

CHAPTER 16

MEDICAL SERVICES

STANDARD OPERATING PROCEDURE

500 BED FLEET HOSPITAL

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500 BED COMBAT ZONE HOSPITAL  
STANDARD OPERATING PROCEDURES  
MEDICAL SERVICES

A. **MISSION:** Maintain health, prevent and treat disease and illness through the use of medicine as distinguished from surgical treatment.

B. **FUNCTIONS:**

1. Responsibility. Coordinate medical services relative to the examination, diagnosis, and treatment of patients.

2. Triage, resuscitate, and stabilize patients admitted to hospital.

3. Provide sub-specialty treatment of patients requiring physicians with special training and use of special equipment.

4. Provide ward medical officer coverage for all in-patient wards.

C. **PHYSICAL DESCRIPTION:**

1. Office of the Director, Medical Services.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tent

Quantity: One Half Section

(c) Material.

IOL:

2. Casualty Receiving Area.

(a) Location within complex: See TAB A, Drawing 1.

(b) Sheltering.

Type: Temper Tent.

Quantity: Thirteen Sections.

(c) Material.

IOL:

3. OR Prep and Hold Ward.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tent.

Quantity: Nine Sections.

(c) Material.

IOL:

4. Intensive Care/Recovery Unit.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tent.

Quantity: Two, Twelve Section Wings.

(c) Material.

IOL:

5. Acute Care Ward.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tent

Quantity: Variable; One to Fourteen, Eleven Wings.

Section

(c) Material.

IOL:

6. Specialty Treatment Area.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tent.

Quantity: Ten Sections.

(c) Material.

IOL:

D. **SPECIAL CONSIDERATIONS:**

1. There is no specific isolation ward.
2. Limited laboratory and radiological capability for making diagnoses.
3. Pharmaceuticals are limited to the inventory found.
4. The physician assistants assigned to the Specialty Treatment Area will work under the supervision of a Medical Department physician.

E. **WORKLOAD:**

1. Steady rate.
  - 80 Admissions per day.
  - 54 Surgical cases.
  - 26 Medical cases.
2. Peak rate.
  - 120 admissions per day.
  - 80 Surgical cases.
  - 40 Medical cases.
3. Average length of stay.
  - Medical admission in ICU = 2 days
  - Medical admission on Acute Care Ward = 4 days
4. Anticipated internal medicine workload for Combat Zone Hospital.

<u>Diagnosis #</u>	<u>Name</u>
192	Hypothermia - Severe - all cases
193	Heat Stroke, Heat Exhaustion - Severe heat stroke
235 attack	Asthma, Severe - Disabling symptoms or repeat
237	Influenza, all types including pneumonia - Severe
238	Influenza, all types no pneumonia - Moderate
239	Viral Pneumonia - Severe - more than one lung lobe involved
240	Viral Pneumonia - Moderate
241	Pneumonia - bacterial - Severe, more than one lung lobe involved
242	Pneumonia - Bacterial - Moderate
245	Shigellosis (Bacillary Dysentery) - Moderate
250	Peptic Ulcer, Gastric, Duodenal - Moderate
251	Regional Ileitis - Severe, disabling symptoms
252	Regional Ileitis - Moderate, less disabling
259	Ischemic, Other Heart Disease - Severe
260	Phlebitis - Severe - Deep Vein involvement
261 involvement	Phlebitis - Moderate - Superficial Vein
264 uncomplicated	Meningococcal Meningitis - Moderate -
265	Meningitis, Aseptic (Viral) Moderate - all cases
266	FUO - Moderate - all cases
272	Glomerulonephritis - Acute - Moderate all cases
273	Glomerulonephritis, Chronic - Moderate all cases
276	Nephrotic Syndrome - Moderate - all cases

281 Mumps - Moderate - all cases  
 282 Mono, Infectious (Viral), Moderate - all cases  
 283 Hepatitis, Infectious (Viral) Moderate - all cases  
 286 Pancreatitis, Acute - Severe - all cases  
 288 Cirrhosis, Moderate - No Hemorrhage  
 289 Neoplasms, Malignant - Severe  
 290 Neoplasms, Benign - Moderate  
 306 Alcohol Dependency Syndrome

5. Anticipated combat diagnosis to be treated by physician assistants.

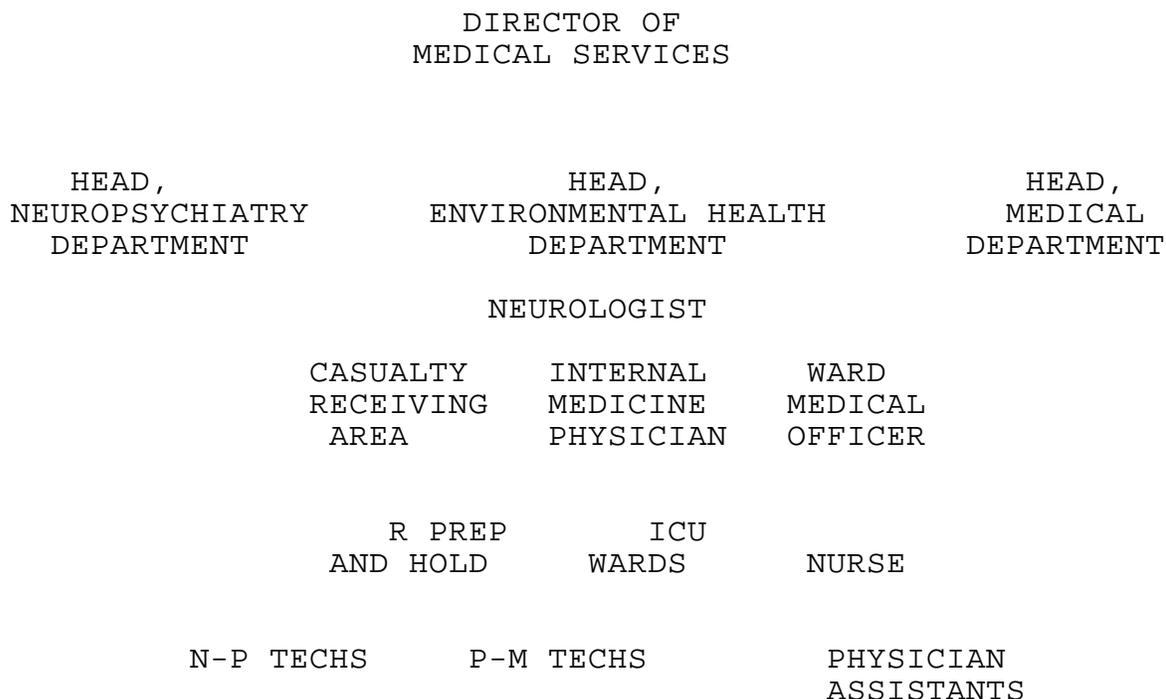
<u>Diagnosis #</u>	<u>Name</u>
187	Trench Foot, Severe - Vesicle Formation
188	Trench Foot, Moderate - No Vesicle Formation
191	Frostbite, Superficial or Deep - Moderate, less than full thickness involved
194	Heat Stroke, Heat Exhaustion, Moderate Heat Exhaustion
198	Inguinal Hernia, Uncomplicated Severe Direct
199	Inguinal Hernia, Uncomplicated Moderate
Direct	
204	Boils, Furuncles, Pyoderma, Severe Require Minor Surgery
218	Herpes Zoster, Moderate - Uncomplicated
270	Chancroid
271	Lymphogranuloma Venereum

F. **ORGANIZATION:**

1. Responsibility. The Director, medical services, who reports to the Executive Officer, is assigned overall management responsibility. Medical services is divided into

three departments: Neuropsychiatry, environmental health, and medical.

2. Organizational chart.



3. Staffing.

(a) Criteria.

(1) One medical officer will be assigned to Specialty Treatment Area each watch.

(2) One Ward Medical Officer will be assigned each watch to the ICUs, OR Prep and Hold Ward, and Ward One.

(3) One Ward Medical Officer will cover two acute care wards on each watch. The wards are 2 and 3, 4 and 5, 6 and 7.

(b) Staffing pattern: Two 12 hour watches.

<u>Personnel Assigned</u>	<u>AM Watch</u>	<u>Night Watch</u>	<u>Total</u>
Medical Corps	13	10	23
Nurse Corps	2	0	2
Medical Service Corps	1	0	1
Physician Assistants	3	3	6
HM Techs	3	3	6

(4) Assignments by Billet Sequence Number: See TAB A, page 12.

(5) Watch Bill: See TAB B, page 22.

(6) Special Watches: N/A.

