistent with the requirements of the accrediting and certifying bodies and the affiliated participating entity.

(3) Arranging and ensuring that all residents participate in an orientation to VA policies, procedures, and the role of residents within the VA system.

(4) Ensuring that residents are provided the opportunity to give feedback regarding their supervising practitioners, the training program, and the VA site.

f. Supervising practitioner is responsible for and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings. Must provide an appropriate level of supervision, which is a function of the experience and demonstrated competence of the resident and the complexity of the Veteran's health care needs. Ultimately, it is the decision of the supervising practitioner as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility.



(1) General. The supervising practitioner directs the care of the patient and provides the appropriate type of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. All services must be rendered under the supervision of the responsible practitioner or must be personally furnished by the supervising practitioner.

(2) Documentation. Documentation of supervision must be entered into the medical record by the supervising practitioner or reflected within the resident progress note. The medical record needs to reflect the involvement of the supervising practitioner.

g. Resident: The residents, as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of service. Each resident is responsible for communicating significant patient care issues to the supervising practitioner. Such communication must be documented in the record. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible supervising practitioner may result in the removal of the resident from VA patient care activities.

5. **REFERENCES:**

M-2, Part 1, Chapter 26, February 12, 1992  
VHA Directive 10-93-081, Supplement No.1, July 8, 1993  
VHA Handbook 1400.1, Resident Supervision, July 27, 2005  
VHA Handbook 1907.1

**VHA Handbook 1004.1, Informed Consent**

6. **RESCISSION:** Medical Center Memorandum 11-08-09 dated September 2008

7. **RECERTIFICATION:** March 2013

Concur/Do Not Concur

Concur/Do Not Concur

Ramu Komanduri, MD  
Chief of Staff

Shirley L. Caldwell-Butts, MSN, RN  
AD Patient Care/Nurse Executive

Concur/Do Not Concur

Approved/Disapproved

Associate Director

John B. Bright  
Director

### **Credentialing and Privileging**

1. **PURPOSE:** To update established policy, procedure, guidance, and delineation of responsibility for credentialing and privileging of physicians, dentists, podiatrists, optometrists, chiropractors and allied health professionals with clinical privileges and/or Scopes of Practice.

2. **POLICY:**

a. All Department of Veterans Affairs privileged professionals will be properly credentialed and privileged (if applicable) in accordance with the requirements of the Joint Commission standards and VHA policies. These policies apply to all VA physicians, dentists, podiatrists, optometrists, chiropractors, and allied health professionals involved in patient care who are appointed or utilized on a full-time, part-time, intermittent, consultant, attending, without compensation (WOC), on-station fee basis, on-station contract, or on-station sharing agreement basis, and who are granted clinical privileges. These policies also apply to all physicians, dentists, podiatrists, optometrists, chiropractors and allied health professionals involved in patient care off-station. These providers will be granted credentials only (no privileges).

b. Physician residents who request appointment and clinical privileges (i.e., fee basis, contract, etc.) to function outside the scope of their training program must meet the credentialing and privileging requirements of this memorandum. In addition, residents applying for appointment are required to be at the senior/chief resident level or above, board certified or board eligible, and have a full, unrestricted license.

c. Every professional, required to be credentialed only, or credentialed and granted clinical privileges, or who operate under a Scope of Practice, will have a standardized credentials folder established and maintained by the Chief of Staff /Medical Staff Office in accordance with VHA regulations.

3. **ACTION:**

a. Definitions:

(1) Credentialing - systematic process of screening and evaluating an individual's qualifications and other credentials, including licensure, required education, relevant training and experience, current competence, and health status.

(2) Clinical Privileging - process by which a practitioner is granted permission by law and by the medical center to independently provide medical or other patient care services based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure.

(3) Reappraisal - process of reevaluating the professional credentials, clinical competence, and health status of professionals who hold clinical privileges.

(4) Reprivileging - process of renewing privileges to practitioners who currently have clinical privileges at the VA Southern Nevada Healthcare System.

(5) Reduction of Privileges - process of restricting performance of specific privileges and/or procedures or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area.

(6) Revocation of Privileges - permanent loss of clinical privilege at the medical center.

(7) Scope of Practice – a description of routine and non-routine professional duties to be performed and the general areas of responsibility.

(8) Joint Privileging (VA and Air Force [AF]) will be completed as outlined in the VA and Mike O’Callaghan Federal Hospital Bylaws.

b. Procedures

(1) All individuals applying for clinical privileges or Scope of Practice will be provided with a copy of the Medical Staff Bylaws and Rules and must agree to accept the professional obligations reflected by the bylaws. The requirements as outlined in the bylaws, as well as the procedures outlined in VHA handbooks, will be followed. Requirements and processes for requesting and granting privileges and/or Scopes of Practice are the same for all practitioners regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.

(2) The credentialing and privileging process requires an average of 6-8 weeks to complete verification and review. It is essential that the completed application be submitted to the Chief of Staff/Medical Staff Office (Credentialing and Privileging), as soon as a candidate is identified.

(3) The practitioner must be fully credentialed and privileged prior to their initial appointment to the medical staff. A pre-employment physical examination is required for full-time, part-time, and intermittent applicants prior to their appointment. Recommendation for initial appointment to the medical staff is made by the Care Line/Service Chief and/or Chief of Staff, through the appropriate Professional Standards Board (PSB) to the Director, in accordance with the regulations of the VHA. Appointment to the medical staff will be made only after documented evidence of the following has been provided:

- (a) Relevant education, training, board certification and/or experience,
- (b) Advanced or basic cardiac life support certification or both if applicable,
- (c) Current competence to fulfill the requirements of the position to support the clinical privileges requested,
- (d) Verification of licensure (may include DEA and State CDS),
- (e) Current health status,
- (f) National Practitioner Data Bank (NPDB), Health Integrity and Protection Data Bank (HIPDB), Federation of State Medical Boards (FSMB) and Office of the Inspector General's List of Excluded Individuals/Entities queries as applicable,
- (g) Ethical behavior, and
- (h) Concern for human rights and welfare.

(4) Biennial reappraisal of each medical staff member and other practitioners who hold clinical privileges or scope of practice is required. Reappraisal includes a review of performance and an evaluation of the practitioner's physical and mental status, as well as assessment of the individual's current privileges or scope. The new clinical privileges or scopes applied for must be commensurate with training, clinical experience, continuing medical education credits, and current competence. A practitioner's profile will be maintained by the Care Line/Service Chief for each practitioner requesting privileges and/or scopes of practice and will contain, as appropriate, results of risk management activities, Quality Assurance activity reports, continuing medical education credits, attendance at committee and staff meetings, and peer recommendations. It is the responsibility of the Care Line/Service Chief to review each practitioner's service profile with members of the PSB and recommend acceptance or denial of the clinical privileges or Scope of Practice being requested. These results will be presented at the time of reappraisal and repriviliging and filed with the practitioner's proficiencies in accordance with the provisions contained in the MCM for Ongoing Professional Practice Evaluation (OPPE)/Focused Professional Practice Evaluation (FPPE).

(5) The denial, reduction, or revocation of clinical privileges of a physician or dentist based on deficiencies in professional performance or lack of training/experience may be separate from the reappraisal and repriviliging process. Data gathered in conjunction with the facility's quality assurance program is an important tool for identifying potential deficiencies. However, material, which is obtained as part of a

protected quality assurance program, may not be disclosed in the course of any action to reduce or revoke clinical privileges, nor may any reduction or revocation of privileges be based directly on such quality assurance data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the quality assurance program, such as administrative reviews and boards of investigation. In these circumstances, the quality assurance data may have triggered the review; however, the quality assurance information is confidential and privileged in accordance with 38 U.S.C. 5706.

(6) Upon notification by Regional Counsel that a medical malpractice claim has been made, the Chief, Quality Management will contact the office of the Director, Medical-Legal Affairs (DML) for assistance in the completion of the required review. Peer reviewers will conduct a review to determine which practitioners were involved in, or responsible for, the care of the patient related to the acts or omissions for which payment was made.

For each of the acts or omissions, and for each of the involved practitioners, the peer panel must determine whether there was substandard care, professional incompetence or professional misconduct. Upon completion of the peer report and prior to filing a report with the National Practitioner Data Bank (NPDB), the individual under consideration will have at least three days to review the information. The individual under consideration for reporting shall be afforded the opportunity for discussion with the Director and any other appropriate individuals as designated by the Director.

(7) General provisions and parameters for reporting adverse actions to clinical privileges are outlined in the Handbook 1100.17, National Practitioner Bank Reports, dated December 28, 2009. Actions related to professional competence or conduct that adversely affect clinical privileges of a physician or dentist for a period longer than 30 days will be reported to the NPDB. Prior to reporting to any state licensing board or the NPDB, due process procedures will be completed pursuant to the provisions of VHA Handbook 1100.19, Credentialing and Privileging, VHA Handbook 1100.17, NPDB Reports, and VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards.

(8) Medical Staff Bylaws: Applicants are responsible for becoming familiar with, and agree to abide by, the facility's Medical Staff Bylaws, which govern medical staff behavior. Applicants are expected to commit to providing continuous care to their assigned patients and arrange for transfer of care as appropriate.

#### **4. RESPONSIBILITY:**

a. The Director through the Chief of Staff is responsible for overall compliance with the Department of Veterans Affairs policies on the credentialing, privileging, reappraisal and reprivileging of all practitioners with clinical privileges or scopes of practice. The Director is responsible for certifying that all practitioners have

been appropriately credentialed and privileged and assures that all practitioners with clinical privileges function within the scope of privileges granted.

b. The Chief of Staff /Medical Staff Office (Credentialing and Privileging, specifically the Credentialing Supervisor) is responsible for maintenance of the credentialing and privileging system for all practitioners with clinical privileges and/or Scope of Practice. The Credentialing Supervisor is responsible for screening all medical staff members and other practitioners who hold clinical privileges and/or Scope of Practice to the NPDB; the Federation of State Medical Boards, where applicable; the Healthcare Integrity and Protection Data Bank (HIPDB), and the Office of the Inspector General's List of Excluded Individuals/Entities. Submission to the data banks will be done at initial appointment and biennially during the re-privileging process.

c. The Care Line/Service Chief is responsible for reviewing all credentialing and privileging information, quality improvement activities, and other pertinent information in individual practitioner profiles. The Care Line/Service Chief, to which the practitioner is to be assigned, is responsible for recommending all types of appointments and/or clinical privileges based on evaluation of credentials and determination that service criteria for clinical privileges are met.

d. The appropriate PSB will make recommendation for appointment and/or clinical privileges based on recommendation of the Care Line/Service and evaluation of credentials of practitioner and a determination that service criteria for clinical privileges are met.

A representative from Human Resource Management Service will serve as a technical advisor to the PSB for physicians, dentists, podiatrists, optometrists, chiropractors and allied health professionals. The PSB's recommendation will be submitted to the Medical Executive Board and ultimately to the Director for final approval.

e. The practitioner is responsible for initiating credentialing information. The practitioner is responsible for obtaining and producing all needed information for evaluation of the practitioner's professional competence, character, ethics, and other qualifications. The practitioner is responsible for furnishing information that will help resolve any doubts concerning such qualifications to the Credentialing Supervisor. Credentialing must be completed by the practitioner in VetPro, the electronic internet-based credentialing data bank and must be verifiable. In addition, the practitioner is required to complete appropriate VA application forms for initial appointment.

## **5. REFERENCES:**

VHA Handbook 1100.17, National Practitioner Data Bank Reports  
VHA Handbook 1100.19, Credentialing and Privileging  
VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards  
VHA Directive 2001-022, Implementation of VetPro

## **6. RESCISSION: Medical Center Memorandum 11-07-10 dated March 2007**

7.     **RECERTIFICATION:** January 2013

Concur / Do Not concur

Concur / Do Not Concur

Ramu Komanduri, M.D.  
Chief of Staff

Shirley Caldwell, MSN, RN  
AD Patient Care/Nurse Executive

Approved / Disapproved

John B. Bright  
Director



## **Monitoring of Resident Supervision**

1. **PURPOSE:** The goal of monitoring resident supervision at the VA Southern Nevada Healthcare System (VASNHS) is to foster a system-wide environment of peer learning and collaboration among managers, supervising practitioners, and residents. The key objectives of the resident supervision monitoring process are to continuously improve and enhance the quality and safety of patient care involving residents, to improve the educational environment of the Veterans Health Administration (VHA) and its culture of learning, to improve the documentation of resident supervision, and to improve systems of care involving residents.

2. **POLICY:** It is the policy of the VASNHS to abide by the most current version of VHA Handbook 1400.1 “Resident Supervision” which sets forth specific processes for the supervision of graduate professional trainees and specifies monitoring procedures that must be followed.

3. **ACTION:** The monitoring of resident supervision is ongoing via medical record review, national performance measures, patient safety, and other quality management review processes. Documents and data arising from this monitoring are confidential and protected under Title 38 United States Code (U.S.C.) 5705, and its revised implementing regulations.

a. Ongoing performance, quality, and patient safety monitors include the following:

(1) Review of quality improvement data (protected by 38 U.S.C. 5705 and its revised implementing regulations and current VA policy):

(a) Incident reports and tort claims involving residents. Incident reports involving residents are reported to the Designated Education Officer (DEO)/Associate Chief of Staff for Education (ACOS/E) or designee by quality management personnel as they arise. Tort claims are reported at least annually or as they arise. Cases are reviewed with the residents, staff practitioners, VA Residency Program Coordinators, and Care Line/Service Chiefs as appropriate to identify areas of improvement in resident care delivery and supervision. Peer review should include assessment of the appropriateness of resident supervision documentation.