G. **TASKS:**

Task	Method
1. PROVIDE INITIAL HOSPITAL CARE Receiving area	1.1 Examine patients in Casualty
	1.1.A Categorize patients.
	1.1.B Initiate life-sustaining
treatment as outlined in Casualty Receiving Area protocol.	
S.F.	1.1.C Record finding on 600.
on all orders.	1.1.D Write doctors orders S.F. 508. Sign doctor's
tests x-ray as	1.2 Order diagnostic from lab and needed.
	1.3 Provide medical treatment to prepare patient for surgery.
	1.3.A Initiate fluid/blood replacement.
	1.3.B Give antibiotics to control infection.
patient.	1.3.C Measure intake and output on

/treatments  
sustain life and  
preserve function.

2. PROVIDE INPATIENT  
MEDICAL CARE

daily.

minimum  
should include:

electrolyte  
(blood  
replacement).

1.3.D Offer patient  
counseling.

1.3.E Order other indicated  
medications  
to

2.1 Admit patient.

2.1.A Examine patient  
thoroughly.

2.1.B Order appropriate  
diagnostic tests.

2.1.C Complete history and  
physical on S.F. 539  
within 24 hours of  
admission to hospital.

2.2 Evaluate patient

2.2.A Make ward rounds to  
check progress of each  
patient.

2.2.B Review chart,  
diagnostic tests,  
information from  
nursing staff.

2.2.C Write a progress note  
on S.F. 509 that  
reflects patient's  
condition, prognosis,  
and treatment plan.

2.3 Prescribe treatment  
and/or diagnostic  
studies. As a  
orders

- Fluid and  
balance

infection.

(I/O,  
other

measurements).

activity,

respiratory care,  
etc.)

with  
procedures.

treatments  
performed within  
accepted principles of  
medicine.

to

3. TRANSFER/DISCHARGE  
PATIENT  
transfer/

- Nutrition.

- Control of

- Observation  
requirements.  
vital signs,  
special

- Comfort/control of  
pain.

- Diagnostic  
Procedures/tests.

- Other required  
medications

- Preventive measures  
(physical  
skin care,

2.4 Supervise/assist  
treatment

2.4.A Observe that  
are

2.4.B Perform procedures if  
nursing staff unable  
do. (Initiate IV  
therapy).

3.0 Observe hospital  
criteria to  
discharge patients.

3.1 Request transfer/  
discharge patient

with  
Administration  
Department.

Patient

transfer/dis-  
charge.

3.1.A Write doctor's orders  
prior to

3.1.B Ensure patient has  
prescriptions filled  
prior to evacuation.

4. PROVIDE INPATIENT  
CONSULTATION SERVICES

4.0 Provide medical  
consultations  
observing hospital  
policy and

priority for  
request.

4.1 Evaluate patient  
appropriate to request  
and condition.

4.2 Record findings in  
sufficient detail  
guide the  
physician.

to  
requesting

5. OUTDATED DRUGS

5.1 Return outdated drugs  
to Pharmacy for  
disposal.

6. CSR  
from  
areas.

6.1 Contaminated items  
other hospital

department  
take items from  
other hospital areas  
to the CSR Support  
Module.

- The using will

the CSR  
Module will  
receive all items.

- The Collection/  
Reissue HM in  
Support

- The Collection/

the CSR  
Module will  
Custody  
Card/Inventory Lists  
for instrument trays  
loaned from CSR to  
other hospital areas.

Reissue Hm in  
Support  
pull

the  
person  
returning the tray/  
equipment.

- Jointly inventory  
tray with

aside  
item IAW  
for repair  
procedures.

-- Note any missing  
items.

-- Record and set  
any damaged  
the SOP

Custody  
Card/Inventory List.

-- Both persons will  
sign the

7. ASSIGN MEDICAL PERSONNEL  
  
will make a  
watch bill and  
assign personnel  
appropriate to their  
specialty.

7.0 Head, Medical  
Department  
monthly

8. PERFORM LEADERSHIP TASKS  
and  
advance  
officers'  
and knowledge.

8.0 Provide training  
supervision to  
medical  
skills

8.1 PROVIDE CONTINUING  
officers' EDUCATION  
IAW Medical  
S.O.P.

8.1.A Orient medical  
to hospital  
Services

8.2 SUPERVISE/COUNSEL

8.2.A Director, Medical  
Services will

counsel specialists.

8.2.B Head, Medical  
Department will  
counsel medical  
officers on wards.

8.3 MONITOR INCIDENT REPORTS 8.3.A Monitor any  
incident report,  
counsel as  
required, and provide  
classes related to the  
incident.

H. **STANDARD OPERATING PROCEDURES:** See TAB C, page 36.

I. **CLINICAL POLICIES/GUIDELINES:** See TAB D, page 75.

J. **STANDARD PROCEDURES:** N/A.

K. **STANDARDS, AND JOB DESCRIPTIONS:** See TAB E, page 87.

L. **DOCUMENTATION:**

1. References: See TAB F, page 104.

2. Forms: See TAB G, page 105.

**TAB A**  
**ASSIGNMENT BY BILLET SEQUENCE NUMBER**  
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**TAB A-1**

**ASSIGNMENTS BY BILLET SEQUENCE NUMBER**

Department: Medical Service Physicians

<u>Billet Section/ Number</u>	<u>Title</u>	<u>Designator/ Spec. Code</u>	<u>Rank/ Rate</u>	<u>Watch</u>
35029	Director, Medical Serv. ICU, AM Watch, Specialty Treatment	2100/ 0020	O-6	1
36029	Head, Medical Dept. ICU 2 Night Watch	2100/ 0101	O-6	2
36049	Internist ICU 1, Night Watch	2100/ 0101	O-4	2
36051	Internist ICU 2, AM Watch	2100/ 0101	O-4	1
36069 2	Internist - Wards	2100/ 0101	O-3	
36071 1	Internist - Wards	2100/ 0101	O-3	
36829	Neurologist Specialty Treatment	2100/ 0121	O-4	1*
36089	Ward Medical Officer for Wards 1-7	2100/ 0102	O-4	1*
36129	Primary Care Physician OR Prep and Hold	2100/ 0102	O-4	1
36131	Primary Care Physician OR Prep and Hold	2100/ 0102	O-4	2

\* NOTE: Physician will cover ICU Ward when Ward Medical Officer is excused

**TAB A-2**

**ASSIGNMENTS BY BILLET SEQUENCE NUMBER**

Department: Ward Primary Care Physicians

<u>Billet Watch Number Section</u>	<u>Title</u>	<u>Designator Spec. Code</u>	<u>Rank/ Rate</u>	
36089	Primary Care Physician	2100/0102	O-6	1
36109	Primary Care Physician	2100/0102	O-5	2
36133	Primary Care Physician	2100/0102	O-4	1
36135	Primary Care Physician	2100/0102	O-4	1
36137	Primary Care Physician	2100/0102	O-4	1
36149	Primary Care Physician	2100/0102	O-3	1
36151	Primary Care Physician	2100/0102	O-3	2
36153	Primary Care Physician	2100/0102	O-3	2
36155	Primary Care Physician	2100/0102	O-3	2
36157	Primary Care Physician	2100/0102	O-3	2
36159	Primary Care Physician	2100/0102	O-3	2
36161 2	Primary Care Physician	2100/0102	O-3	
36163 2	Primary Care Physician	2100/0102	O-3	

**TAB A-3**

**ASSIGNMENTS BY BILLET SEQUENCE NUMBER**

DEPARTMENT: Casualty Receiving Area

Billet Watch Number <u>Section</u>	<u>Title</u>	Designator/  <u>Specialty Code</u>	Rank/  <u>Rate</u>	
1. Nurse Corps.				
42089	Emer. Med. Nurse	2900/0963	0-5	1*
31003	Charge Nurse T1	2900/0940	0-4	2
31005	Staff Nurse T1	2900/0944	0-3	1
31007	Staff Nurse T2	2900/0944	0-3	1
31008	Staff Nurse T3	2900/0944	0-3	1
31009	Staff Nurse T2	2900/0944	0-3	2
31011	Staff Nurse T3	2900/0944	0-3	2
31113	Staff Nurse T1	2900/0944	0-3	1
31117	Staff Nurse T2	2900/0944	0-3	2
31225	Staff Nurse T3	2900/0944	0-2	1
2. Dental Corps.				
65029	Dental Officer T0	2200/0020	0-6	1*
3. Medical Corps.**				
42029	Emergency Medicine, In Head of Casualty Receiving	2100/0102	0-5	1*
42049	Emer. Med Physician T2	2100/0102	0-4	1
42051	Emer. Med Physician T3	2100/0102	0-4	1
42069	Emer. Med Physician T0	2100/0102	0-3	2
42071	Emer. Med Physician T1	2100/0102	0-3	2
42-73	Emer. Med Physician T2	2100/0102	0-3	1
4. Warrant Officers (Optional).				
42109	Sr. Physician Asst. CR/T37540		W-4	1*
42129	Physician Asst. ST + 7540		W-3	1
42149	Physician Asst. ST + 7540		W-2	2
5. Hospital Corpsman.				
42019	EMT Senior Corpsman	8425	E-6	1
42039	Gen Duty Corpsman T1	0000/HM	E-5	1
42041	Gen Duty Corpsman T2	0000/HM	E-5	1