(b) Risk events including adverse events and “near misses” involving residents are reported to the DEO (ACOS/E) by quality management personnel as they arise. Cases are reviewed with the residents, staff practitioners, VA Residency Program Coordinators, and Care Line/Service Chiefs as appropriate to identify areas of improvement in resident care delivery and supervision. The medical centers utilize the Root Cause Analysis (RCA) process. RCA teams are instructed to identify specific issues that may require improvement regarding the care delivered by and supervision of residents.

(c) Patient complaints involving residents are directed to the DEO (ACOS/E) by the Customer Service Manager who reviews them and informs the appropriate VA Residency Program Coordinator and Care Line/Service Chief. The review will seek to identify any patterns of complaints that may indicate problems with a particular resident or system problems that do not support optimal resident-patient interaction.

(d) Review of externally derived quality management data such as External Peer Review Program (EPRP) and Inspector General will be conducted by the DEO (ACOS/E). Data will be reviewed with the VA Residency Program Coordinators and Service Chiefs quarterly or as it becomes available in the case of the Inspector General.

(e) Results of medical record reviews and other locally derived quality management data concerning patient care involving residents.

(2) Review of reports by accrediting and certifying bodies will be reviewed by the DEO (ACOS/E) at least annually or as they arise. Deficiencies related directly to the residents' VA experience will be addressed in an action plan developed by the DEO (ACOS/E), the Program Coordinator, Program Director, and facility leadership, as necessary.

(3) Residents' comments and survey responses related to their VA experience through the National Learners' Perceptions Survey or locally conducted surveys, if available, will be reviewed at each medical center's Medical Executive Committee. Areas of improvement will be identified and an action plan developed by the DEO (ACOS/E) along with the Program Coordinator, Program Director and facility leadership.

(4) Identification of opportunities for improvement in resident supervision and creation of action plans.

b. The medical record reviews will cover care provided in the following locations and settings:

(1) Inpatient care involving residents: No less than a total of 30 charts or 5% of hospital admissions involving residents per quarter will be reviewed covering care across all of these inpatient areas. Specifically, evidence of the presence and content of the supervising practitioner's admission note and evidence of ongoing involvement and supervision by the supervising practitioner will be recorded by chart review and compiled in a database. Additionally, an automated report is available through VISTA identifying the presence of a supervising practitioner's note for each patient admitted to the hospital by the end of the next calendar day after admission that can be used for real-time monitoring. If after the initial screening, an area is found to be deficient, further review and action will be taken as appropriate. The review sheet for inpatient charts is attached

(2) Outpatient care involving residents: No less than a total of 30 charts per quarter will be reviewed covering care across all of these outpatient areas. The chart review will focus on documentation of supervising practitioner involvement with new patients and consultations seen by residents in the clinic as well as evidence of ongoing involvement and supervision by the supervising practitioner in subsequent visits to the clinic. If after the initial screening, an area is found to be deficient, further review and action will be taken as appropriate. The review sheet for outpatient charts is attached.

(3) Procedural care involving residents: Procedural settings include certain Surgical Clinics and Areas, all inpatient units and Intensive Care Units. Intensive care and invasive inpatient bedside procedures (thoracentesis, paracentesis, central line insertion, intubation, chest tube insertions, etc.) will also be reviewed. No less than a total of 30 charts per quarter will be reviewed covering care across all of these areas. For operating room procedures, the VISTA Surgical Package Data will be reviewed at least quarterly. Operating procedures at level E or F will be reviewed for appropriateness by the Surgical Service Chief and reported to the DEO (ACOS/E). If after the initial screening, an area is found to be deficient, further review and action will be taken as appropriate. The review sheet for procedural care charts is attached.

(4) Emergency care involving residents: A total of 30 charts per quarter when available will be reviewed. If after the initial screening, an area is found to be deficient, further review and action will be taken as appropriate. Emergency Department (ED) care involving residents, specifically ED visits, discharges and consultations will be reviewed using the inpatient criteria. The review sheet for emergency care charts is attached

(5) Consultative care involving residents: Consultative care is delivered by virtually every medical specialty and subspecialty, and residents are involved in many of these activities. No less than a total of 30 charts per quarter will be reviewed, spanning the breadth of all consultative activities involving residents. If after the initial screening, certain types of consults are found to be deficient, further review and action will be taken as appropriate. The review sheet for consultative care is attached

(6) Surgical care involving residents including a review of the appropriateness of Surgical VISTA levels E (Emergency Care) and F (Non-OR case in OR) by Surgery Service staff: The Chief of Surgery will, on a quarterly basis, present the data concerning the use and appropriateness of Surgery Package VISTA Levels E and F to the Executive Committee of the Medical Staff. This review will be of 100% of identified records. In addition, a total of no less than 30 surgery (OR) charts per quarter will be reviewed. The review sheet for surgical care is attached.

c. Nursing staff will be provided with a mechanism by which they can independently confirm a resident's qualifications to perform a procedure without direct supervision. If nurses are unable to confirm residents' qualifications, they are instructed

to contact the supervising practitioner who ultimately holds the responsibility of determining the resident's qualifications.

**4. RESPONSIBILITIES:** The basic foundation for resident supervision ultimately resides in the integrity and good judgment of professionals (supervising practitioners and residents) working collaboratively in well-designed health care delivery systems. Monitoring of resident supervision is a shared responsibility of national, VISN, and local facility leaders. The local responsibilities are delineated below.

a. The Medical Center Director is responsible for ensuring that a local monitoring process exists for resident supervision.

b. The Designated Education Officer (DEO)/Associate Chief of Staff for Education (ACOS/E), who reports to the Chief of Staff, is responsible for:

(1) Ensuring there are appropriate ongoing monitors of resident supervision.

(2) Will review reports of accrediting and certifying bodies for issues involving resident supervision.

(3) Will also receive, review and analyze data from the national Learner's Perception Survey, especially with regards to the educational environment and supervision issues, exit interviews with residents, receive reports as indicated from clinical service chiefs, HIMS/HAS staff, Chair of the Medical Record Committee, and Facility Compliance Officer.

(4) Is responsible for preparing and submitting to the Medical Center Director the Annual Review of Residency Training Programs (ARRTP), RCN 10-0906, which is shared with the Executive Committee of the Medical Staff (ECMS) and forwarded to the VISN and national leadership offices (Office of Academic Affiliations).

c. The Quality Management Section will ensure appropriate reporting to service chiefs and/or the Chief of Staff based on their ongoing monitoring processes.

d. Care Line/Service Chiefs (or Section Chiefs) are responsible for reviewing and acting on performance, medical records, patient safety, and other ongoing monitoring information referred to them. Responsibility for ensuring appropriate resident supervision is an integral part of the service-level oversight process. If opportunities for improvement are identified, the Care Line/Service Chief (or Section Chief) is responsible for corrective actions including educating practitioners, and evaluating improvement.

e. The Chief of Surgery is responsible for the quarterly review and reporting of the appropriateness of the Surgery Package VISTA Level E (Emergency Care) and F (Non-OR Case in OR) levels of supervision. The data and an analysis of appropriateness shall be reported quarterly to the ECMS.

f. Customer Service Staff facilitate the resolution of individual patient complaints and also provide aggregate reporting of patient complaints and concerns. Individual complaints related to residents and/or attendings are referred to the clinical service chiefs for review and/or further action. Aggregate patient advocate reports are presented to the Performance Improvement Council on a regular (quarterly) basis.

g. Supervising Practitioners are licensed independent practitioners with appropriate clinical privileges. Supervising practitioners must abide by the supervision and documentation standards as set forth in VHA Handbook 1400.1.

h. Residents, as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. Residents must abide by all supervision and documentation standards as set forth in VHA Handbook 1400.1.

**5. REFERENCES:**

Veterans Health Administration Handbook 1400.1, Resident Supervision, dated May 3, 2004  
Veterans Health Administration Directive, November 2001, Annual Report on Residency Training Programs (ARRTP), RCN 10-0906

**6. RESCISSION:** Medical Center Memorandum 11-08-17, Monitoring of Resident Supervision, dated September 2008

**7. RECERTIFICATION:** April 2013

Concur/Do Not Concur

Concur/Do Not Concur

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Concur/Do Not Concur

Approved/Disapproved

Associate Director

John B. Bright  
Director

### **Cardiopulmonary Resuscitation Certification Program**

1. **PURPOSE:** To establish policy and procedure for an American Heart Association (AHA) approved Cardiopulmonary Resuscitation (CPR) certification program.
2. **POLICY:** The Veterans Affairs Southern Nevada Healthcare System (VASNHS) maintains AHA community training center status and provides CPR courses defined by the AHA as Advanced Cardiac Life Support (ACLS), Healthcare Provider (HCP) Basic Life Support (BLS), and Heart Saver/Automated External Defibrillator (HS/AED). Designated VASNHS staff will maintain a specified level of AHA approved CPR certification (Attachment A). The VASNHS will offer CPR courses on an as needed basis for VASNHS staff. Minimally, the classes will be offered as follows: ACLS initial and/or renewal quarterly, BLS initial and renewal monthly, and HS/AED quarterly. An AHA approved Training Center or Military Training Network CPR card is acceptable evidence of current verification. All AHA CPR certification cards are valid for a two-year period from the recommended renewal dates that appear on the front of the cards. Employees with expired CPR certifications may be temporarily reassigned to non-clinical duties and/or are subject to disciplinary action. Individuals unable to perform CPR may be medically exempt with proof of letter by their physician.
3. **ACTION:**
  - a. Designated employees are required to successfully complete AHA approved ACLS, BLS, and HS courses to achieve certification status. ACLS certification requires successful completion of case evaluations and a minimum written examination score of 85%. BLS certification requires successful completion of a written examination with a minimum written examination score of 85%. BLS and HS require a demonstration of BLS/HS and AED psychomotor skills.
  - b. Credentialed and privileged clinical staff with Mike O’Callaghan Federal Hospital (MOFH) Emergency Department, Intensive Care Unit, Operating Room, Post Anesthesia Care Unit, and Step-Down Unit is required to maintain current ACLS certification.
  - c. Nursing personnel at MOFH Emergency Department, Intensive Care Unit, Operating Room, Post Anesthesia Care Unit, and Step-Down Unit are required to maintain current ACLS certification.
  - d. Credentialed and privileged clinical staff, including those who provide direct patient care or direct diagnostic testing, will maintain current AHA approved HCP BLS certification.
  - e. Nursing personnel (Registered Nurses, Licensed Practical Nurses, Nursing Assistants, Registered Nurse Practitioners, Clinical Nurse Specialists, Clinical Nurse Leaders, and Veterans Administration Learning Opportunity Residency program students

/VALOR) will complete an annual HCP BLS competency evaluation. One year from the time of the last successful class and conferral of a BLS card, employees listed in this section will verify their CPR competency through successful completion of a BLS renewal course.

f. Students, such as those in nursing and medical programs, must have current BLS certification.

g. Non-clinical staff at the MOFH must have current HS/AED certification.

h. Enrolled course participants will obtain course manuals from the Training Center Coordinator (TCC) located at the Central Clinic or from designated point of contacts.

#### **4. RESPONSIBILITIES:**

a. Chief of Staff has overall responsibility for implementation and enforcement of this policy.

b. Associate Director Patient Care (ADPC)/Nurse Executive provides CPR program compliance and facility AHA Training Center Coordination oversight.

c. The facility AHA TCC:

(1) Acts as liaison to the AHA.

(2) Monitors annually the competencies of Training Center Faculties (TCF), CPR instructors, and instructor trainers.

(3) Provides TCF and CPR instructors with the required AHA forms, supplies, and equipment and how to maintain and clean the CPR equipment.

(4) Assesses CPR programs and recommends and/or implements actions for quality improvement.

(5) Maintains integrity and security of all AHA materials and written examinations.

(6) Maintains CPR Access database and annual calendar.

(7) Monitors and reports to VASNHS leadership, joint venture, credentialing and privileging, professional standards boards, and other appropriate entities, CPR compliance statistics/information.

(8) Submits to AHA required VASNHS Training Center status reports.

(9) Assesses CPR program infection control practices through consultation with infection control practitioner.

(10) Provide CPR instructor courses on an as needed basis.

(11) Maintain and demonstrate competency per AHA guidelines.

d. Training Center Faculty is responsible to:

(1) Serve as quality assurance and educational leadership for the Training Center (TC)

(2) Conduct instructor courses and monitor, update, and coach instructors

(3) Ensure that the TC is capable of conducting quality instructor courses, course monitoring, and instructor updates within the TC

e. CPR Instructors are responsible to:

(1) Maintain current AHA CPR instructor status.

(2) Demonstrate knowledge and appropriate utilization of AHA materials, maintain integrity of CPR cards and examinations, clean CPR equipment per facility and manufacturer guidelines.

(3) Complete and submit to TCC the instructor feedback form documenting any defective equipment, missing parts, and/or inadequate supplies.

f. Contracting Officer Technical Representatives are responsible to monitor the CPR compliance of contracted medical group healthcare providers and submit documented evidence to the credentialing and privileging staff.

g. SPD staff is responsible to:

(1) Provide adequate levels of CPR supplies as determined by the TCC.

(2) Retrieve from the training site used/reusable CPR supplies.

(3) Process reusable CPR supplies per manufacturers' and facility guidelines.