<u>Billet Number Section</u>	<u>Title</u>	<u>Designator Team Spec.</u>	<u>Code</u>	<u>Rank/ Rate</u>	<u>Watch</u>
42043	Gen Duty Corpsman	T3	0000/HM	E-5	1
42045	Gen Duty Corpsman	GD	0000/HM	E-5	1
42047	Gen Duty Corpsman	GD	0000/HM	E-5	1
42059	Gen Duty Corpsman	T2	0000/HM	E-3	1
42061	Gen Duty Corpsman	T3	0000/HM	E-3	1
42063	Gen Duty Corpsman	GD	0000/HM	E-3	1
42065	Gen Duty Corpsman	GD	0000/HM	E-3	1
42067	Gen Duty Corpsman	T1	0000/HM	E-3	1
42069	Gen Duty Corpsman	T2	0000/HM	E-3	1
42071	Gen Duty Corpsman	T3	0000/HM	E-3	2
42073	Gen Duty Corpsman	GD	0000/HM	E-3	2
42075	Gen Duty Corpsman	GD	0000/HM	E-3	2
42077	Gen Duty Corpsman	GD	0000/HM	E-3	2
51039	Gen Duty Corpsman	T1	0000/HM	E-4	1
51041	Gen Duty Corpsman	T2	0000/HM	E-4	1
51043	Gen Duty Corpsman	T3	0000/HM	E-4	1
51045	Gen Duty Corpsman	GD	0000/HM	E-4	1
51061	Gen Duty Corpsman	GD	0000/HM	E-3	1
51063	Gen Duty Corpsman	T1	0000/HM	E-3	2
51065	Gen Duty Corpsman	T2	0000/HM	E-3	2
51067	Gen Duty Corpsman	T3	0000/HM	E-3	2
51069	Gen Duty Corpsman	GD	0000/HM	E-3	2
51071	Gen Duty Corpsman	GD	0000/HM	E-3	2
51073	Gen Duty Corpsman	GD	0000/HM	E-3	2
51075	Gen Duty Corpsman	GD	0000/HM	E-3	2
51077	Gen Duty Corpsman	GD	0000/HM	E-3	2
36039	Gen Duty Corpsman	GD	0000/HM	E-5	1
36041	Gen Duty Corpsman	GD	0000/HM	E-5	1
36059	Gen Duty Corpsman	GD	0000/HM	E-3	1
16043	Patient Affairs	HM --	0000/HM	E-4	1
16045	Patient Affairs	HM --	0000/HM	E-4	2

Key:

CR = Casualty Receiving Area  
ST = Specialty Treatment Area  
T1 = Treatment Team 1  
T2 = Treatment Team 2  
T3 = Treatment Team 3  
TO = Triage Officer  
TR = Triage Recorder  
GD = General Duty

\* Permanent watch stander.

\*\* General surgeons will be assigned on a rotating basis to head treatment teams.

+ During steady state AM watch, Physician Assistants will be assigned to the Specialty Care Area. During peak states, they will assist treatment teams in Casualty Receiving. On the night watch, Physician Assistants will be assigned to treatment teams 2 and 3.

TAB A-4

ASSIGNMENTS BY BILLET SEQUENCE NUMBER

Department: Physician Assistants

<u>Billet Watch Number Section</u>	<u>Title</u>	<u>Designator/ Specialty Code</u>	<u>Rate/ Rank</u>	
36169	Senior Physician Assistant	7540	W-4	1
36189	Physician Assistant	7540	W-2	1
36191	Physician Assistant	7540	W-2	1
36209	Physician Assistant	7540	W-2	2

TAB A-5

ASSIGNMENTS BY BILLET SEQUENCE NUMBER

Department: Environmental Health Department

Billet Watch	<u>Number</u> <u>Section</u>	<u>Title</u>	Designator <u>Specialty Code</u>	Rank/ <u>Code</u>	<u>Rate</u>
48029		HEAD, ENVIRONMENTAL HEALTH	2300/0861	0-3	
48019		PREV MED TECH SUPV	8432/HM	E-7	
48039		PREV MED TECH	8432/HM	E-5	

TAB A-6

ASSIGNMENT BY BILLET SEQUENCE NUMBER

Department: Neuropsychiatry

<u>Billet Number</u>	<u>Title</u>	<u>Designator</u>	<u>Rank/ Rate</u>
1. Medical Corps.			
41029	Head, Neuropsych. Department	2100/0115	0-5
41049	Psychiatrist	2100/0115	0-4
41069	Psychologist	2100/0851	0-4
2. Nurse Corps.			
34029	Hd. Amb. Care Nurse	2900/1930	0-5
34049	Amb. Care Nurse	2900/0935	0-3
3. Hospital Corpsmen.			
41019	Psych Tech	0000/HM	E-5
41021	Psych Tech	0000/HM	E-5
41039	Psych Tech	0000/HM	E-3
41041	Psych Tech	0000/HM	E-3

\* Permanent watch stander.

TAB A-7

ASSIGNMENTS BY BILLET SEQUENCE NUMBER

Department: Specialty Treatment Area

Billet Watch Number <u>Section</u>	Title	Designator/ <u>Spec. Code</u>	Rank/ <u>Code</u>	<u>Rate</u>
1. <u>Medical Corps.</u>				
36829	Neurologist	2100/0121	0-4	
40029	Head, Dermatology Department	2100/0111	0-5	
40049	Dermatologist	2100/0111	0-4	
2. <u>Nurse Corps.</u>				
34049	Ambulatory Care Nurse	2900/0935	0-3	1
301119	Asst. Ambulatory Care Nurse	2900/0940	0-3	2
3. <u>Physician Assistants.</u>				
36169	Senior Physician Assistant	7540	W-4	1
36189	Physician Assistant	7540	W-2	1
36191	Physician Assistant	7540	W-2	2
36209	Physician Assistant	7540	W-2	2
3. <u>Hospital Corpsman.</u>				
34039	Senior Corpsman		E-5	1
31101	General Duty Corpsman		E-5	1
34041	General Duty Corpsman		E-5	2
31363	General Duty Corpsman		E-3	1
31365	General Duty Corpsman		E-3	2
36019	Adv. Corpsman		E-6	1
40019	Dermatology Tech	8495	E-4	1
40021	Dermatology Tech	8495	E-4	2
35019	Admin. Asst.	8404	E-4	1

**TAB B**  
**WATCH BILLS**  
**INDEX**

<u>NUMBER</u> <u>PAGE</u>	<u>TITLE</u>
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B-6 33	Neuropsychiatry
B-7 34	Specialty Treatment Area

**TAB B-1**

**WATCH BILL FOR MEDICAL SERVICE PHYSICIANS**

BILLET#

M T W T F S S M T W T F S S M T W T F S S

35029

A1 A1 A1 E A1 A1 A1 A1 A1 A1 A1 E A1 A1 A1 A1 A1 A1 A1 E A1

36029

N2 N2 N2 N2 E N2 N2 N2 N2 N2 N2 N2 E N2 N2 N2 N2 N2 N2 N2 E

36049

N1 N1 N1 N1 N1 N1 E N1 N1 N1 N1 N1 N1 N1 E N1 N1 N1 N1 N1 N1

36051

A2 A2 A2 A2 A2 E A2 A2 A2 A2 A2 A2 A2 E A2 A2 A2 A2 A2 A2  
A2

36069

N1 N1 N1 N1 N1 N1 E N1 N1 N1 N1 N1 N1 N1 E N1 N1 N1 N1 N1  
N1

36071

A2 A2 A2 A2 A2 E A2 A2 A2 A2 A2 A2 A2 E A2 A2 A2 A2 A2 A2  
A2

36829

AS AS AS AS N2 E N1 AS AS AS AS A1 AS A2 AS E AS AS AS AS  
AS

36089

AW AW AW A1 AW A2 AW E AW AW AW AW N2 AW N1 E AW AW AW A1  
AW

36129

AH AH E AH AH AH AH AH AH AH E AH AH AH AH AH AH AH E AH  
AH

36131

NH E NH NH N2 NH N1 NH NH E NH NH N2 NH N1 NH NH E NH NH  
N2

KEY:

A = AM watch (0700-1900).

N = Night watch (1900-0700).

D = Duty.  
E = Excused.  
1 = ICU 1.  
2 = ICU 2.  
W = All wards.  
H = OR Prep and Hold Ward.  
S = Specialty Treatment Area.

**TAB B-2**

**WATCH BILL FOR WARD PRIMARY CARE PHYSICIANS**

BILLET#	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
36089	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
36109	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
36133	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36135	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
36137	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
36149	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
36151	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
36153	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	N	D	E	A	A	A
36155	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N	N	N	N
36157	N	N	N	N	N	E	D	N	N	N	N	N	N	N	E	D	A	A	A	A	A
36159	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	N	D	E	A	A	A
36161	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N	N	N	N
36163	N	N	N	N	N	E	D	N	N	N	N	N	N	N	E	D	A	A	A	A	A

KEY:

A = AM watch (0700-1900).