(4) Deliver appropriate CPR supplies to the CPR training site in a timely manner.



g. Employees are responsible to:

- (1) Provide evidence of current AHA-approved CPR competencies and appropriate verifications.
- (2) Obtain from the TCC or designated point of contacts the appropriate CPR training manual with CD and review before scheduled course.
- (3) Complete pre-course assignments and pre-tests in accordance to course instructions.
- (4) Provide supervisor and TCC evidence of successful CPR course completion from courses completed outside the VASNHS.
- (5) Provide TCC timely notification of the need to cancel CPR course enrollment.

h. Supervisors are responsible to:

- (1) Enforce CPR MCM.
- (2) Support employee attendance for CPR courses and annual skills verification.
- (3) Maintain copies of employees' CPR certification cards in continuing education folder

**5. REFERENCES:**

AHA Program Administration Manual-Guidelines for Program Administration and Training, 2008  
MOFH-Instruction 44-6, Chapter 3: Bylaws of the Medical Staff, 2009  
VASNHS Bylaws of the Medical Staff, 2007

**6. RESCISSION:** MCM 11-07-27, Cardiopulmonary Resuscitation Certification Program dated April 2007.

**7. RECERTIFICATION:** April 2013

Concur/Do Not Concur

Concur/Do Not Concur

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Approved/Disapproved

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## PEER REVIEW FOR QUALITY MANAGEMENT

1. **PURPOSE:** The purpose of this memorandum is to state policy, assign responsibilities and provide procedures for the peer review processes at the VA Southern Nevada Healthcare System (VASNHS).

2. **POLICY:** It is the policy of VASNHS to establish and maintain a program of protected (confidential) peer review for quality improvement purposes (including resource utilization) relevant to the care provided by individual practitioners, in support of clinical care programs and professional services. This is in compliance with the requirements set forth by Veterans Health Administration (VHA) for initiating, conducting and documenting protected peer review for quality management of care, purposes (including resource utilization) of peer review, and oversight agencies that periodically review VHA healthcare facilities, including, but not limited to the Joint Commission.

3. **ACTION:**

a. Definitions:

(1) **Confidential Documents:** The term “confidential documents” includes all documents or parts of documents produced by, or for, VA in the process of conducting systematic health care reviews for the purpose of improving the quality of health care or improving the utilization of health care resources, which are considered privileged under 38 U.S.C. § 5705, and its implementing regulations.

(2) **High Risk Level 1 Cases:** Include, but are not limited to, cases involving high alert medications, systems issues, communication issues, or any case that results in a Root Cause Analysis (RCA).

(3) **Provider:** The term “provider” is defined as anyone credentialed, privileged, or working within a professional scope of practice. This does not apply to health care profession trainees acting within the scope of their training program.

(4) **Peer:** The term “peer” is defined as an individual of similar education, training, licensure, and clinical privileges or scope of practice.

(5) **Protected Peer Review:** The term “peer review” is defined as critical reviews of an episode of care performed by a peer and/or group of peers. Critical review includes the dimensions (efficacy, appropriateness, availability, timeliness, effectiveness, continuity and efficiency) of performance of services, including any system problems identified in the course of the peer review. Peer review findings are confidential. Peer review, as designated by the Secretary, Department of Veterans Affairs (conducted for the purpose of improving the quality of health care and/or

improving the utilization of health care resources) is protected by 38 U.S.C. § 5705, and its implementing regulations.

Peer review is a traditional organizational function designed to contribute to improving the quality of care and/or the appropriate utilization of health care resources.

(a) Essential elements of protected peer review include:

1. Evaluation of the care provided by individual clinicians when care provided is of concern,
2. Determination of the necessity of specific actions recommended by the peer review process, and
3. Confidential communications back to appropriate providers regarding the results and any recommended actions to improve performance.

(b) Protected peer review documents for quality improvement include all reviews of patient care by an individual provider that are performed for the purpose of improving the quality of health care and/or improving the utilization of health care resources. In order for the documents generated by a peer review to be protected confidential under 38 U.S.C. § 5705, and its implementing regulations, each peer review must be designated in writing as being conducted and/or prepared for quality management and/or resource utilization purposes prior to the initiation of the peer review. This designation can be issued by the Under Secretary for Health (for all VHA facilities), by a Veterans Integrated Services Network (VISN) Director (for VHA facilities within the VISN), and /or by the facility Director (for the individual facility).

1. The following statement is required for protected peer review documents:

*“The documents, records, and other information contained herein, which resulted from \_\_\_\_\_, (name of specific quality program or resource utilization activity), are confidential and privileged under the provisions of 38 U.S.C. § 5705, and its implementing regulations. This material cannot be disclosed to anyone without authorization as provided for by that law or its regulations. The statute provides for fines up to \$20,000 for unauthorized disclosures.”*

2. A protected peer review will be conducted as part of this facility’s quality management program and may not be disclosed outside of the quality management process. For example, a protected peer review may be initiated when a malpractice claim is filed, and will be a protected peer review so long as the purpose of the review is to identify, evaluate, and, where appropriate, correct circumstances having the potential to adversely effect the delivery of care.

3. Peer review findings may be disclosed as long as they are aggregated and documented in a way that strictly protected the confidentiality of

those involved and are communicate solely for the purposes of promoting organizational performance (including appropriate resource utilization) and optimal patient outcomes.

4. The protected peer review for quality improvement always starts with an “initial review”, which must be completed within 45 days.

(6) **Performance Issues:** Clinical deficiencies of such significance that they may affect the quality of care provided would be referred directly to the service chief/supervisor for appropriate action.

b. Peer Review Process:

(1) The initial peer review results in determination of a Level of Care as a Level 1, Level 2, or Level 3 (see Attachment B). Completed initial protected peer reviews for quality management that were conducted by an individual reviewer must be sent to a multi-disciplinary Peer Review Committee chaired by the Chief of Staff or designee.

(a) **Level 1.** Most experienced, competent practitioners **would** have handled the case **similarly** in all of the aspects listed. (See Attachment B)

(b) **Level 2.** Most experienced, competent practitioners **might** have handled the case **differently** in one or more aspects listed. (See Attachment B)

(c) **Level 3.** Most experienced, competent practitioners **would** have handled the case **differently** in one or more aspects listed. (See Attachment B)

(2) The Peer Review Committee will reconsider all peer review cases when the level of review is determined to be a Level 2 or Level 3. Since the Peer Review Committee oversees all peer reviews, a sufficient and representative sample of Level 1 peer review cases, at least 30 per year or 20 percent whichever is greater, or all level 1's if the total number does not reach 30, need to be reviewed to ensure the validity and reliability of the findings and to evaluate the peer review process itself. If there are fewer than eight Level 1's per quarter, all Level 1's need to be reviewed on a quarterly basis.

(3) Process:

(a) All clinical staff will participate in peer review activities as assigned. Cases for peer reviews may be identified or referred from various sources such as tort claims, patient incident reports (negative outcomes), occurrence screens (mortality reviews), patient advocates, committees, providers, etc. to the Quality Management Office. The risk manager performs the initial review. A determination will be made on cases meeting criteria (Attachment A) as to whether the case should be referred for peer; service, (process or program issues referred to the Care Line/Service Chief for action); or, committee, (issues that are referred to other committees for action) review. Service and committee reviews are not considered protected peer review unless designated as protected in writing by the Peer Review Committee or COS. Medical record

documentation issues should be noted while performing the clinical review. The identified issues will be forwarded to the applicable services for appropriate corrective actions.

(b) Peer reviews (initial) will be completed within 45 days of the date.

(c) Peer review findings of clinical issues will be based upon accepted current quality of care standards. The peer reviewer will determine if the practice of the clinician met those standards.

An outside consultant (within VISN 22, within VHA, or within DoD/Military) will be utilized when a practitioner working in the same specialty area is not available locally to review a case.

(d) All peer review decisions (Attachment B) will have the rationale documented as to how or why that decision was made. All comments will be authenticated.

(e) Level 2 or 3 findings:

1. Notification of peer review determinations of Level 2 or Level 3 will be sent by the Chief of Staff via Care Line/Service Chief to the clinician (Attachment C) to provide an opportunity for additional comments/explanation. The clinician will be provided with information that will include the patient identification, the indicator that fell out and the peer reviewer's comment. Failure of the practitioner to reply within ten (10) administrative days will constitute agreement/acceptance/concurrence with peer review findings. All peer review comments will remain anonymous.

2. Returned comments from the provider will be sent and reviewed by the Peer Review Committee (PRC) along with the initial peer reviewer's findings. The PRC will either concur with the individual peer reviewer's findings or change the level of care after reviewing the provider's response. The PRC will take appropriate corrective action. (Attachment D).

3. The results of the final decision will be shared with the practitioner by the service chief, and secured in the Quality Management Office for inclusion in the peer review log.

4. Liability for damages: Peer reviewers are protected from damage suits if review activities are conducted:

a. In the reasonable belief that action would further the provision of quality health care;

b. After reasonable effort to ascertain the facts of the matter at hand;

c. After adequate notice and hearing procedures have been afforded to the health care provider involved,

d. In the reasonable belief that the action was warranted by the facts; and

e. UNLESS the person(s) knowingly provides false information.

5. Flowchart for Peer Review Process (see Attachment E).

(4) Indicators: Attention is paid to the Indicators for Protected Peer Review. The following need to be considered for a Protected Peer Review:

(a) Mortality Review: All deaths must be screened against death review criteria and exceptions to the death review criteria. Cases that meet the criteria must be referred for protected peer review for quality management. Mortalities associated with any surgical procedure (elective or not) or any mortality later during the same hospitalization (or related to readmission for the same condition within 30 days) need to undergo peer review.

***NOTE:*** The diagnosis of a “terminal” illness, the existence of an advanced directive, or a Do Not Resuscitate status is not considered an exception from Protected Peer Review.

(b) Major Morbidities associated with Surgical Procedures.

(c) All Suicide Attempts and Completed Suicides within 30 days of any Encounter with a health care provider. This includes telephone visit, telemedicine, etc.

(d) Unexpected or Negative Occurrences: These occurrences include events in which a patient has experienced a negative or unexpected outcome that may be related to the care provided and for which facility management considers peer review the best method for determining if the care was appropriate.

(e) Executive Concerns. These concerns about quality management issues from members of leadership or service and/or department chiefs may be requested when specifically related to the provision of patient care by a provider under the charge of the executive. Executive Leadership may submit a request for Protected Peer Review for quality improvement purposes including resource utilization. These types of reviews may focus on:

1. Operative reports,
2. Invasive and non-invasive procedures,
3. Blood usage,

4. Medication usage,
5. Restraint and seclusion,
6. Resuscitation,
7. Care to high-risk populations,
8. Efficiency of clinical practice patterns,
9. Significant departures from established patterns of clinical practice,
10. Completion of medical records,
11. Patient Event Reports,
12. Occurrence screens, and
13. Resource Utilization.

(f) Concerns of Other Facility Groups: These concerns are from established organizational groups within the facility, which may submit a request for Protected Peer Review for quality management purposes.

(g) Tort Claims: Initial notification of the filing of a tort claim may generate an immediate Protected Peer Review for quality management.

(5) Timeframes: Timeframes for completion of protected peer review activities, including when reviews are to be conducted, and when results are to be reported to all parties concerned, including the providers whose care is under review and VISN leadership.

Time begins with the date that the determination of Protected Peer Review is necessary.

(a) Screen for Need for Protected Peer Review: This must be completed within 3 business days of identification or discovery of the event.

(b) Initial Review Completed: This must be completed within 45 calendar days from determination to conduct Protected Peer Review is identified.

(c) Final Review Completed: This must be completed within 120 calendar days from determination to conduct Protected Peer Review is identified.

#### **4. RESPONSIBILITIES:**

a. Facility Director: The facility Director has the ultimate responsibility for peer review for quality management that are protected and performed within the facility. He is responsible for ensuring that:

- (1) A multi-disciplinary Peer Review Committee is established.
- (2) Appropriate education is provided, to include:



(a) All clinical health care professionals are educated on the Protected Peer Review policy/processes within 6 months of entry on duty (EOD).

(b) Participants in the Protected Peer Review process (assigned reviewers and committee members) receive training upon assignment to the committee or prior to participating in a review. Refresher training will be completed biennially.

(3) An initial peer review is initiated, as appropriate.

b. Chief of Staff: It is the responsibility of the Chief of Staff to implement the contents of this policy in coordination with the Quality Management Office, and to provide oversight to the Peer Review Committee.

c. Peer Review Committee: The Peer Review Committee is chaired by the Chief of Staff or designee. The committee membership will be multi-disciplinary, to include non-physicians, and will include the Chief Nurse Executive. The committee is responsible for:

(1) Meeting on a regular scheduled basis, at least quarterly, and consist of a quorum of members for voting purposes. The Chair or Co-Chair may call ad hoc meetings or add ad hoc members as needed.

(2) Reporting quarterly to the Executive Leadership Board (ELB, the Medical Executive Board (MEB), and the Network Quality Management Office.

(3) Completing the final review of each protected peer review within 120 days from the determination that a peer review is necessary (the initial peer review must be completed within 45 days).

(4) Coordinate the referral of significant information to appropriate leadership/committees when a systems issue is identified as a result of the protected peer review process.

(5) Assigning, in writing, a final Level, based on deliberations, along with any appropriate non-punitive, non-disciplinary actions to improve the quality of health care delivered or utilization of health care resources to the appropriate supervisor. The supervisor is responsible for initiating appropriate action and follow-up.

(a) It is expected that the supervisor of the individual(s) that was assigned the Level 2 or Level 3 will communicate with the individual(s) in their service and ensure that appropriate non-disciplinary, non-punitive action is implemented.

(b) Feedback of action must be accomplished by the supervisor's written notification to the Peer Review Committee upon completion of the action.

(6) Ensuring that, in most circumstances, health care profession trainees are acting within the scope of their training program, are not independent, and are under the supervision of a VA staff provider. If care delivered by a health care profession trainee is identified as Level 2 or Level 3, a decision must be made by the Peer Review Committee as to whether a failure of supervision contributed to the outcome.

(a) If the supervision was deemed appropriate, a Level of Care must still be assigned but will not be attributable to either the trainee or supervising practitioner. The Peer Review Committee's data will document the Level of Care without attribution. The Peer Review will be referred to the health care profession trainee's Chief of Service and/or Program Director for follow-up, which ever is appropriate.

(b) If the supervision was deemed inappropriate, the Level of Care will be assigned to the supervising practitioner. *In no case should the Level of Care be attributable to the trainee alone unless there is clear cut evidence of gross negligence or willful professional misconduct.*

(7) Documenting issues related to patient safety, law enforcement, or potential administrative investigations determined during the peer review process and referring these concerns to the appropriate management, professional, or law enforcement official in a timely manner utilizing existing Privacy Act routine-use exceptions involving those issues. The Peer Review Committee is responsible for monitoring follow-up action on these concerns and documenting closure. *Only the initial report ("charging facts") can be communicated when starting a non-protected review, which means that a new and separate investigation(s) must begin.*

(8) Tracking, quarterly, an analysis of data with findings and recommendations, and forwarding this information to the ELB and MEB.

(a) The number of completed peer reviews and number of deaths referred to peer review tracked and trended by the provider under review, patient identifier, level of care, and service.

(b) The number of peer reviews not in compliance with the timelines defined in the local facility policy, tracked and trended by service.

(c) The number of changes from one level to another by the protected Peer Review Committee tracked and trended by service.

(d) Tracking and trending the aspect of care.

(e) Systems issues identified and actions completed.

(f) Tracking of actions completed by service

(9) Seek, as necessary, peer reviewers from outside the facility or VISN. If external assistance is required, outside assistance may be sought from another facility or VISN CMO.

(10) Conducting each review through an explicit application of current standards of care based on accepted practice and analysis of reviewed professional literature published within the United States health care community.

(11) Reporting Peer Review Activity data on a quarterly basis using VISN Sharepoint website to the VISN QMO for VISN analysis. In collaboration with the VISN CMO, outlier data will be identified and follow-up action documented to the VISN Director and the medical center Director. Necessary actions will be documented to closure.

(a) The number of reviews;

(b) The outcome by Level 1, Level 2, and Level 3; and

(c) The number of changes from one level to another during the review process (e.g., the initial reviewer determines a Level 2, but it is changed to a Level 1 by the Committee).

(12) Ensuring that formal discussions about peer review (e.g., occurring during peer review committee meetings) are recorded in formal meeting minutes. Documentation relevant to protected peer reviews must be kept by a Peer Review Committee official in a folder(s) that is not identifiable by provider; the folder must be stored in a secure location.

(13) Inviting the provider whose care is under review by the Peer Review Committee (only Level 2 and Level 3), to appear before the Peer Review Committee, if the provider chooses, before a final committee decision is reached. The responsible Peer Review Committee Official must fully document discussions held with a provider.

d. The Providers are responsible for participation in peer review and/or the Peer Review Committee as appointed by the Chief of Staff. Peer review reports are completed within 120 calendar days of receipt of the case. Extensions may be granted on a case-by-case basis by the COS.

(1) Qualifications: A peer reviewer must:

(a) Possess the relevant clinical expertise necessary to make accurate judgments about the decisions being reviewed. The term "Peer" is as an

individual of similar education, licensure, training and clinical privileges or scope of practice.

(b) Possess knowledge of relevant current standards of care.

(c) Be formally trained regarding the peer review process, the responsibilities, and the facility's legal and ethical requirements.

(2) Responsibilities:

(a) The initial peer reviewer uses the aspects for review of care presented in Attachment B to evaluate quality and/or resource issues related to the care given by an individual provider.

(b) No peer reviewer may have direct involvement with the care in question.

(c) Peer reviewers must:

1. Withdraw from a case if determined that the specialized knowledge required exceeds their expertise or when they feel uncomfortable about judging the care.

2. Abstain from review of cases in which there is a conflict of interest or, for any other reason, the reviewer is unable to conduct an objective, impartial, accurate, and informed review.

(d) Completion of the initial protected peer review with assignment of Level of Care must be timely and consistent with facility policy that is not to exceed 45 days. On the rare occasion when the initial protected peer review is anticipated and cannot be completed within 45 days, a written request for an extension must be submitted to the COS prior to the due date.

(e) If the matter being reviewed raises concerns about the possibility of substandard care, negligence, or any other competency issue that might impact safety or privileges, immediate notification is to be given to the COS, the Nurse Executive, and other Executives as appropriate.

(3) Providers will not be involved in his own case in peer review activities due to conflict of interest.

(4) No professional review action will be taken pursuant to a peer review, due to the confidential and privileging status of the peer review process. A Board of Investigation should be considered by the Chief of Staff and facility Director if disciplinary action is contemplated.

Adequate notice and hearing must be provided to the involved providers in accordance with VHA policy. A Board of Investigation will then be convened to investigate the situation. Any Board recommendations regarding provider performance will be forwarded to the Director in the Board's Report and forwarded to the Chief of Staff for action.

(5) Confidentiality: Information from the Peer Review is confidential and cannot be revealed to any one outside the protected Quality Management process except as provided in 38 U.S.C. § 5705(b), and 38 C.F.R. §§ 17.508 and 17.509.

e. The Risk Manager (RM) or designee of Quality Management is responsible for notifying the VISN of incidents that require prompt reporting in accordance with VHA handbook 1051; reviewing the quality of care against approved criteria; coordinating the peer review process; notifying involved providers; and tracking peer review results. The RM is responsible for quarterly tracking of peer review activity.

f. The Medical Executive Board, in its deliberations, must utilize the data analysis information from the Peer Review Committee to determine the need for further action. Criteria which may engender further action are:

- (1) A lower number of peer reviews.
- (2) Overwhelming majority of Level 1 assignments.
- (3) Absence of Level 3 assignments.
- (4) Consistent absence of changes of levels.
- (5) Facility defined criteria that may define further review or action.
- (6) Consistent assignment of Level 3 for a provider.
- (7) All level changes result in a decrease in the assigned level (i.e., Level 3 to a 2 or a 1.)

g. The Executive Leadership Board will review data from the Peer Review Committee for leadership information.

## **5. REFERENCES:**

VHA Directive 2008-004, "Peer Review for Quality Management" dated January 28, 2008. VHA National Patient Safety Improvement Handbook dated April 18, 2008.

Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101-52.

VASNHS Medical Staff Bylaws

Lang, D. 1991. Medical Staff Peer Review, A strategy for motivation and performance.

6. **RESCISSION:** 11-08-50 Revised, Peer Review for Quality Management, dated August 2008.

7. **RECERTIFICATION:** March 2013.

Concur/Do Not Concur

Concur/Do Not Concur

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## **RESIDENT SUPERVISION**

**1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook provides the procedural requirements pertaining to the supervision of residents and focuses on resident supervision from the educational perspective.

**2. SUMMARY OF MAJOR CHANGES.** The Handbook has been rewritten with specific emphasis on areas that:

- a. Reflects current accreditation standards by the Accreditation Council for Graduate Medical Education (ACGME) and other relevant accrediting bodies for residency training programs;
- b. Enhances the description of supervision and the documentation requirements in various settings;
- c. Reflects new standards for documentation of new outpatient encounters;
- d. Reflects the level of documentation needed for intensive care unit inpatient settings;

## **RESIDENT SUPERVISION**

### **1. PURPOSE**

This Veterans Health Administration (VHA) Handbook provides the procedural requirements pertaining to the supervision of residents and focuses on resident supervision from the educational perspective. **NOTE:** *This Handbook applies to residents in medicine, dentistry, optometry, and podiatry. See the most current VHA Directive on Billing for VHA policy regarding billing procedures for resident-related care.*

### **2. BACKGROUND**

In a health care system where patient care and the training of health care professionals occur together, there must be a clear delineation of responsibilities to ensure that qualified practitioners provide patient care, whether they are trainees or full-time staff. As resident trainees acquire the knowledge and judgment that accrue with experience, they are allowed the privilege of increased authority for patient care.

a. VHA follows the institutional requirements of the Accreditation Council for Graduate Medical Education (ACGME) and other accrediting and certifying bodies. ACGME states that the Residency Program Director and faculty are responsible for providing residents with direct experience in progressive responsibility for patient management. The process of progressive responsibility is the underlying educational principle for all graduate medical and professional education, regardless of specialty or discipline. Supervising clinician educators involved in this process must understand the implications of this principle and its impact on the patient and the resident. **NOTE:** *Accreditation bodies for the disciplines of dentistry, optometry, and podiatry have similar requirements.*

b. VHA must comply with the institutional requirements and accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other health care accreditation bodies. Qualified health care professionals with appropriate credentials and privileges provide veteran patient care and provide the supervision of residents.

**NOTE:** *Policy and procedural requirements pertaining to the supervision of medical*

*students and trainees in other disciplines are addressed in VHA Manual M-8, Part II, or superseding Handbook.*

c. The intent of this Handbook is to ensure that patients are cared for by clinicians who are qualified to deliver that care and that this care is documented appropriately and accurately in the patient record. This is fundamental both for the provision of excellent patient care and for the provision of excellent education and training for future health care professionals.

d. The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinician educator is the appropriate supervision of the residents as they acquire the skills to practice independently

### **3. SCOPE**

The provisions of this Handbook are applicable to patient care services including, but not limited to inpatient care, outpatient care, community and long-term care, emergency care, and the performance and interpretation of diagnostic and therapeutic procedures.

a. Supervising practitioners are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires personal involvement with each patient and each resident who is participating in the care of that patient. Each patient must have a supervising practitioner whose name is identifiable in the patient record. Other supervising practitioners may at times be delegated responsibility for the care of the patient and the supervision of the residents involved. It is the responsibility of the supervising practitioner to be sure that the residents involved in the care of the patient are informed of such delegation and can readily access a supervising practitioner at all times.

b. Within the scope of the training program, all residents must function under the supervision of supervising practitioners. Services that provide 24-hour, 7-day a week (24/7) resident coverage and call schedules must be provided to the medical center administration. Call schedules are to delineate both resident and attending coverage.

c. Each training program is constructed to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment. **NOTE:** *The determination and documentation of graduated levels of responsibility are outlined in paragraph 6.*

d. Each facility must adhere to current accreditation requirements as set forth by the ACGME, Commission on Dental Accreditation (CDA), the Executive Committee of the Council on Postdoctoral Training (ECCOPT), the Council on Podiatric Medical Education (CPME), the American Osteopathic Association (AOA), and Accreditation Council on Optometric Education (ACOE) for all matters pertaining to the resident training program, including the level of supervision provided.

e. The requirements of the various certifying bodies, such as the pertinent member boards of the American Board of Medical Specialties (ABMS), Bureau of Osteopathic Specialists (BOS), American Board of Podiatric Surgery (ABPS), CDA, American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM), and ACOE must be incorporated into Department of Veterans Affairs (VA) training programs and fulfilled through local facility policy to ensure that each successful program graduate is eligible to sit for a certifying examination.

f. In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is



expected that an appropriately-privileged supervising practitioner is available for supervision during clinic hours. Patients followed in more than one clinic must have an identifiable supervising practitioner for each clinic. Supervising practitioners are responsible for ensuring the coordination of care that is provided to patients.

g. Facilities must ensure that their training programs provide appropriate supervision for all residents as well as a duty hour schedule and a work environment that are consistent with proper patient care, the educational needs of residents, and all applicable program requirements.

#### **4. DEFINITIONS**

a. **Chief Academic Affiliations Officer.** The Chief Academic Affiliations Officer is the national leader of VHA's teaching mission. The Under Secretary for Health appoints the Chief of the Office of Academic Affiliations, VHA, Washington, DC. The Chief Academic Affiliations Officer is responsible for the largest coordinated education and training effort for health care professionals in the nation.

b. **Network Academic Affiliations Officer.** The Network Academic Affiliations Officer is a designated education leader at the Veterans Integrated Services Network (VISN) level with expertise in Graduate Medical Education (GME). Each VISN must appoint a Network Academic Affiliations Officer for coordination of certain regional education activities. This assignment may be collateral, part-time, or full time, depending on the size and complexity of the VISN education programs.

c. **VA Designated Education Officer (DEO).** The DEO is the single designated VA employee who has oversight responsibility for all clinical training at each VA facility that either sponsors or participates in accredited training programs. The title for this education leader may be the Associate Chief of Staff for Education, Director of Education, Chief Education Service Line, or other similar title. ***NOTE:** The DEO describes a functional assignment and not an organizational title. Each facility involved with residency programs must appoint a DEO for coordination of local GME and other education activities as assigned (see subpar. 5d).*

d. **Associate Chief of Staff for Education (ACOS/E).** The ACOS/E is a designated education leader with expertise in GME and health professions education. ***NOTE:** ACOS/E is the preferred organizational title for individuals assigned the responsibilities of the DEO role.*

e. **Designated Institutional Official (DIO).** The DIO is an individual employed by the sponsoring entity who has the authority and responsibility for the oversight and administration of trainees in discipline-specific programs. ACGME requires that each institution sponsoring ACGME-accredited programs have an individual appointed as the DIO. The DIO is responsible for ensuring compliance with ACGME institutional requirements. ***NOTE:** A VA facility that sponsors ACGME-accredited programs independently must have a DIO, although the responsibilities and functions overlap with those described for the DEO (see par. 5).*

f. **Residency Program Director.** The Residency Program Director is the education leader with full authority and responsibility for the administration of a single residency program in a specialty or subspecialty. The Residency Program Director is responsible for full compliance with standards of accrediting and certifying bodies (see subpar. 3d).

g. **VA Residency Program Coordinator.** In accordance with accrediting and certifying body requirements, appropriately-credentialed local VA clinicians are appointed as VA residency training program coordinators for each residency training program. In affiliated programs, these designations must be made with the concurrence of the sponsoring entity

of the residency program. The VA Residency Program Coordinator is responsible for the management and monitoring of training program activities at the VA site.

h. **Supervising Practitioner.** Supervising practitioner refers to licensed, independent physicians, dentists, podiatrists, and optometrists, regardless of the type of appointment, who have been credentialed and privileged at VA medical centers in accordance with applicable requirements. A supervising practitioner must be approved by the sponsoring entity in order to supervise residents. In some training settings, other health care professionals with documented qualifications and appropriate academic appointments (i.e., psychologists, audiologists), may function as supervising practitioners for selected training experiences. Supervising practitioners can provide care and supervision only for those clinical activities for which they have clinical privileges. **NOTE:** *The term “supervising practitioner” is synonymous with the term “attending” or “faculty.” ACGME defines supervising “faculty” as “any individuals who have received a formal assignment to teach resident physicians.” Per accreditation requirements, the Program Director at the sponsoring entity determines the assignment to teach and supervise residents. In the absence of a formal academic appointment as faculty with the sponsoring entity, written documentation of approval and assignment to supervise residents from the Program Director is required in order to supervise residents. Appointment or assignment of supervising practitioners needs to be coordinated with the Program Director, the VA Program Coordinator, the applicable VA Service Chief, and the affiliated Department Chair as appropriate.*

i. **Chief Resident.** The Chief Resident is an individual who is considered senior in the training program and who may or may not be a licensed independent practitioner. Chief residents are designated by the Residency Program Director and may assume advanced administrative responsibilities necessary for the operation of the residency program. Chief residents fall into one of two categories:

(1) **Chief Resident – In Training.** Chief residents who are currently enrolled in an accredited residency program, but who have not completed the full academic program leading to board eligibility. These chief residents are not independent and cannot be privileged to work in the discipline for which they are being trained. This model is common in surgery programs.