N = Night watch (1900-0700).

D = Duty.

E = Excused.

1/2 = ICU 1 and ICU 2.

W1 = Ward 1.

W2 = Wards 2 and 3.

W4 = Wards 4 and 5.

W6 = Wards 6 and 7.

TAB B-3

WATCH BILL FOR CASUALTY RECEIVING AREA

BILLET #

M T W T F S S M T W T F S S M T W T F S S

Triage

TO 65029

AT AT AT AT E AT AT AT AT AT AT AT E AT AT AT AT AT AT AT E

HM 36059

AT AT AT E AT AT AT AT AT AT AT E AT AT AT AT AT AT AT E AT

HM 42045

AT AT AT AT AT AT AT E AT AT AT AT AT AT AT E NT NT NT NT NT

TO 42069

NT NT NT NT NT E NT NT NT NT NT NT NT E NT N1 N1 N1 N1 N1 N1

HM 42059

NT NT NT E NT NT NT NT NT NT E NT NT NT NT NT NT NT E NT

HM 42065

NT NT NT NT NT NT NT E NT NT NT NT NT NT NT E AT AT AT AT AT

Patient Affairs

\*HM 16043

AP AP AP AP AP AP \*E AP AP AP AP AP AP \*E NP NP NP NP NP NP

\*HM 16045

NP NP NP NP NP \*E NP NP NP NP NP NP MP \*E AP AP AP AP AP AP  
AP

General Duty

Nrs 42089

AG AG AG AG AG AG AG E AG AG AG AG AG AG E N1 N1 N1 N1 N1

Nrs 31113

AG AG AG AG AG AG E AG AG AG AG AG AG E NG NG NG NG NG NG

Nrs 31117

AG A3 AG E AG AG AG AG A3 AG E AG AG AG AG A3 AG E A3 AG AG

Nrs 31225

AG E AG AG A3 AG AG AT AG E AG A3 AG AG AG AT E AG AG AG AG

SrHM 42019

AG AG AG AG AG AG E AG AG AG AG AG AG E NG NG NG NG NG NG NG

HM 42047

AG A3 AG E AG AG AG AG A3 AG E AG AG AG AG A3 AG E A3 AG AG

HM 42061

AG E AG AG A3 AG AG AT AG E AG A3 AG AG AG AT E AG AG AG AG

HM 42063

AG AG E AG AG AG AG AG E AG AG AG AG AG E AG AT AT AT AT AT

HM 51045

AG AG A1 A2 E AG AG AG AG AG A1 AG E AG AG AG AG A1 E A2 AG

51061

AG AG A2 AG A1 AG E AG AG AG A2 A2 A1 E AG AG AG AG A2 E AG

HM 36039

AG AG AG AT AG E AG AG AG AG AG AG E AG AG AG AG AG E AT AG

HM 36041

AG AG E AG AG AG AG AG AG E AG AT AG AG AG AG E AG AG AG AG

Asr HM 42067

NG NG NG NG NG NG E NG NG NG NG NG NG NG E AG AG AG AG AG AG

HM 42069

NG N2 NG NG NG E N3 NG NG N2 NG NG E NG NG NG NG NG NG E NG

HM 51069

NG NG E NT NG NG NG NG NG E NG NG NG NG NG NG E N2 N2 NG NG

HM 51071

NG E NG N2 NG NG NG NG E NG NG N2 NG NG NG E NG NG NG NG NG

HM 51073

NG NG NG E N3 NG NG NG NG NG E NG NG N3 NG N1 N1 E NG NG NG

HM 51075

NG NG NG NG NG NG NG E NG NG NG N3 NG NG E NG NG NG N3 NG N3

HM 42071

NG N1 N1 NG NG NG E NT NG NG NG NG NG E NG NG NT NG NG NT E

HM 42073

NG NG NG NG E NG NG NG N1 N1 NG E NG NG NG NG NG NG E NG NG

Team 1

MO 42029

A1 A1 A1 A1 AT A1 E A1 A1 A1 A1 A1 AT E A1 A1 A1 A1 A1 A1 A1

Nrs 31005

A1 A1 A1 E A1 A1 A1 AG A1 A1 A1 E A1 A1 A1 A1 A1 A1 E A1 A1

HM 42039

A1 A1 E A1 A1 A1 A1 A1 A1 A1 E A1 A1 A1 A1 A1 E A1 A1 A1 A1

HM 51039

A1 A1 A1 A1 E A1 A1 A1 A1 A1 A1 A1 E A1 A1 A1 A1 A1 A1 A1 E

MO 42071

N1 N1 N1 N1 N1 NT N1 E N1 N1 N1 N1 N1 NT NT E NT NT NT NT NT

Nr 31003

N1 N1 N1 N1 N1 N1 E N1 N1 N1 N1 N1 N1 N1 E AG AG AG AG AG AG

HM 51063

N1 N1 E N1 N1 N1 N1 N1 N1 E N1 N1 N1 N1 N1 N1 E N1 N1 N1 N1

Team 2

MO 42049

A2 A2 A2 A2 A1 E A1 A2 A2 A2 A2 E A1 A1 A2 A2 A2 A2 A2 E A2

Nrs 31007

A2 E A2 A1 A2 A2 A2 A1 A2 E A2 A1 A2 A2 A2 A2 E A2 A1 A2 A2

HM 51041

A2 A2 A2 E A2 A2 A2 A2 A2 A2 A2 E A2 A2 A2 A2 A2 A2 A2 E A2

HM 42041

A2 A2 E A2 A2 A2 A2 A2 A2 A2 E A2 A2 A2 A2 A2 A2 A2 E A2 A2

+Sur On Call

N2 N2 N2 N2 N2 N1 N2 N2 N2 N2 N2 N2 N2 N1 N2 N2 N2 N2 N2 N2 N2

Nrs 31009

N2 N2 E N2 N2 N2 N1 N2 E N2 N2 N2 N2 N2 N1 E N2 N2 N2 N2 N2

HM 42075

N2 E N2 N2 N2 N2 N2 N2 N2 E N2 N2 N2 N2 N2 N2 N2 E N2 N2 N2

HM 51065

N2 N2 N2 E N2 N2 N2 N2 N2 N2 E N2 N2 N2 N2 N2 N2 E N2 N2

PA 51077

N2 N2 N2 N2 N2 E N2 N2 N2 N2 N2 N2 E N2 N2 N2 N2 N2 N2 E N2

Team 3

MO 42051

A3 A3 A3 A3 A2 A2 A2 E A3 A3 A3 A2 A2 A2 E A3 A3 A3 A3 A2 A3

Nrs 31008

A3 A2 A3 A2 A3 E A3 A2 A3 A2 A3 A2 E A3 A3 A3 A2 A3 A2 A3 E

HM 51043

A3 E A3 A3 A3 A3 A3 A3 E A3 A3 A3 A3 A3 A3 E A3 A3 A3 A3 A3

HM 42043

A3 A3 A3 A3 E A3 A3 A3 A3 A3 A3 E A3 A3 A3 A3 A3 A3 E A3 A3

SrPA 42109

A3 A3 E A3 A3 A3 A3 A3 A3 A3 E A3 A3 A3 A3 A3 A3 E A3 A3 A3

+Sur On Call

N3 N3 N3 N3 AN AN AN AN N3 N3 N3 AN AN AN N3 N3 N3 N3 N3 AN N3

Nrs 31011

N3 N3 N3 E N3 N3 N2 N3 N3 N3 E N3 N3 N3 N2 N2 N3 E N3 N3 N3

HM 42077

N3 N3 N3 N3 N3 N3 E N3 N3 N3 N3 N3 N3 E N3 N3 N3 N3 N3 N3 E

HM 51067

N3 N3 N3 N3 E N3 N3 N3 N3 N3 N3 E N3 N3 N3 N3 N3 N3 E N3 N3

Specialty Treatment

\*\*PA 42129

AS A3 A3 A3 AS A3 E A3 AS A3 A3 AS A3 E AS AS A3 A3 AS E A3

\*\*PA 42149

NS NS N3 N3 E NS N3 NS NS N3 N3 E NS NS N3 N3 N3 N3 E NS NS

Key:

First digit = watch

A = AM

N = Night

Second Digit = Assignment

T = Triage

G = General Duty -- Substitute Assignment.

P = Patient Affairs

S = Specialty Treatment Area

1 = Treatment Team One

2 = Treatment Team Two

3 = Treatment Team Three

- \* Patient Affairs department will provide relief.
- + Surgeons will rotate coverage to treatment teams.
- \*\* PA in Specialty Treatment area will substitute for PAs on team 3.