(2) **Chief Resident – Post Training.** Chief residents who have completed an accredited residency program, but engage in an additional year of training and responsibility. These chief residents are board-eligible or board-certified and are able to be privileged in the discipline of their completed specialty-training program. These chief residents are frequently licensed independent practitioners. This model is common in internal medicine programs.

j. **VA Special Fellow.** The term VA Special Fellow refers to a VA-based physician or dentist trainee who has enrolled in a VA Special Fellowship Program for additional training, primarily in research. Special fellowships are non-accredited training programs that are funded directly from the Office of Academic Affiliations in a separate allocation process from residency positions. Physicians in VA Special Fellowships have completed an ACGME-accredited core residency (medicine, surgery, psychiatry, etc.) and may also have completed an accredited sub-specialty fellowship. They are board-eligible or board-certified, and consequently, are licensed independent practitioners. Dentists in VA Special Fellowships have completed a CDA-accredited residency and are licensed independent practitioners. All VA Special Fellows must be credentialed and privileged in the

discipline(s) of their completed (subspecialty-training) programs. VA Special Fellows may function as supervising practitioners for other trainees.

k. **Resident.** The term 'resident' refers to an individual who is engaged in a graduate training program in medicine (which includes all specialties like internal medicine, surgery, psychiatry, radiology, nuclear medicine, etc.), dentistry, podiatry, or optometry, and who participates in patient care under the direction of supervising practitioners. Such programs must be accredited or certified as appropriate and as described in subpar. 3d.

*NOTE: The term "resident" includes individuals in their first year of training often referred to as "interns" and individuals in approved subspecialty graduate medical education programs who historically have also been referred to as "fellows" by some sponsoring institutions.*

l. **Graduate Medical Education (GME).** GME programs focus on the development of clinical skills, attitudes, and professional competencies, and an acquisition of detailed factual knowledge in a clinical specialty. GME is the process by which clinical and didactic experiences are provided to residents enabling them to acquire those skills, knowledge, and attitudes, which are important in the care of patients. The purpose of GME is to provide an organized and integrated educational program providing guidance and supervision of the resident, to facilitate the resident's professional and personal development, and to provide safe and appropriate care for patients.

m. **Supervision.** Supervision is an intervention provided by a supervising practitioner to a resident. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the resident while monitoring the quality of professional services delivered. Supervision is exercised through observation, consultation, directing the learning of the resident, and role modeling. *NOTE: This definition is adapted from Bernard, J. M., & Goodyear, R. K., Fundamentals of Clinical Supervision (2<sup>nd</sup> ed.). Needham Heights, MA: Allyn & Bacon 1998.*

n. **Documentation.** Documentation is the written or computer-generated medical record evidence of a patient encounter. In terms of resident supervision, documentation is the written or computer-generated medical record evidence of the interaction between a supervising practitioner and a resident concerning a patient encounter.

o. **Electronic signature.** VA's electronic health record defines three types of electronic signature (see VHA Handbook 1907.1)

(1) A "signer" is the author of the document.

(2) A "co-signer" is the supervising practitioner. A co-signer may also be a service chief, or designee, as defined by the organization's bylaws and/or policies.

(3) "Identified signer" and "additional signer" are synonymous and either is a communication tool used to alert a clinician about information pertaining to the patient. This functionality is designed to allow clinicians to call attention to specific documents and for the recipient to acknowledge receipt of the information. Being identified as an additional signer does not constitute a co-signature. This nomenclature in no way implies responsibility for the content of or concurrence with the note. *NOTE: "Identified signer" is nomenclature used by the Computerized Patient Record System (CPRS), Veterans Health Information Systems and Technology Architecture (VistA), and Text Integration Utilities (TIU); "additional signer" is nomenclature used by graphic user interface (GUI).*

## **5. ROLES AND RESPONSIBILITIES**

Resident training occurs in the context of different disciplines and in a variety of appropriately structured clinical settings, including inpatient, outpatient, long-term care, and community settings. Although specific titles for positions within these settings may

vary by facility and VISN, the following functions must be implemented:

a. **Chief Academic Affiliations Officer.** The Chief Academic Affiliations Officer is responsible for defining national policies pertinent to residents in VA medical centers. The Chief Academic Affiliations Officer must complete an annual review of all VISN and facility reports submitted through the Annual Report on Residency Training Programs (ARRTP) process (Report Control Number (RCN) 10-0906). These results are shared with appropriate VHA leadership to ensure that VA continuously improves its ability to provide safe and effective patient care, while providing excellent educational opportunities for future practitioners. Applicable feedback is provided to VISNs and their respective facilities. The Chief Academic Affiliations Officer must present pertinent decision-making information to VHA's leadership.

b. **VISN Director.** The VISN Director is ultimately responsible for addressing GME and other residency program needs and obligations in VISN planning and decision-making, and making necessary resources available to the respective affiliated medical centers to ensure resident supervision is provided as outlined in this Handbook.

c. **Network Academic Affiliations Officer.** The Network Academic Affiliations Officer is responsible for assisting the VISN Director by:

- (1) Reviewing each facility's Annual Report on Resident Training Programs (RCN 10-0906) to identify opportunities for improvement or areas that need further review.
- (2) Preparing a summary report that is provided to VHA Central Office.
- (3) Ensuring that educational needs and obligations are considered in VISN planning and decision-making.
- (4) Assisting medical centers in implementing graduate training policies.
- (5) Coordinating and overseeing the annual resident allocation process.
- (6) Providing guidance to network educational institutions.
- (7) Guiding, coordinating, and assisting individual medical centers in negotiating their specific affiliation agreements.
- (8) Helping ensure network-wide educational goals are accomplished and comply with system-wide education policies (e.g., resident supervision).
- (9) Providing guidance and assistance to individual medical centers in writing and implementing their local monitoring policies and procedures for resident supervision.

d. **Medical Center Director.** The medical center Director is responsible for establishing local policy to fulfill the requirements of this Handbook and the applicable accrediting and certifying body requirements. The medical center Director appoints or assigns the duties of the DEO to the appropriate local education leader. ***NOTE: When possible, the local policy needs to be consistent with the policies of the affiliated schools or universities. If there is a discrepancy between policies, VA policy takes precedence.***

e. **Chief of Staff (COS).** The medical center COS is responsible for assessing the quality of residency training programs at the VA medical facility, and the quality of care provided by supervising practitioners and residents (see subpar. 11b for details on quality

assessment). **NOTE:** *An ACOS for Education, or DEO, may assist the COS in fulfilling these requirements.*

f. **Designated Education Officer (DEO) or ACOS/E.** The DEO or the ACOS/E assists the COS in assessing the quality of residency training programs and the quality of care provided by supervising practitioners and residents. This individual is also responsible for ensuring that:

- (1) A facility resident supervision policy is in place.
- (2) Graduated levels of responsibility are established in each specialty and/or subspecialty.
- (3) Facility monitoring and reporting requirements regarding training issues and resident supervision are met.
- (4) A process is established for monitoring resident supervision that results in identification of areas for improvement and facility action plans.

**NOTE:** *All facilities with more than a single residency program must have one designated responsible individual for these functions.*

g. **Residency Program Director.** The Residency Program Director is responsible for the quality of the overall education and training program in a given discipline (i.e., medicine, dentistry, optometry, and podiatry) and for ensuring that the program is in compliance with the policies of the respective accrediting and/or certifying bodies. The Residency Program Director defines the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform. **NOTE:** *In affiliated programs, the Residency Program Director is customarily at the affiliated institution, but may also be a VA practitioner.*

h. **VA Residency Program Coordinator.** The VA Residency Program Coordinator is responsible for ensuring that supervising practitioners are appropriately fulfilling their responsibilities to provide supervision to residents and that ongoing evaluation of supervisors, residents, and the VA site are conducted. The VA Residency Program Coordinator is responsible for ensuring that residents function within their assigned graduated level of responsibility, and is responsible for:

- (1) Assessing resident supervision within the program via a systematic review process.
- (2) Structuring training programs consistent with the requirements of the accrediting and certifying bodies identified in subparagraph 3d and the affiliated participating entity.
- (3) Arranging and ensuring that all residents participate in an orientation to VA policies, procedures, and the role of residents within the VA health care system.
- (4) Ensuring that residents are provided the opportunity to give feedback regarding their supervising practitioners, the training program, and the VA site. **NOTE:** *Facilities are encouraged to include resident representation on appropriate medical center committees.*

i. **Designated Institutional Official (DIO).** The DIO has the authority and responsibility for the oversight and administration of the sponsoring institution's ACGME accredited programs and is responsible for ensuring compliance with ACGME institutional requirements. The DIO reviews and co-signs all program information forms and documents submitted by the program directors that either addresses program citations or request changes in the programs that would have an impact on the educational program or the institution.

j. **Supervising Practitioner.** The supervising practitioner is responsible for, and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings as well as long-term care and community settings. When a resident is involved in the care of the patient, the responsible supervising practitioner must continue to maintain a

personal involvement in the care of the patient. A supervising practitioner must provide an appropriate level of supervision. Determination of this level of supervision is a function of the experience and demonstrated competence of the resident and of the complexity of the veteran's health care needs.

(1) **General.** The supervising practitioner directs the care of the patient and provides the appropriate type of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. All services must be rendered under the supervision of the responsible practitioner or must be personally furnished by the supervising practitioner.

(2) **Documentation.** Documentation of supervision must be entered into the medical record by the supervising practitioner or reflected within the resident progress note. The medical record needs to reflect the involvement of the supervising practitioner. *NOTE: Types of documentation are discussed in paragraph 7.*

k. **Chief Resident – In Training.** These chief residents, while quite senior, are still considered residents and must be supervised by a supervising practitioner. Graduated levels of responsibility, however, may allow a wide range of practice.

l. **Chief Resident – Post Training.** These chief residents may function either as a trainee, as a staff physician and supervising practitioner, or as a hybrid trainee and supervising practitioner, depending on the type of personnel appointment, salary level and source, and privileges according to the following three options. *NOTE: The requirements for billing are outside the scope of this resident supervision handbook. Refer to the current VHA Directive for billing policy.*

(1) **Option 1. Chief Resident as Trainee.** Chief residents may be paid as trainees at a trainee salary scale and have resident appointments. They do not need to go through the credentialing process nor have a full license to practice. These chief residents are bound by this Handbook and resident supervision standards.

(2) **Option 2. Chief Resident as Staff Physician and Supervising Practitioner.** Chief residents may be paid and appointed as staff physicians. They must go through the credentialing process, have full medical licensure, and be granted privileges by VA to function independently within their specialty. These chief residents may countersign other resident and student notes, supervise other trainees, and in general, function as independent practitioners. Supervision of residents is contingent upon assignment as a supervising practitioner or "faculty" by the Residency Program Director.

(3) **Option 3. Chief Resident as Hybrid Trainee and Supervising Practitioner.** Chief residents may be paid as trainees, but also credentialed and privileged for independent practice. Intermittently, they may be allowed and/or required to function as supervising practitioners in either an inpatient or outpatient setting. In order to function as licensed independent practitioners, they must go through the credentialing process, have full medical licensure, and be granted privileges by VA to function independently within their specialty. These chief residents may countersign other resident and student notes, supervise other trainees, and function as independent practitioners within the specialty for which they have independent privileges, provided they have been assigned to serve as a supervising practitioner or "faculty" by the Residency Program Director.

m. **Resident.** The residents, as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not

practice outside of that scope of service. Each resident is responsible for communicating significant patient care issues to the supervising practitioner. Such communication must be documented in the record. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible supervising practitioner may result in the removal of the resident from VA patient care activities. **NOTE:** *In some cases, residents including chief residents have completed one residency program and are board-eligible or board-certified while enrolled in an additional residency training program. These individuals may be credentialed and privileged for independent practice only in the discipline of their board eligibility or certification.*

## **6. GRADUATED LEVELS OF RESPONSIBILITY**

- a. As part of their training program, residents earn progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervising practitioner present, or to act in a teaching capacity is based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the supervising practitioner as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. In general, however, residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, residents are allowed to certify and re-certify certain treatment plans (e.g., Physical Therapy, Speech Therapy) as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising practitioner over and above standard setting-specific documentation requirements. The overriding consideration in determining assigned levels of responsibility must be the safe and effective care of the patient.
- b. The Residency Program Director defines the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform. The Residency Program Director makes this list of graduated levels of responsibility available to other appropriate staff. Annually, at the time of promotion, or more frequently as appropriate, this document, along with a list of residents assigned to each year or level of training, is provided to the relevant VA Residency Program Coordinator, service chief, and COS. The Residency Program Director must include a specific statement identifying the evidence on which such an assignment is made and any exceptions for individual residents, as applicable.

## **7. DOCUMENTATION OF SUPERVISION OF RESIDENTS**

- a. **Supervising Practitioner Involvement.** The medical record must clearly demonstrate the involvement of the supervising practitioner in each type of resident-patient encounter described in subparagraphs 7c and 7d. **NOTE:** *Documentation requirements are outlined in subparagraph 7b.*
- b. **Supervision Documentation.** Documentation of supervision must be entered into the medical record by the supervising practitioner or reflected within the resident progress note or other appropriate entries in the medical record (e.g., procedure reports, consultations, discharge summaries). Pathology and radiology reports must be verified by a supervising practitioner.
  - (1) Types of allowable documentation are:
    - (a) Progress note or other entry into the medical record by the supervising practitioner.

- (b) Addendum to the resident progress note by the supervising practitioner.
- (c) Co-signature of the progress note or other medical record entry by the supervising practitioner. **NOTE:** *Supervising practitioner's co-signature signifies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry. Use of "additional signer" or "identified signer" options in CPRS is not an acceptable form of documenting resident supervision. (See VHA Handbook 1907.1)*
- (d) Resident progress note or other medical record entry documenting the name of the supervising practitioner with whom the case was discussed, a summary of the discussion, and a statement of the supervising practitioner's oversight responsibility with respect to the assessment or diagnosis and/or the plan for evaluation and/or treatment. **NOTE:** *Statements such as the following are acceptable to demonstrate the supervising practitioner's oversight responsibility: I have seen and discussed the patient with my supervising practitioner, Dr. "X" and Dr. "X" agrees with my assessment and plan. I have discussed the patient with my supervising practitioner, Dr. "X" and Dr. "X" agrees with my assessment and plan. The supervising practitioner of record for this patient care encounter is Dr. "X".*
- (2) The type of allowable documentation varies according to the clinical setting and kind of patient encounter as outlined in subparagraph 7c. In all cases, the responsible supervising practitioner must be clearly identifiable in the documentation of the patient encounter or report of reviews of patient material (e.g., pathology or imaging reports). **NOTE:** *An independent note or addendum by the supervising practitioner is required for inpatient admissions, pre-operative assessment, and extended care admissions. The frequency of documentation of involvement of the supervising practitioner depends upon the setting and the patient's condition. The timeframe for signing or co-signing the progress notes, consultations, and reports is delineated in local facility policy or local medical staff bylaws.*

### c. **Patient Settings**

#### (1) **Inpatient Care**

- (a) **Inpatient Admission.** For patients admitted to an inpatient service of the medical center, the supervising practitioner must physically meet, examine, and evaluate the patient within 24 hours of admission including weekends and holidays. Documentation of the supervising practitioner's findings and recommendations regarding the treatment plan must be in the form of an independent progress note or an addendum to the resident note, which must be entered by the end of the calendar day following admission. If the specific requirements of the pre-operative notes are included, the admission note (or addendum) may also serve as the pre-operative note. **NOTE:** *The time requirement for seeing and evaluating the patient (per JCAHO guidelines) is different from that of documentation in the medical record by the supervising practitioner. Use of appropriate note titles in CPRS is encouraged.*
- (b) **Night Float Admissions.** For patients admitted to an inpatient service of the medical center, a "night float" resident occasionally provides care before the patient is transferred to an inpatient ward team. In these cases, the supervising practitioner must physically meet and examine the patient within 24 hours of admission by the night float to the inpatient service, irrespective of the time the ward team assumes responsibility for the patient. In addition, the supervising practitioner for night float admissions must be clearly designated by local policy. **NOTE:** *Documentation requirements are the same as in preceding subparagraph 7c(1)(a).*
- (c) **Continuing Care of Inpatients.** Supervising practitioners are expected to be personally involved in the ongoing care of the patients assigned to them in a manner consistent with the



clinical needs of the patient and the graduated level of responsibility of the resident. **NOTE:** *Any of the four types of documentation referenced in subpar. 7b(1) is acceptable.*

(d) Discharge from Inpatient Status. The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from an inpatient service of the medical center is appropriate and based on the specific circumstances of the patient's diagnoses and therapeutic regimen; this may include physical activity, medications, diet, functional status, and follow-up plans. Evidence of this assurance must be documented by the supervising practitioner's countersignature of the discharge summary or discharge note.

(e) Transfer from One Inpatient Service to Another, or Transfer to a Different Level of Care (Inter-service or Inter-ward Transfer). The supervising practitioner, in consultation with the resident, ensures that the transfer of the patient from one inpatient service to another or transfer to a different level of care is appropriate and based on the specific circumstances of the patient's diagnoses and condition. The supervising practitioner from the transferring service must be involved in the decision to transfer the patient. The supervising practitioner from the receiving service must treat the patient as a new admission and must write an independent note or an addendum to the resident's transfer acceptance note (see subpar. 7c(1)(a) and 7c(3)(a). **NOTE:** *This provision covers transfers into and out of intensive care units or transfers to extended care. The only exception is whenever the same supervising practitioner is responsible for the patient across different levels of care.*

(f) Inpatient Consultations. A supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents. **NOTE:** *Any of the four types of documentation referenced in subpar. 7b(1) is acceptable.*

(g) Intensive Care Units (ICU), including Medical, Cardiac, and Surgical ICUs. For patients admitted to, or transferred into, an ICU of the medical center, the supervising practitioner must physically meet, examine, and evaluate the patient as soon as possible, but no later than 24 hours after admission or transfer, including weekends and holidays. An admission note or addendum to the resident's admission note is required within 1 day of admission. Because of the unstable nature of patients in ICUs, frequent evidence of involvement of the supervising practitioner is expected. **NOTE:** *Supervising practitioner involvement is expected on a daily or more frequent basis and may be documented using any of the four types of documentation referenced in subpar. 7b(1).*

## **(2) Outpatient Clinic**

(a) Physical Presence. The supervising practitioner must be physically present in the clinic area during clinic hours.

(b) New Outpatient Encounters. New patients to a facility require a higher level of supervising practitioner documentation than other outpatients. Each new patient needs to be seen by or discussed with the supervising practitioner. Documentation of supervising practitioner involvement must be according to subpars. 7b(1)(a), 7b(1)(b), or 7b(1)(d).

**NOTE:** *Supervising practitioner's co-signature of the resident's note is not sufficient documentation of resident supervision.*

(c) Outpatient Consultations. A supervising practitioner is responsible for clinical consultations from each outpatient clinic to another supervising practitioner within the local facility. When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents. **NOTE:** *Any of the four types of documentation referenced in subpar. 7b(1) is acceptable.*

(d) Continuing Care in the Outpatient Setting. The supervising practitioner must be identifiable for each resident's patient care encounter. Return patients must be seen by, or

discussed with, the supervising practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate. **NOTE:** Any of the four types of documentation referenced in subpar. 7b(1) is acceptable.

(e) Discharge from Outpatient Clinic. The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from clinic is appropriate. **NOTE:** Any of the four types of documentation referenced in subpar. 7b(1) is acceptable.

**(3) Extended Care (Nursing Homes)**

(a) New Extended Care Admissions. Each new patient admitted to an extended care facility must be seen by the responsible supervising practitioner within 72 hours of admission. **NOTE:** Any of the first two types of documentation referenced in subpar. 7b(1) is acceptable.

(b) Continuing Care in the Extended Care Setting. The supervising practitioner must be identifiable for each resident's patient care encounter. Extended care patients must be seen by, or discussed with, the supervising practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate. **NOTE:** Any of the four types of documentation referenced in subpar. 7b(1) is acceptable.

**(4) Emergency Department**

(a) Physical Presence. The supervising practitioner for the emergency department must be physically present in the emergency department.

(b) Emergency Department Visits. Each new patient to the emergency department must be seen by or discussed with the supervising practitioner. **NOTE:** Documentation of supervising practitioner involvement must be according to subpars. 7b(1)(a), 7b(1)(b), or 7b(1)(d).

(c) Discharge from the Emergency Department. The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from the emergency department is appropriate. **NOTE:** Any of the four types of documentation referenced in subpar. h 7b(1) is acceptable.

(d) Emergency Department Consultations. A supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the consulting service supervising practitioner is responsible for supervision of these residents. Residents from a consulting service are expected to contact their supervising practitioners while the patient is still in the emergency department in order to discuss the case and to develop and recommend a plan of management. The emergency room practitioner is responsible for the disposition of the patient. **NOTE:** Any of the four types of documentation referenced in subpar. 7b(1) is acceptable. The emergency room practitioner is not the supervisor of the consulting resident, but is the responsible practitioner for the patient.

**(5) Operating Room (OR) Procedures.** Supervising practitioners must provide appropriate supervision for the patient's evaluation, management decisions, and procedures. Determination of the level of supervision is a function of the level of responsibility assigned to the individual resident involved and the complexity of the procedure (see subpars. 7c(5)(a) – 7c(5)(c)).

(a) Pre-procedure Note. The pre-procedure supervising practitioner note requirement applies to OR and same day (ambulatory) surgical procedures; it does not apply to routine bedside procedures and clinic procedures such as skin biopsy, central and peripheral lines, lumbar punctures, centeses, incision and drainage, etc. For all elective or scheduled surgical procedures, a supervising practitioner must evaluate the patient and write a pre-procedural note or an addendum to the resident's pre-procedure note describing the findings, diagnosis, plan for treatment, and/or choice of specific procedure to be done. This pre-procedural

evaluation and note may be done up to 30 days in advance of the surgical procedure. All applicable JCAHO standards concerning documentation must be met. **NOTE:** *A pre-procedure note may also serve as the admission note if it is written within 1 calendar day of admission by the supervising practitioner with responsibility for continuing care of the inpatient, and if the note meets criteria for both admission and pre-operative notes. (see subpar. 7c(1)(a)). Use of appropriate note titles in CPRS is encouraged. Other services involved in the patient's operative care (e.g., Anesthesiology) must write their own pre-procedure notes (such as for the administration of anesthesia) as required by JCAHO, but such documentation does not replace the pre-operative documentation required by the surgery supervising practitioner.*

**(b) Informed Consent. Informed consent must be obtained as detailed in VHA Handbook 1004.1.**

(c) Veterans Health Information Systems and Technology Architecture (VistA) Surgical Package. Staff involvement in procedures as defined in the VistA Surgical Package must be documented in the computerized surgical log (a part of the VistA Surgical Package) and reported to VA Central office via the Surgical Quarterly Report consistent with the following scale:

1. **Level A: Attending Doing the Operation.** The staff practitioner performs the case, but may be assisted by a resident.
2. **Level B: Attending in OR, Scrubbed.** The supervising practitioner is physically present in the operative or procedural room and directly involved in the procedure. The resident performs major portions of the procedure.
3. **Level C: Attending in OR, Not Scrubbed.** The supervising practitioner is physically present in the operative or procedural room. The supervising practitioner observes and provides direction. The resident performs the procedure.
4. **Level D: Attending in OR Suite, Immediately Available.** The supervising practitioner is physically present in the operative or procedural suite and immediately available for resident supervision or consultation as needed.
5. **Level E: Emergency Care.** Immediate care is necessary to preserve life or prevent serious impairment. The supervising practitioner has been contacted (see par. 8).
6. **Level F: Non-OR Procedure.** Routine bedside and clinic procedure done in the OR. The supervising practitioner is identified.

**(6) Non-OR Procedures**

(a) Routine Bedside and Clinic Procedures. Routine bedside and clinic procedures include: skin biopsies, central and peripheral lines, lumbar punctures, centeses, and incision and drainage. Supervision for these activities is dependent on the setting in which they occur. Documentation standards must follow the setting-specific guidelines (see subpars. 7c(1)-7c(5)).

(b) Non-routine, Non-bedside Diagnostic, or Therapeutic Procedures. Non-routine, non-bedside, diagnostic, or therapeutic procedures (e.g., endoscopy, cardiac catheterization, invasive radiology, chemotherapy, radiation therapy) are procedures that require a high level of expertise in their performance and interpretation. Although gaining experience in doing such procedures is an integral part of the education of the resident, such procedures may be done only by residents with the required knowledge, skill, and judgment and under an appropriate level of supervision by a supervising practitioner. Supervising practitioners are responsible for authorizing the performance of such procedures and must be physically present in the procedural area. Supervision for these procedures takes into account the complexity and inherent risk of the procedure, the experience of the resident, and assigned graduated levels of responsibility (see par. 6). Documentation standards must follow the

setting-specific guidelines (see subpars. 7c(1)-7c(5)). **NOTE:** *Documentation of the degree of supervising practitioner involvement is encouraged. Any of the four types of documentation referenced in subparagraphs 7b is acceptable. With respect to chemotherapy and radiation therapy, the supervising practitioner must be present during the treatment planning (i.e., choice of modality and regimen), dosage or dosimetry determinations, and writing of chemotherapy or radiation therapy orders. Neither the supervising practitioner nor the resident need to be present during the administration of either chemotherapy or radiation therapy since therapy delivery is a function of associated health personnel.*

## **8. EMERGENCY SITUATIONS**

An “emergency” is defined as a situation where immediate care is necessary to preserve the life of or to prevent serious impairment of the health of a patient. In such situations, any resident, assisted by medical center personnel, is (consistent with the informed consent provisions of VHA Handbook 1004.1) permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible. The resident must document the nature of that discussion in the patient's record.