**TAB B-4**

**WATCH BILL FOR PHYSICIAN ASSISTANTS**

BILLET#

M T W T F S S M T W T F S S M T W T F S S

36169

A2 E A2 A2 A3 A3 A3 A3 A2 E N2 N2 N2 N2 N2 N2 N2 E A2 A2 A2

36189

AS AS AS AS E AS AS AS A3 A3 A3 AS E NS NS NS NS NS NS NS E

36191

NS NS NS NS NS NS E AS AS AS AS E AS AS AS A3 A3 A3 AS E NS

36209

A3 A2 E N2 N2 N2 N2 N2 N2 N2 E A3 A2 A2 A2 E A2 A2 A3 A3 A3

KEY:

A = AM watch (0700 - 1900).

N = Night watch (1900-0700).

E = Excused.

S = Specialty Treatment Area.

2 = Treatment Team 2/Casualty Receiving Area.

3 = Treatment Team 3/Casualty Receiving Area.

NOTE: All Physician Assistants will work in the Specialty Treatment Area until activated to work on a treatment team in Casualty Receiving Area. Team 2 will be activated first, then Team 3.

TAB B-5

WATCH BILL FOR ENVIRONMENTAL HEALTH DEPT

Billet#

M T W T F S S M T W T F S S M T W T F S S

48029

\*A A \*A \*A \*A A D N N N N N N E \*A \*A A \*A \*A \*A E

48019

A A A A A \*A \*A \*A \*A \*A \*A E N N N N N N E D A

48039

N N N N N N E D A A A A A A A A A A N N N

Key:

A = AM Watch (0700-1900).

N = Night Watch (1900-0700).

E = Excused.

D = Duty.

\* = Call.

**TAB B-6**

**WATCH BILL FOR NEUROPSYCHIATRY DEPARTMENT**

Billet#

M T W T F S S M T W T F S S M T W T F S S

Medical Officers

41029

A A A A E A A A A A A A E A A A A A A A E

41049

A A A A A E A A A A A A A E N N N N N N E

41069

N N N N N N E N N N N N E A A A A A A E N

Nurse Corps

34029

A A A A A E N N N N N N N E A A A A A A A

34049

N N N N N N E A A A A A A A E N N N N N E

Hospital Corpsmen

41019

A D A E A A A A A D A E A A A A A D A E A

41021

A A E D A A A A A A E D N N N N N N E D N

41039

N E D N N N N N N E D A A A A A A E D A A

41041

A D A E A A A A A D A E A A A A A D A E A

KEY:

A = AM watch (0700-1900).

N = Night watch (1900-0700).

E = Excused.

D = Duty.

TAB B-7

WATCH BILL FOR SPECIALTY TREATMENT AREA

BILLET#

M T W T F S S M T W T F S S M T W T F S S

Medical Corps

36829  
AS AS AS AS N2 E N1 AS AS AS AS A1 AS A2 AS E AS AS AS AS AS

44029  
AS AS AS AS AS AS E AS AS AS AS AS AS E AS AS AS AS AS AS E

44049  
NS NS NS NS NS E NS NS NS NS NS NS E NS NS NS NS NS NS E NS

Nurse Corps

34049  
A A A A A A \* N N N N N N \* A A A A A A \*

31119  
N N N N N \* A A A A A A \* N N N N N N \* N

Physician Assistants

36169  
A2 E A2 A2 A3 A3 A3 A3 A2 E N2 N2 N2 N2 N2 N2 N2 E A2 A2 A2

36189  
AS AS AS AS E AS AS AS A3 A3 A3 AS E NS NS NS NS NS NS NS E

36191  
NS NS NS NS NS NS E AS AS AS AS E AS AS AS A3 A3 A3 AS E NS

36209  
N2 N2 N2 E A2 A2 A2 A2 E A2 A2 A2 A3 A3 A3 A2 E N2 N2 N2 N2

Hospital Corpsman

36019+  
A A A A A \* A A A A A A \* A A A A A A \* A

34039  
A A A A A A \* A A A A A A \* A A A A A A \*

31101

A A A A A E D N N N N N N E A A A A A E D

34041

N N N N N N E A A A A A E D N N N N N N E

31363

A A A A A A D N N N N N N E A A A A E A D

31365

N N N N N N E A A A A E A D N N N N N N E

35019+

A A A A A E A A A A A A \* A A A A A A E A

44019

N N N N N N E A A A A A E D N N N N N N E

44021

A A A A A A D N N N N N N E A A A A E A D

Key:

A = AM watch (0700 - 1900).

N = Night watch (1900-0700).

E = Excused.

**NOTE:** All Physician Assistants will work in the Specialty Treatment Area until activated to work on a treatment team in Casualty Receiving Area. Team 2 will be activated first, then Team 3.

**TAB C**  
**PROCEDURES**  
**INDEX**

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**TAB C-1**

**CARDIAC ARREST PROCEDURE**

A. **POLICY:** In the event of sudden cessation of breath, heartbeat, or both, every effort shall be made to re-establish respiratory and/or circulatory function as soon as possible. Cardiopulmonary resuscitation shall initiated in each incident, unless counter-manded by a Medical Officer or by written order in the patient's record.

B. **PROCEDURE:**

1. After assessment of cardiac or respiratory arrest is made, immediately initiate basic life support.

(a) Verify unresponsiveness.

(b) Call for help.

(c) If unresponsive, open the airway.

(d) Check for breathing.

(e) If not breathing, give 2 full ventilations, 1 to 1 1/2 seconds each.

(f) Check carotid pulse.

(g) If pulse is absent, start chest compressions 80 - 100 per minute.

2. Have second person call arrest team.

(a) Using field phone state "Code Blue" in \_\_\_\_\_.

(b) Communication personnel will announce over "PA" system "Code Blue" and location of code.

3. Have second or third person bring emergency equipment to the scene.

(a) Emergency Cardio Resuscitation Kit.

(b) Oxygen cylinder.

(c) Suction machine with all catheters attached

4. Members of arrest team will:

- (a) Perform chest compression (one member)
- (b) Manage airway and do ventilation (one member)
- (c) Start an IV
- (d) Draw up and administer medications as directed by ACLS certified member or Medical Officer. (One member)
- (e) Recorder will document arrest on Cardiac Arrest Flow Sheet. This member will be the same throughout the emergency.

C. **VITAL POINTS:**

- 1. Basic life support must not be interrupted for more than 5 seconds.
- 2. Advanced life support is only effective if proper basic life support is initiated and maintained.
- 3. Complete specific nursing notes showing the exact time events were done on Cardiac Arrest Flow Sheet.

D. **EDUCATION REQUIREMENTS:**

- 1. All medical personnel must maintain Basic Cardiac Life Support (BCLS) certification.
- 2. All medical officers and Critical Care Area Nurses should maintain advanced Cardiac Life Support (ACLS) certification.
- 3. CPR drills will be conducted monthly on all nursing wards in order to assure medical personnel awareness of their role in a code.

E. **RESPONSIBILITY:**

The Medical Officer in area.

## TAB C-2

### DEFIBRILLATION

A. **PURPOSE:** To terminate ventricular fibrillation immediately, facilitating the establishment of an effective cardiac rhythm. This is the first and only treatment for ventricular fibrillation.

B. **DEFINITION:** Also known as precordial shock, it is the conduction of an electrical impulse into the heart to depolarize cardiac muscle and convert fibrillation rhythm into normal sinus rhythm.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Defibrillator with external paddles.
2. Batteries.
3. ECG monitor with recorder.
4. Conductive medium.
5. Cardio Resuscitation Kit (Sparks Kit).
6. Oxygen therapy equipment.
7. Airways.
8. Endotracheal Anesthesia Set.
9. AMBU bag.
10. Suctioning equipment.

D. **CRITERIA:**

1. Conversion of an abnormal rhythm following a precordial thump or cough has been well demonstrated in patients with ventricular tachycardia and complete heart block. Recently, it has been demonstrated as well for ventricular fibrillation. Because the speed of defibrillation is critical, a solitary precordial thump is recommended for all witnessed cardiac arrests when a defibrillator is unavailable. When a precordial thump is used in patients who have ventricular tachycardia and a pulse, a defibrillator should be available since ventricular fibrillation can be induced. A precordial thump is delivered to the center of the sternum with the hypothenar aspect of the fist and from a

height of no more than 12 inches.

2. Defibrillator battery will be charged and ready to use at all times.

3. Person in charge of the arrest will insure all personnel stand clear so that only the patient will receive the electrical current when "ALL CLEAR" is called.

E. **STEPS:**

1. Initiate basic cardiac life support (BCLS) and summon defibrillation equipment and assistance.

2. Verify ventricular fibrillation by ECG. Correlate with the clinical state of patient.

(a) Establish an airway or use existing endotracheal tube if in place.

(b) Perform external cardiac massage until defibrillator is ready. In the OR, internal cardiac massage may be necessary.

(c) When patients are monitored and defibrillation equipment is available, proceed with defibrillation.