## **9. SUPERVISION OF PHYSICIAN RESIDENTS PROVIDING EMERGENCY CARE COVERAGE**

a. **Emergency Department Physician (sometimes called the Admitting Officer of the Day)** Physicians providing independent Emergency Department coverage must be credentialed, privileged, and fully licensed. **NOTE:** *PGY-3 and above residents are normally subject to the same supervisory requirements as specified in subparagraph 9b(1). However, in a critical staffing emergency situation, permission to use a PGY-3 and above, non-board-eligible resident for sole, unsupervised coverage may be requested from the respective VISN Director. When such an emergency exists, the VISN Director may approve the use of a PGY-3 and above, non-board-eligible resident on a short-term, time-limited basis, when truly exceptional circumstances exist. In these rare instances, the resident must be appropriately credentialed and privileged and be an approved provider of Advanced Cardiac Life Support (ACLS) (see VHA Handbook 1100.19).*

b. **Supervision of PGY-4 and above Board-Certified or Board-Eligible Residents**

(1) Physician residents who are board-certified or board-eligible may be privileged as independent practitioners for purposes of Emergency Department coverage. Privileges sought and granted may only be those delineated within the general category for which the resident is board-certified or board-eligible.

(2) Residents who are appointed as such, outside the scope of their training program (i.e., fee basis), must be fully licensed, credentialed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program and must meet the requirements for appointment and are subject to the provisions contained in VHA Handbook 1100.19. Specialty privileges, which are within the scope of the resident's training program, may not be granted. **NOTE:** *Refer to paragraph 6 for assigning, as appropriate, graduated levels of responsibility for activities within the scope of training.*

## **10. EVALUATION OF RESIDENTS, SUPERVISORS, AND TRAINING SITES**

a. **Evaluations of Residents**

(1) Each resident must be evaluated according to accrediting and certifying body requirements on patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Evaluations occur as indicated by the accrediting or certifying body, or at least semiannually, and are communicated to each resident in a timely manner. Evaluations must be accessible to

the resident at the end of the resident's rotation or every 6 months, whichever is more frequent. Written evaluations must be discussed with the resident.

(2) When a resident's performance or conduct is judged to be detrimental to patient care, evaluation of the resident, in mutual consultation with the faculty, must be done. Residents may be dismissed from VA assignment in accordance with VA Handbook 5021, Part VI, paragraph 18, which includes a requirement to notify the Residency Program Director of the affiliated participating institution of a proposed dismissal of a resident in an integrated program.

b. **Evaluation of Supervising Practitioner and Training Site.** Each resident rotating through a VA facility must be given the opportunity to complete confidential written evaluations of the supervising practitioner(s) and the VA training site(s). Evaluations must be conducted in accordance with the standards of the appropriate accrediting and/or certifying bodies. Evaluations need to conform to program-specific requirements. Academic evaluations are the confidential property of the residency program and Residency Program Director, who may be located at a non-VA site.

c. **Storage and Use of Evaluations.** Secure storage of evaluations of residents, supervisors, and training sites is the responsibility of the Residency Program Director. The evaluations are aggregated and analyzed in compliance with accrediting and certifying body standards. The evaluations must be communicated to the responsible VHA service chief and/or VA Residency Program Coordinator in a manner and timetable agreeable to both.

## **11. MONITORING PROCEDURES**

### **a. Goals and Objectives**

(1) The goal of monitoring resident supervision is to foster a system-wide environment of peer learning and collaboration among VHA managers, supervising practitioners, and residents. The monitoring process involves the use of existing information, the production of a series of evaluative reports, the accompanying process of public review of key findings, and discussion of policy implications. ***NOTE: This process helps identify key resident supervision issues that now influence the quality of care and suggests effective ways for addressing them.***

(2) The basic foundation for resident supervision ultimately resides in the integrity and good judgment of professionals (supervising practitioners and residents) working collaboratively in well-designed health care delivery systems. Accordingly, monitoring of resident supervision is a shared responsibility of national, VISN, and local facility leaders.

(3) The key objectives of the resident supervision monitoring process are to continuously improve and enhance:

- (a) The quality and safety of patient care involving residents.
- (b) VHA's educational environment and culture of learning.
- (c) The documentation of resident supervision.
- (d) The systems of care involving residents.

(4) The monitoring of resident supervision is a medical record review process, and a quality management activity. Documents and data arising from this monitoring are

confidential and protected under Title 38 United States Code (U.S.C.) 5705, and its revised implementing regulations.

**b. Responsibilities of the VA Medical Center**

Resident training occurs in the context of different disciplines and in a variety of appropriately structured clinical settings, including inpatient, outpatient, extended care, and community settings. Although specific titles for positions within these settings may vary by facility and VISN, the following functions must be assigned:

(1) The VA medical center Director is responsible for ensuring that a local monitoring process exists for resident supervision. The monitoring process must include the following:  
(a) Creation of a local policy entitled “Monitoring of Resident Supervision.” This policy must define the procedures that are to be followed for the monitoring of resident supervision. The policy must include procedures for monitoring the following elements:

1. Inpatient care involving residents.
2. Outpatient care involving residents.
3. Procedural care involving residents.
4. Emergency care involving residents.
5. Consultative care involving residents.
6. Surgical care involving residents including a review of the appropriateness of Levels E and F (see subpar. 7c(5)(i)).

***NOTE:** The first five of the preceding elements (subpars. 11b(2)(a)1 through 11b(2)(a)5) may be monitored using sampling techniques. For element 6, each instance of surgical care performed at levels E and F (as coded in the VistA surgical package) must be reviewed.*

(b) Review of quality improvement data (protected by 38 U.S.C. 5705 and its revised implementing regulations and current VA policy):

1. Results of medical record reviews and other locally-derived quality management data concerning patient care involving residents.
2. Incident reports and tort claims involving residents.
3. Risk events including adverse events and “near misses” involving residents.
4. Patient complaints involving residents.
5. Review of externally-derived quality management data such as External Peer Review Program (EPRP) data
6. Review of reports by accrediting and certifying bodies.

(c) Review of residents’ comments related to their VA experience, if available.

(d) Identification of opportunities for improvement in resident supervision and creation of action plans.

(e) Completion of the yearly Annual Report on Residency Training Programs (RCN 10-0906).

***NOTE:** The local monitoring process will be most successful if it is a collaborative activity among the medical staff, education leadership, and quality management.*

**c. Responsibilities of the VISN.** VISN monitoring processes for resident supervision are designed to meet VISN and VHA strategic goals, identify VISN trends, practices and areas for improvement, and support formulation of appropriate action plans. The VISN Director or designee (chief medical officer, network academic affiliations officer, or other designee), is responsible for:

(1) Ensuring that each affiliated VA medical center has a monitoring process in place as detailed in subpar. 11b.

(2) Reviewing the annual reports of all affiliated facilities in the VISN to identify opportunities for improvement or areas that need further review.

(3) Submitting the VISN reviews to the Chief Academic Affiliations Officer through the RCN 10-0906 process.

d. **Responsibilities of VHA Central Office.** National monitoring processes for resident supervision are designed to meet VHA strategic goals and identify national trends, practices, and areas for improvement. National monitoring processes include the following:

(1) The Office of Academic Affiliations, in collaboration with the Office of Quality and Performance, develops measures of appropriate and timely resident supervision using methodologically sound sampling and reporting procedures

(2) EPRP and other nationally-contracted abstractors must complete medical record reviews using methodologically sound sampling procedures. Data are reviewed quarterly and evaluated annually.

(3) National Surgical Quality Improvement Project (NSQIP) data are reviewed quarterly and evaluated annually.

(4) Annual Review of Residency Training Programs (RCN 10-0906) is reviewed and evaluated annually.

(5) VHA Learners' Perceptions Survey and other qualitative and quantitative reviews of resident's experiences and perceptions are reviewed and evaluated annually.

(6) Special reviews including site visits are conducted as appropriate.

(7) Applicable feedback is provided to VISNs and their respective facilities.

**NOTE:** *Future national monitoring efforts will be focused on automating and systematizing data collection and documentation.*

## **12. ANNUAL REPORT ON RESIDENCY TRAINING PROGRAMS (ARRTP) (RCN 10-0906)**

a. **Description.** The ARRTP (RCN 10-0906) is a web-based registry of residency education that is updated annually by each facility with residents and by each VISN. The report identifies medical, dental, optometric, and podiatric school affiliations, facility, and educational program leadership, and includes any actions taken by accrediting or certifying bodies, any changes in the status of affiliations, and a specific analysis of resident supervision issues that are identified by the medical center's monitoring processes. The information is requested from each affiliated VA facility for all resident training programs (i.e., medical (allopathic and osteopathic), dental, optometric, and podiatric programs). Many elements of this report are confidential and privileged under the provisions of 38 U.S.C. 5705, and its implementing regulations, and current VA policy. Protected material cannot be disclosed to anyone without authorization as provided for by that law and its regulations.

b. **Content of the ARRTP RCN 10-0906.** RCN 10-0906 includes:

(1) Identification of medical, dental, optometric, and podiatric school affiliations.

(2) Identification of facility and program leadership.

(3) Accreditation status of programs and citations or concerns, if applicable.

(4) A summary of facility monitoring activities for resident supervision (see par. 11).

(5) Facility response to local and/or national information about resident experiences and perceptions.

(6) Identification of opportunities for improvement with action plans.

c. **Responsibilities**

(1) **Medical Center Director.** Where residents are present, the DEO through the COS and the medical center Director, must report annually to the VISN Director, or designee, the status of resident training programs in that medical center. This reporting must take place through the ARRTP (RCN 10-0906) process.

(2) **VISN Director.** The VISN Director, in conjunction with the Network Academic Affiliations Officer, must complete an annual review of facility residency training activities

throughout the VISN, identifying opportunities for improvement or areas that need further review. VISN reviews must be submitted to the Office of Academic Affiliations through the AR RTP (RCN 10-0906) process.

(3) **Chief Academic Affiliations Officer.** The Chief Academic Affiliations Officer must complete an annual review of all VISN and facility reports through the AR RTP (RCN 10-0906) process and share the results of the review with appropriate VHA leaders to demonstrate that VA continuously improves its ability to provide safe and effective patient care while providing excellent educational opportunities for future practitioners. The Chief Academic Affiliations Officer is responsible for presenting pertinent decision-making information to VHA's leaders.



## INTERNET/INTRANET POLICY

1. **PURPOSE:** This memorandum establishes policy and responsibilities for the use of the VA Southern Nevada Healthcare System Internet / Intranet and related automated information security requirements.
2. **POLICY:** This VA Southern Nevada Healthcare System will provide access to the Internet to authorized users, while ensuring that adequate protection exists to safeguard VA assets from misuse. This policy governs user behavior for access to, and usage of, sensitive VA information systems connected to public networks such as the Internet. The goals of this policy are to protect sensitive data from disclosure or modification, avoid compromise of VA, VHA or this VA Southern Nevada Healthcare System's Automated Information Systems (AIS) and operations, and protect the interests of this Facility and all of its users.
3. **ACTION:** This policy establishes information security requirements for access and use of Internet / Intranet connections at this Facility. This policy applies to any individual accessing, using, and/or providing sensitive data on behalf of this facility. This includes, but is not limited to, employees, trainees, volunteers, Without Compensation (WOC) staff, contractors, Fee Basis employees, medical residents, students, interns, patients, and visitors. This policy generated in collaboration with the Information Security Officer (ISO); the Chief, Information Technology Service (ITS); and ITS Network Staff.

a. **DEFINITIONS:**

- (1) **Automated Information System** - Any organized collection, processing, transmission, and dissemination of information that is automated.
- (2) **Bug(gy)** - A defect or imperfection that prevents software from functioning properly.
- (3) **File Transfer Protocol (FTP)** software allows for connection to and transfer of files to FTP servers on the Internet.
- (4) The **Internet** is an international network of telecommunications networks interconnecting corporate and private enterprises, universities, government agencies, and individuals, providing users and organizations with quick and easy access to information, data, software, and discussion groups on a variety of subjects.
- (5) The **Intranet** is the local area network, which is not connected to the Internet, but has similar functions. VA, VHA and this Facility, among many others, have set up World Wide Web servers on our own internal networks so authorized users have access to the organization's Web documents. For the purposes of this document, all references to Internet will apply to both Internet and Intranet access and use.

(6) Risk Assessment - A study of the vulnerabilities, threats, likelihood of loss or impact, and the theoretical effectiveness of security measures.

(7) Rules of Behavior - The document stating the responsibilities of Internet users. See Attachment A.

(8) Sensitive Data/Information - Any information, the loss, misuse, or modification of, or unauthorized access to or disclosure to the public, could be detrimental to agency operations or could affect the privacy to which individuals are entitled under the Privacy Act, Section 552a of Title 5, United States Code, or which is protected under any other confidentiality statute. Data that requires protection due to the risk and magnitude of loss or harm that could result from inadvertent or deliberate disclosure, alteration, or destruction of the data. The term includes data whose improper use or disclosure could affect the ability to accomplish a mission, proprietary data, records about individuals requiring protection under the Privacy Act of 1974 and data not releasable under the Freedom of Information Act and/or other confidentiality statutes. This definition includes sensitive information as set forth in 15 United States Code (U.S.C.) 278g-3-(d)(4), as amended by Section 3 of the Computer Security Act of 1987, Public Law No. 100-235, 101 Statute 1724, 1727 (1988).