3. Prepare to defibrillate.

(a) Obtain battery operated defibrillator.

(b) Check battery level.

(c) Prepare defibrillator paddles by covering entire metal surface with conductive medium. (The conductive medium is needed to reduce skin resistance to current flow, prevent skin burns, and allow for optimal current flow to the myocardium.)

(d) Dial 200 watts/seconds (Joules).

(e) Activate charge button to charge unit with electrical current.

(f) Validate that defibrillator unit is in the non-synchronized mode so machine will fire correctly.

(g) Place paddles firmly into position against chest wall using 25-30 pounds of pressure.

(1) Best position - transverse position.

a Place one paddle at 2nd intercostal space right of sternum.

b Place second paddle at 5th intercostal space mid-clavicular line, left of sternum.

(2) Alternate position - anterior-posterior position.

a Place one paddle at anterior-precordial area.

b Place 2nd paddle at posterior-intrascapular area.

(h) Recheck ECG rhythm on cardioscope to validate Ventricular fibrillation pattern.

(i) Give command to stand clear of bed/litter/OR table prior to defibrillation to minimize risk of micro or macro shock to staff.

4. Defibrillate the patient.

(a) Depress the discharge button while simultaneously keeping both paddles in place until the electrical current is delivered.

(b) Check ECG rhythm on cardioscope for changes in pattern.

1 If ventricular fibrillation persists, repeat defibrillation immediately.

2 Continue CPR during any delays in defibrillation.

3 If a second attempt is unsuccessful, immediately defibrillate with up to 360 Joules.

4 If the ECG monitor shows an organized rhythm, check for a pulse. Continue CPR if no pulse present.

5 If unsuccessful, continue with current ACLS protocol.

---

**VENTRICULAR FIBRILLATION**

This sequence was developed to assist in teaching how to treat a broad range of patients with ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT). Some patients may require care not specified herein. This algorithm should not be construed as prohibiting such flexibility. The flow of the algorithm presumed that VF is continuing. CPR indicates cardiopulmonary resuscitation.

Witnessed Arrest

Unwitnessed Arrest

Check pulse - If no pulse  
pulse

Check pulse - If no

Precordial Thump  
defibrillator  
available

CPR until a  
is

Check pulse - If no pulse

Check monitor for rhythm - if VF or VT

Defibrillate, 200 Joules <sup>b</sup>

Defibrillate, 200-300 Joules <sup>b</sup>

Defibrillate with up to 360 Joules <sup>b</sup>

CPR if no pulse

Establish IV access

Epinephrine, 1:10,000, 0.5-1.0 mg IV push <sup>c</sup>

Intubate if possible <sup>d</sup>

Defibrillate with up to 360 Joules <sup>b</sup>

Lidocaine, 1 mg/kg IV push

Defibrillate with up to 360 Joules <sup>b</sup>

Bretylium, 5mg/kg IV push <sup>e</sup>

(Consider Bicarbonate)<sup>f</sup>

Defibrillate with up to 360 Joules <sup>b</sup>

Bretylium, 10 mg/kg IV push <sup>e</sup>

Defibrillate with up to 360 Joules <sup>b</sup>

Repeat Lidocaine or Bretylium

Defibrillate with up to 360 Joules <sup>b</sup>

NOTES:

1. Pulseless ventricular tachycardia should be treated identically to ventricular fibrillation.

2. Check pulse and rhythm after each shock. If VF recurs after transiently converting (rather than persists without ever converting), use whatever energy level has previously been successful for defibrillation.

3. Epinephrine infusion should be repeated every five (5) minutes.

4. Intubation is preferable. If it can be accomplished simultaneously with other techniques, then the earlier the better. However, defibrillation and epinephrine are more important initially if the patient can be ventilated without intubation.

5. Some may prefer repeated doses of lidocaine, which may be given in 0.5 mg/kg doses every 8 minutes to a total dose of 3 mg/kg.

6. The value of sodium bicarbonate is questionable during cardiac arrest, and it is not recommended for the routine cardiac arrest sequence. Consideration of its use in a dose of 1 mEq/kg is appropriate at this point. One half of the original dose may be repeated every 10 minutes if it is used.

---

**SUSTAINED VENTRICULAR TACHYCARDIA**

This sequence was developed to assist in teaching how to treat a broad range of patients with sustained ventricular tachycardia (VT). Some patients may require care not specified herein. This algorithm should not be construed as prohibiting such flexibility. The flow of the algorithm presumes that VT is continuing. VF indicates ventricular fibrillation; IV, intravenous.

<u>No Pulse</u>	<u>Pulse Present</u>	
Treat as VF	Stable	Unstable
	O <sub>2</sub>	O <sub>2</sub>
	IV Access	IV Access
sedation) <sup>c</sup>	Lidocaine, 1 mg/kg	(Consider
	Lidocaine, 0.5 mg/kg every 8 min. until VT resolves, or up to 3 mg/kg.	Cardiovert, 50 Joules <sup>d,e</sup>  Cardiovert, 100 Joules <sup>d</sup>
	Procainamide, 20 mg/min until VT resolves, or up to 1,000 mg.	Cardiovert, 200 Joules <sup>d</sup>  Cardiovert, with up to 360 Joules

<sup>a</sup>

Cardiovert as in unstable patients °	If recurrent, add Lidocaine and cardiovert again starting at energy level previously successful; then procainamide or Bretylum.
---	--

NOTES:

1. If the patient becomes unstable (see Footnote b for definition) at any time, move to the "Unstable" arm of the algorithm.

2. Unstable = symptoms (e.g. chest pain, dyspnea), hypotension (systolic BP <90 mm Hg), congestive heart failure, ischemia, or infarction.

3. Sedation should be considered for all patients, including those defined in Footnote b as unstable, except those who are hemodynamically unstable (e.g., hypotensive, in pulmonary edema, or unconscious).

4. If hypotension, pulmonary edema, or unconsciousness is present, unsynchronized cardioversion should be done to avoid the delay associated with synchronization.

5. In the absence of hypotension, pulmonary edema, or unconsciousness, a precordial thump may be employed prior to cardioversion.

6. Once VT has resolved, begin an IV infusion of the antiarrhythmic agent that has aided the resolution of the VT.

If hypotensive, in pulmonary edema, or unconscious, use lidocaine if cardioversion alone is unsuccessful, followed by bretylium. In all other patients, the recommended order of therapy is lidocaine, procainamide, and the bretylium.

---

**ASYSTOLE (CARDIAC STANDSTILL)**

This sequence was developed to assist in teaching how to treat a broad range of patients with asystole. Some patients may require care not specified herein. This algorithm should not be construed to prohibit such flexibility. The flow of

the algorithm presumes asystole is continuing. CPR indicates cardiopulmonary resuscitation; VF, ventricular fibrillation; IV, intravenous.

If rhythm is unclear and possibly ventricular fibrillation, defibrillate as for VF.

If Asystole is present: <sup>a</sup>

Continue CPR

Establish IV access

Epinephrine, 1:10,000, 0.5-1.0 mg IV push <sup>b</sup>

Intubate when possible <sup>c</sup>

Atropine, 1.0 mg IV push (repeated in 5 min)

(Consider bicarbonate) <sup>d</sup>

Consider pacing

#### NOTES:

1. Asystole should be confirmed in two leads.
2. Epinephrine should be repeated every 5 minutes.
3. Intubation is preferable; if it can be accomplished simultaneously with other techniques, then the earlier the better. However, CPR and the use of epinephrine are more important initially if the patient can be ventilated without intubation. (Endotracheal epinephrine may be used.)
4. The value of sodium bicarbonate is questionable during cardiac arrest, and it is not recommended for the routine cardiac arrest sequence. Consideration of its use in a dose of 1mEq/kg is appropriate at this point. One half of the original dose may be repeated every 10 minutes if it is used.

---

### ELECTROMECHANICAL DISSOCIATION

This sequence was developed to assist in teaching how to treat a broad range of patients with electromechanical dissociation (EMD). Some patients may require care not

specified herein. This algorithm should not be construed to prohibit such flexibility. The flow of the algorithm presumes that EMD is continuing. CPR indicates cardiopulmonary resuscitation; IV, intravenous.

Continue CPR

Establish IV access

Epinephrine, 1:10,000, 0.5-1.0 mg IV push <sup>a</sup>

Intubate when possible <sup>b</sup>

(Consider bicarbonate) <sup>c</sup>

Consider Hypovolemia,  
Cardiac Tamponade,  
Tension Pneumothorax,  
Hypoxemia,  
Acidosis,  
Pulmonary Embolism

NOTES:

1. Epinephrine infusion should be repeated every 5 minutes.

2. Intubation is preferable. If it can be accomplished simultaneously with other techniques, then the earlier the better. However, epinephrine is more important initially if the patient can be ventilated without intubation.