(9) Shareware is software that is copyrighted, but may be downloaded and used for a limited time for free, after which the user is asked to voluntarily send the author a small payment. Some shareware products offer additional features, documentation, technical support, and/or updates to registered users.

(10) Transmission Control Protocol/Internet Protocol (TCP/IP) is the basic suite of protocols upon which the Internet runs.

(11) Telecommunications Network (Telnet) is a TCP/IP protocol and service that lets a user on one computer emulate a terminal attached to another computer.

(12) Users include all full-time, part-time, and intermittent employees, trainees, volunteers, WOCs, contractors, Fee Basis employees, medical residents, students, interns, and other individuals who are granted access to the VA Southern Nevada Healthcare System Automated Information Systems (AIS) and the sensitive data and information stored there.

(13) Web - The World Wide Web (www) consists of computers of all makes and locations connected over the Internet using the hypertext transfer protocol (HTTP).

b. **PROCEDURES:**

(1) System Management:

(a) Management of Internet / Intranet: The management of Internet resources at this Facility will be the responsibility of Information Technology Service (ITS), in cooperation with the Information Security Officer (ISO). ITS will provide appropriate security mechanisms, establish procedures for user access and ensure that an ongoing awareness program is conducted for all users of Internet / Intranet.

(b) Software: All software available on the Internet (including, but not limited to screen savers and shareware) must be considered potentially dangerous. It may contain malicious software, such as viruses. It may be erratic or "buggy" and damage this Medical Center's AIS or other government systems. Retrieval of software or files from the Internet will be for official use only. The decision to retrieve software from the Internet must be made within the context of this Medical Center's need for the software. All software retrieved off the Internet must be analyzed for viruses or other malicious software before use. It must be tested for the presence of dangerous "bugs" and features.

(c) Virus Protection: All computers at this Medical Center will make use of virus scanning software. Users will keep computers configured as installed. Any notification of an active virus found on a system or diskette will be reported immediately to the ISO and/or ITS. Specific actions to be taken to recover from a virus infection will be provided by ITS when the virus incident is reported. Whenever possible downloaded software should be isolated on a separate computer, not attached to the Network, for scanning and testing. Computers will be configured for real-time virus detection.

(d) Protection of Sensitive Information: Internet may NOT be used to convey information on subjects protected under provisions of the Privacy Act due to the inability to ensure the protection of sensitive information. Such sensitive information can be shared within VA on a need-to-know basis and Federal law requires that the information be protected when being transmitted over data networks.

(2) Utilization of Internet:

(a) Users are responsible for assuring that they use Internet or any external networking connection appropriately. System abuse is strictly prohibited. Instances of possible inappropriate use should be brought to the attention of the relevant supervisor, the Information Security Officer, and/or the Chief, ITS. The Medical Center maintains the right to monitor usage of all Intranet / Internet and other computing resources by any users, including key stroke monitoring, in order to assure that such appropriate usage is observed. Confirmed instances of inappropriate use of Internet, or any external networking connection will be dealt with through the normal disciplinary procedures. Penalties for misuse or abuse of Internet as with other VA systems, resources and/or data and information may include loss of access privileges, disciplinary action up to and including dismissal, which may be in addition to any penalty prescribed

by law, and any appropriate criminal action. See Attachment A. Internet Rules of Behavior for a list of actions defined to be system abuse.

(b) Methods of Utilization:

1) File Transfer Protocol (FTP): File Transfer Protocol software allows for connection to and transfer of files to FTP servers on the Internet. Access is often to an anonymous FTP server that allows the connectivity. When using FTP, users are also guests on another organizational system and should follow basic guidelines:

a) For anonymous FTP servers, login as "anonymous" but provide your full Internet E-mail address where required.

b) Avoid transferring large files during peak business hours.

c) Transfer files (download) to your network server, workstation's hard drive, or diskette, as soon as possible. Before downloading files, validate that the executable files do not carry viruses. Allowing outside access to this Medical Center's system via the FTP process could pose significant threats to our computing environment. It is the policy of VHA and of this Medical Center that File Transfers are only allowed in one direction. Users may FTP to sites on the Internet but no system or user on the Internet may FTP into any computer being operated on behalf of this Medical Center which is not expressly set up for that purpose by ITS.

(3) Telnet: Telecommunications Network (Telnet) is a TCP/IP protocol and one of the most powerful capabilities of the Internet. Workstations can be connected as terminals to any system on the Internet. To connect to and use a remote computer on the Internet, special communications software must be installed on the User's workstation. When using Telnet to access remote computer systems, users should remember that they are guests on another organization's system and should observe basic courtesies:

(a) Log-off a remote computer system when finished. Maintaining an open connection may prevent others from connecting to that system.

(b) Read or obtain documentation files when using a system for the first time.

(c) Be cognizant of the time and resource limitations for the remote system and adhere to its restrictions.

(d) Use a signature block at the bottom of Internet E-mail messages. Some E-mail systems strip header information from messages, including the

sender's E-mail address. For example, the contents of a signature block: legal name, E-mail address, and telephone number or postal address.

(e) Be cognizant that personal opinions expressed in documents on Internet might be mistaken as VHA's position. A disclaimer may be included in the document, e.g., "The opinions expressed here are my own and do not necessarily represent official policy of VHA."

(4) World Wide Web (WWW) Access: World Wide Web is among the most popular and has become the most used connection to the Internet. When using World Wide Web to access remote computer systems, users must remember that they do so as representatives of VA and this Medical Center and should observe all established policies as well as basic courtesies:

(a) Be aware that user conduct could reflect upon the reputation of this Medical Center and its staff.

(b) Be cognizant of the time and resource limitations for this Medical Center and the remote system and adhere to its restrictions.

(c) Be aware that due to the increased use of World Wide Web, during peak hours performance may be noticeably slow. ITS can provide no assistance when this occurs, since they have no control or responsibility for the performance of World Wide Web.

(5) User Access:

(a) User access will be granted in accordance with procedures outlined in the Automated Security Program Medical Center Memorandum 00-17. Internet access is incorporated with basic Network access. Access to all AIS is controlled and limited based on positive user identification and authorization in the form of mandatory individual security codes. Users are responsible for all actions resulting from use of their access.

(b) Use of Government-owned Systems: Internet connections on government-owned systems may be used for official VA business and authorized personal use. Internet may be used to transmit official business messages and official documents to VA and non-VA individuals only if the transmission is authorized and proper security mechanisms are employed to protect the confidentiality and integrity of the information being transmitted. System abuse is strictly prohibited. Actions considered misuse and abuse are detailed in Attachment A, Internet Rules of Behavior. Unlawful or malicious activities and the use of abusive or objectionable language are strictly prohibited. No games may be downloaded from or played on Internet on government-owned systems and participation in non-VA chat room is expressly prohibited.

(c) No Internet connections of any kind are allowed without the express knowledge and appropriate written approval of the Medical Center Director, or designee. This includes any official VA, commercial or privately purchased connection placed on or which results in connection of federally owned systems to the Internet.

(d) Non-Compliance: All users of government data and systems are responsible for complying with this and all applicable policies, laws and regulations associated with AIS, as well as procedures and practices developed in support of this policy. All Internet activity is associated with the network passwords assigned to individual users and users are responsible for all actions resulting from use of their system access. The Information Security Officer, Network and/or System Administrators, Medical Center Management, auditors and investigators, as appropriate, will monitor network activities including use of Internet. Anyone suspecting misuse or attempted misuse of VA information systems or resources must report such activity to the relevant supervisor, or to the Information Security Officer immediately. Confirmed violations of standards, procedures, or practices in support of this policy will be brought to the attention of Management for appropriate action. Users will be subject to penalties for confirmed misuse or abuse of VA systems, resources and/or data and information. Penalties may include loss of networking privileges, disciplinary action up to and including dismissal, which may be in addition to any penalty prescribed by law, and any appropriate criminal action.

#### 4. **RESPONSIBILITIES:**

a. The Medical Center Director is responsible for safeguarding the AIS assets under his management control, including those shared with other VA organizations. The Director, or designee, shall ensure that a program is in place within this facility to deal with all aspects of Internet operations and activities which meets all requirements outlined in associated Federal, VA and VHA policies and guidelines.

b. Chief, Information Technology Service (ITS), or designee, will be responsible to:

(1) Coordinate all Internet operations at the VA Southern Nevada Healthcare System.

(2) Provide the resources (hardware and software) necessary for each authorized user of Internet.

(3) Maintain and review audit logs on all Intranet connections at this VA Southern Nevada Healthcare System. The VA National Internet Gateway Filtering Policy will monitor Internet connections at the VA Southern Nevada Healthcare System.

(4) Work with the Information Security Officer (ISO) to ensure that a thorough risk assessment and contingency planning program are implemented for all sensitive systems within the VA Southern Nevada Healthcare System.

(5) Incorporate all appropriate security mechanisms, including but not limited to approved security firewall techniques, to ensure the safety of sensitive systems and the data they contain.

c. Information Security Officer (ISO) is responsible for:

(1) Reviewing audit logs maintained by ITS on all Internet connections at this Facility.

(2) Providing ITS with criteria to conduct periodic risk assessments and to develop contingency plans.

(3) Assisting in the development of security criteria and guidelines on which systems will be measured and certified.

(4) Assisting in the development and implementation of an ongoing user awareness program that will include networking issues, user rights and responsibilities and individual accountability.

d. Care / Service Line Chiefs and Managers are responsible for all ongoing Internet activities within their service. Specifically, care line managers/service chiefs, or their designees, will:

(1) Ensure that policies relating to Internet access and use are communicated to all users under their management control and that the users are aware of their responsibilities regarding Internet use.

(2) Monitor the activities of all users under their management control to ensure appropriate use of Intranet / Internet resources.

(3) Take appropriate disciplinary actions and document disciplinary activities relating to inappropriate conduct, misuse or system abuse on external networks like Internet by any users under their management control.

e. Users are responsible for adhering to all VA Southern Nevada Healthcare System policies and applicable laws and regulations related to external networks like Internet, as well as those governing access to and use of any government AIS and the security and privacy of the stored data. Users are responsible for all actions resulting from use of their system access. Users are cautioned that what they say or do while on external networks like Internet may be interpreted as VA, VHA or this VA Southern Nevada Healthcare System opinion or policy. Users should be aware that their conduct could reflect upon the reputation of this Facility and its staff. Internet access is a

privilege, not a right, which may be revoked at any time for inappropriate conduct. Instances of possible inappropriate use should be brought to the attention of the relevant supervisor, the Information Security Officer, and/or the Chief of ITS.

Specifically, Internet users:

- (1) Must not download games from or play games on Internet or participate in non-VA-related chat rooms.
- (2) Must not access inappropriate sites, including but not limited to any site displaying or offering pornographic material, or download any material that can be considered inappropriate in a business environment.
- (3) Must not be harassing, libelous, or disruptive to others or send threatening, racially harassing, or sexually harassing messages while using VA-provided Internet resources.
- (4) Must not transmit personal data or unauthorized government-owned data across the Internet.
- (5) Must obey all copyright laws.
- (6) Must not attempt to exceed access privileges or use VA-provided access or systems as a staging ground or platform to gain unauthorized access to other systems whether federal or private.
- (7) Must not willfully circumvent the security features of the automated information systems or network access systems at this or any other facility.
- (8) Must not participate in unlawful or malicious activities or use objectionable language while using Internet.
- (9) Must not knowingly introduce computer viruses, worms, Trojan horses or other types of malicious computer software to government computers.
- (10) Must not use Internet for personal use when they are expected to be performing official duties.
- (11) Must not make any personal use of Internet that could cause congestion, delay or disruption of service to any government system or equipment (i.e., continuous data streams, video, sound, or other large file attachments can degrade the performance of the network), or for any activities that are illegal, inappropriate, or offensive to fellow employees and the public.
- (12) Are aware that violations of standards, procedures, or practices in support of this policy will be brought to the attention of Management for appropriate action. They will be subject to penalties for misuse or abuse of VA systems, resources



and/or data and information may including loss of networking privileges, disciplinary action up to and including dismissal, which may be in addition to any penalty prescribed by law, and any appropriate criminal action.

**5. REFERENCES:**

Computer Security Act of 1987, PL 100-235.  
Privacy Act of 1974 (5 U.S.C. 552a, as amended).  
Electronic Communications Privacy Act of 1986, PL 99-508.  
MP-1, Part II, Chapter 21, Access to VA Systems of Records under the Privacy Act of 1974.  
M-11, Chapter 16, Automated Information System Security, dated January 17, 1995.  
OMB Circular A-130, "Management of Federal Information Resources."  
VA Directive 6001, Limited Personal Use of Government Office Equipment, Including Information Technology  
VA Directive 6102, Internet/Intranet Services, January 2006,  
<http://vaww.va.gov/6102/index.asp>  
VA Handbook 6102, Internet/Intranet Services, June 2005  
VA Web Best Practices Guide to be used in conjunction with VA Handbook 6102  
VA Directive 6500, Information Security Program  
VA Directive 6504, Restrictions on Transmission, Transportation and Use of, and Access to, VA Data Outside VA Facilities, June 2006  
VA Directive 6502.3, Web Page Privacy Policy, April 2006  
VA Directive 6212, Security of External Electronic Connections, September 2000  
VA Memorandum dated 11/7/95, Interim Guidance/re Internet Gateway Approval Process.  
15 United States Code (U.S.C.) 278g-3-(d)(4)

**6. RESCISSION:** Medical Center Memorandum 00-10-16, dated April 2010

**7. RECERTIFICATION:** April 2010

Concur/Do Not Concur

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