3. The value of sodium bicarbonate is questionable during cardiac arrest, and it is not recommended for the routine cardiac arrest sequence. Consideration of its use in a dose of 1 mEq/kg is appropriate at this point. One half of the original dose may be repeated every 10 minutes if it is used.

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**PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA**

This sequence was developed to assist in teaching how to treat a broad range of patients with sustained PSVT. Some patients may require care not specified herein. This algorithm should be not construed as prohibiting such flexibility. The flow of the algorithm presumes PSVT is

continuing.

<u>Unstable</u>	<u>Stable</u>
Synchronous Cardioversion 75 - 100 Joules	Vagal Maneuvers
Synchronous Cardioversion 200 Joules	Verapamil, 5 mg IV
Synchronous Cardioversion 360 Joules	Verapamil, 10 mg IV (in 15-20 min)
Correct underlying abnormalities	Cardioversion, Digoxin B-Blockers, Pacing as indicated
Pharmacological Therapy - Cardioversion	

If conversion occurs but PSVT recurs, repeated electrical cardioversion is not indicated. Sedation should be used as time permits.

---

### BRADYCARDIA

This sequence was developed to assist in teaching how to treat a broad range of patients with bradycardia. Some patients may require care not specified herein. This algorithm should not be construed to prohibit such flexibility. A-V indicates atrioventricular.

Slow Heart Rate (<60 beats/min) <sup>a</sup>

Sinus or Degree Junctional	Second Degree A-V Block Type I	Second Degree A-V Block Type II	Third A-V Block
----------------------------------	--------------------------------------	---------------------------------------	--------------------

Signs or Symptoms <sup>b</sup>

Signs or Symptoms <sup>b</sup>

No	Yes	No
Observe	Atropine, 0.5-1.0 mg	
Transvenous		Pacemaker
Continued Signs and Symptoms <sup>b</sup>		
No		Yes
For Second	For Second	Repeat
Atropine, 0.5-1.0 mg.	Atropine, 0.5-1.0 mg.	
<sup>D</sup> egree Type II	Degree Type I,	
or Third	sinus or junctional:	
Degree:		
Transvenous	Observe	Continued Signs/Symptoms <sup>b</sup>
Pacemaker		Yes
		External Pacemaker <sup>c</sup>
		or
		Isoproterenol, 2-10
mg/min <sup>c</sup>		Transvenous Pacemaker

NOTES:

a. A solitary chest thump or cough may stimulate cardiac electrical activity and result in improved cardiac output and may be used at this point.

b. Hypotension (BP <90 mm Hg), PVCs, altered mental status or symptoms (e.g., chest pain, dyspnea), ischemia, or infarction.

c. Temporizing therapy.

---

**VENTRICULAR ECTOPY:**  
**ACUTE SUPPRESSIVE THERAPY**

This sequence was developed to assist in teaching how to treat a broad range of patients with ventricular ectopy. Some patients may require therapy not specified herein. This algorithm should not be construed as prohibiting such flexibility.

Assess for need for  
Acute Suppressive Therapy

Rule out treatable cause

Consider serum potassium

Consider digitalis level

Consider bradycardia

Consider drugs  
Lidocaine, 1 mg/kg

If not suppressed, repeat lidocaine ,  
0.5 mg/kg every 2-5 min. until no ectopy,  
or up to 3 mg/kg given

If not suppressed, procainamide 20 mg/min  
until no ectopy, or up to 1,000 mg given

If not suppressed, and not contraindicated,  
bretylum, 5-10 mg/kg over 8-10 min.

If not suppressed, consider overdrive pacing

Once ectopy resolved, maintain as follows:

After Lidocaine, 1 mg/kg	Lidocaine drip, 2 mg/min
After Lidocaine, 1-2 mg/kg	Lidocaine drip, 3 mg/min
After Lidocaine, 203 mg/kg	Lidocaine drip, 4 mg/min
After Procainamide	Procainamide drip, 1-4

mg/min (check blood level)

After Bretylium

Bretylium drip, 2 mg/min

---

6 Assess patient status and precipitating factors to prevent further decompensation of the patient.

5. Provide post defibrillation care.

(a) Perform a complete base-line physical assessment of patient. Assess vital signs, peripheral pulses, respiratory pattern, and level of consciousness.

(b) Monitor ECG rhythm watching for arrhythmias.

(c) Obtain a 12 lead ECG to assess myocardial damage.

(d) Administer oxygen to reduce hypoxemic state.

(e) Assess chest wall for any burns. Apply Silver Sulfadiazine to any burned areas.

(f) Establish an IV line for medication administration, if not present.

(g) Administer prescribed medications IAW Physician Orders.

1 Monitor drips of antidysrhythmic drugs (lidocaine) carefully.

2 Observe patient and ECG pattern for medication effects.

6. Document defibrillation on Cardiac Arrest Flow Sheet. Record the following:

(a) Ventricular fibrillation was observed on monitor. If available, include pre-defibrillation ECG rhythm strip.

(b) Number of times defibrillation was attempted.

(c) Voltage used with each attempt.

(d) Post-defibrillation ECG rhythm. Include an ECG rhythm strip if available.

(e) Physiological multisystem status.

(f) Death.

F. **PRECAUTIONS:**

1. Check that equipment is properly grounded to prevent current leakage.

2. Disconnect other electrical equipment attached to patient to prevent possible equipment damage from the voltage surge.

3. Use conductive medium on paddles conservatively to prevent over arcing of the current flow to the patient.

4. Clean defibrillator of remaining electrical current immediately after use. Never set charged defibrillator paddles down.

5. Check that defibrillator is in non-synchronized mode such that it is not dependent upon an R wave to trigger defibrillation.

G. **COMPLICATIONS:**

1. Dysrhythmias.

2. Cardiac arrest.

3. Respiratory arrest.

4. Neurological impairment.

5. Altered skin integrity.

6. Pulmonary edema.

7. Pulmonary or systemic emboli.

8. Equipment malfunction.

9. Death.

H. **RESPONSIBILITY:**

1. Medical Officer will defibrillate the patient.

2. Nurse will administer medication, assist with CPR, and record the information in the patient's chart.

3. Hospital Corpsman will inspect and maintain the defibrillator equipment and supplies in working order. Supplies for the Sparks Kit will be obtained from Material Management Department.

I. **REFERENCE:**

1. Interim Guideline for Advanced Cardiac Life Support (ACLS), The American Heart Association.

2. Textbook of Advanced Cardiac Life Support (ACLS), The American Heart Association.

**TAB C-3**

**ROUTINE MEDICATION TIMES**

A. **PURPOSE:** To standardize medication administration times so that nursing service and pharmacy can perform this task most efficiently.

B. **SCHEDULE:**

1. Routine times.

qd	0900
bid	0900-2100
tid	0600-1400-2200
qid	0600-1200-1800-2400
q4hr	0200-0600-1000-1400 etc
q6hr	0600-1200-1800-2400
q8hr	0600-1400-2200
q3hr	0300-0600-0900 etc
q12hr	0600-1800
qhs	2200

Daily insulin 0700.

Insulin sliding scale 0700-1100-1600-2100.

2. Special considerations for adjusting times.

(a) Triple IV antibiotics are ordered.

(b) Diuretics are ordered: Best to administer before 2200.

(c) Oral antibiotics scheduled for 2400 should be given at 2200 so sleep is not interrupted.

C. **CRITERIA:**

Medications will be given at routine times unless adjusted for reason specified.

D. **STEP:**

1. Complete medication cards and MAR sheet with times stated above.

2. For medication times differing from the routine, note this in margin of Doctor's Orders Sheet, SF 508, prior to sending to Pharmacy.

D. **RESPONSIBILITY:**

Charge Nurse.

TAB C-5

ORDERING NON-AMBULATORY PATIENT MEALS

A. **PURPOSE:** To stipulate specific uniform requirements for ordering meals for bed-ridden patients.

B. **DEFINITION:** N/A.

C. **CRITERIA:**

Non-ambulatory patient meals are ordered accurately and in time.

D. **STEPS:**

1. Prepare a ward diet roster by 0400 each day. Supplies of rosters must be maintained on each ward and may be obtained from operating management service.

2. Complete form as indicated, providing at minimum, patient name, assigned bed and diet order.

3. Enter any special requirements as indicated.

4. Make diet changes by calling food service. Changes will be accepted up to:

(a) 0400 for breakfast.

(b) 0900 for lunch.

(c) 1400 for supper.

**TAB C-6**

**WARD DELIVERY AND RETRIEVAL SCHEDULE/PROCEDURE**

A. **PURPOSE:** To promulgate uniform procedures to accomplish non-ambulatory patient meal service.

B. **DEFINITION:** N/A.

C. **CRITERIA:** N/A.

D. **STEPS:**

	<u>WARD</u>	<u>Delivery</u>	<u>Pickup</u>
BREAKFAST	2	0530	0630
	4	0540	0640
	6	0550	0650
	7	0600	0700
	5	0610	0710
	3	0620	0720
	1	0630	0730
LUNCH	2	1030	1130
	4	1040	1140
	6	1050	1150
	7	1100	1200
	5	1110	1210
	3	1120	1220
	1	1130	1230
DINNER	2	1630	1730
	4	1640	1740
	6	1650	1750
	7	1700	1800
	5	1710	1810
	3	1720	1820
	1	1730	1830

1. Two mess specialists will be assigned at each meal to deliver and serve patient meals. Each MS will be assigned responsibility for specific wards.

(a) MS #1 is responsible for Wards 1,5,6, and 2.

(b) MS #2 is responsible for Wards 3, 7, and 4.

2. When the delivery vehicle arrives at each ward, the responsible Mess Specialist will notify the responsible Charge Nurse.

3. Each Ward Charge Nurse will assign a staff corpsman to assist during meal periods.

4. The responsible HM and MS will unload all gear required for each respective ward and carry it into the ward.

5. As each ward is delivered, the vehicle will move on to the next ward in sequence.

6. On the ward, the MS will:

(a) Set up a meal assembly line.

(b) Portion items required to support each diet ordered on the roster.

(c) Leave the remaining material set up on the ward.

(d) Proceed to the next assigned ward.

7. On the ward the HM will:

(a) Present and hold the necessary trays for each patient while the MS portions the meal.

(b) Deliver the meal to the appropriate patient.

(c) Dispense appropriate beverages.

(d) Dispense any remaining food consistent with specific diet orders.

(e) Retrieve soiled gear.

(f) Stage soiled gear adjacent to the exit vestibule for subsequent pick up by MS.

8. Upon completion:

(a) Mess specialist 1 retrieves soiled mess gear from Wards 3, 7, and 4.

(b) Mess specialist 2 retrieves soiled mess gear from wards 1, 5, 6, and 2.

9. Assigned vehicle will pick up soiled mess gear and deliver to scullery.

10. Assigned mess specialist 1 and 2 will assist in scullery clean up of soiled ward gear.

11. Wash, rinse, and air dry ward mess gear.

TAB C-7

**SUPPLEMENTAL FEEDINGS**

A. **PURPOSE:** To prescribe policy and procedures for obtaining subsistence that is medically required at other than routine meal periods.

B. **DEFINITION:** N/A.

C. **CRITERIA:** Patients whose clinical conditions require supplemental feedings receive same.

D. **EQUIPMENT, SUPPLIES AND FORMS REQUIRED:** N/A.

E. **STEPS:**

1. The Combat Zone environment, austere staffing, limited storage capacity, and absence of single service and/or individual portion containers dictate that supplemental feeding be kept to an absolute minimum and that each be physician prescribed.

2. When a supplemental feeding is required, the ward charge nurse will:

(a) Verify that a chart entry supports the order.

(b) Notify food service by phone of the requirement, providing patient's name, ward number, diet order, and subsistence items required.

(c) Request the time that the order be ready for pick-up (not less than 2 hours after request).

(d) Dispatch an individual to pick up the items at the agree-upon time.

3. Food service will:

(a) Accommodate supplemental feeding requests.

(b) Obtain required subsistence items and package them suitably.

(c) Release them to the ward representative.

## TAB C-8

### HAZARDOUS WASTE

A. **PURPOSE:** To provide guidance for the collection, handling and disposal of hospital generated wastes which have contacted living organisms or may otherwise be considered infectious or hazardous.

B. **DEFINITION:**

1. Background: The operation of health care facilities creates waste materials, some of which are hazardous. A subset of hazardous waste is infectious waste; proper handling of infectious waste is mandatory, to prevent spread of infectious diseases. The methods of handling infectious waste, from its generation to its ultimate disposal, must be adhered to strictly by all hands, without exception.

2. Relationship With Host Nations: It is anticipated that the 250 bed hospital will be operating, in a wartime or conflict mode, on foreign soil. Close liaison with force planners during the pre-deployment planning phase is essential for the hospital command to determine host nation requirements for handling, storage and disposal of infectious hazardous wastes. Whenever possible, agreements and/or contracts with host nations should be secured for the incineration or sanitary burial of wastes in accordance with the host nation's regulations. During peacetime exercises on U.S. soil, adherence to federal, state and local environmental laws and regulations, partially listed in Appendix A, shall be strictly enforced.

3. Categories Of Hospital Generated Waste: It must be clearly understood that the field hospital will generate four distinct categories of waste. Each type will require special handling procedures from generation to disposal. These categories are:

(a) Infectious waste - generated in patient contact, laboratory and surgical areas.

(b) Hazardous waste - usually chemical in nature and generated in the laboratory, x-ray and public works department.

(c) Infectious hazardous waste - generated in the laboratory.

(d) Non-infectious waste - generated in all areas of the hospital.

#### 4. Definitions:

(a) Infectious waste is defined as waste originating from the diagnosis and treatment of people. There are five (5) broad categories of infectious waste recognized by the Centers for Disease Control (CDC): microbiological, blood and blood products, pathological, sharps, and isolation waste. Examples of each of these types include, but are not necessarily limited to, the following:

(1) Microbiological - wastes generated in laboratories processing bacterial, fungal, mycobacterial, or viral materials, such as media-containing plates, tubes, or diagnostic strips; swabs; glass slides; pipettes. Live virus vaccines (including smallpox, yellow fever, rubella, measles, mumps, polio, and adenovirus) and any of the associated equipment for their use also fall into this classification.

(2) Blood and blood products - wastes generated in the collection processing, and use of blood and blood products; tubes for diagnostic blood collection; items and materials contaminated with blood or blood products that are not designed for cleaning, reesterilization, and reuse.

(3) Pathological - pathologic specimens, body tissues, contaminated disposable instruments, and laboratory waste generated in the performance of medical treatment reprocedures and diagnostic laboratory testing.

(4) Sharps - any diagnostic or therapeutic item possessing a surface capable of piercing human skin, not designed for cleaning, reesterilization, and reuse. Examples would include needles for injections, preparation of intravenous medicinals, indwelling cannulae, and diagnostic testing (e.g., lumbar puncture, thoracentesis, paracentesis, etc.); scalpels; and other disposable instruments with a surface capable of piercing human skin.

(5) Isolation waste - wastes generated in the therapy of patients on isolation precautions. Examples would include gowns; gloves; masks; head covers; dressings; disposables basins; paper towels used in isolation rooms; and other such items and materials used in the care of isolation patients that are not designed for cleaning, reesterilization, and reuse.

(b) Fomites - an object or item that is not of itself harmful, but may harbor pathogenic microorganisms and serve as a vehicle in the transmission of infections. Examples would

include but are not limited to bedding, linen, cloth towels and washrags, diagnostic medical instruments (e.g., stethoscopes, sphygmomanometers, thermometers), and personal items (e.g., razors, toothbrushes, toiletries).

(c) Hazardous waste - any wastes, or combination of wastes, which because of its quantity, concentration, physical or chemical properties may pose a substantial present or potential threat to human health or the environment when improperly treated, stored, transported, disposed of or otherwise managed.

(d) Infectious hazardous waste - any combination of materials and agents that meet the definitions described in 2-4.a and 2-4.c above. These wastes will typically be generated in the laboratory when organic pathogens are combined with hazardous chemicals or reagents.

(e) Non-infectious waste - waste generated from non-clinical spaces and waste from patients and their related procedures, where no infection or contagious disease exists.

(f) Storage - the holding of infectious hazardous waste for a temporary period, at the end of which the waste is treated, disposed of, or stored elsewhere.

(g) Treatment - any method, technique, or process designed to change the chemical, physical, or biological characteristics of any infectious hazardous waste so as to render such waste nonhazardous, or less hazardous or safer for transportation, storage or disposal.

(h) Autoclave - an apparatus using steam under pressure for sterilizing medical equipment.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:** N/A.

D. **CRITERIA:**

Hazardous waste is properly handled and disposed.

E. **STEPS:**

1. Handling.

(a) Infectious and infectious hazardous waste.

(1) Ward and laboratory personnel shall utilize personal protective clothing and procedures which would normally be practiced in a traditional health care setting for the control of the spread of disease.

(2) Personnel shall wear disposable gloves, gowns, and shoe and hair covers.

(3) Patient contact and laboratory areas will utilize clearly marked, impervious, containers for the disposal of all sharps. When full, the sharps container shall be securely closed with autoclave tape.

(4) Patient areas will utilize clearly marked containers lined with double plastic bags, the outer bag being an orange autoclavable "biological hazard" bag. These containers will be separate from non-infectious "trash" containers. When full, the inner bag will be sealed with autoclave tape. The outer bag will be sealed with filament reinforced tape and autoclave tape.

(b) Hazardous waste.

(1) Protective equipment, as described in DHHS (NIOSH) Publication No. 81-123 will be utilized by personnel handling hazardous waste.

(2) All hazardous waste will be containerized. Ideally, in the original container or containers designed for the collection of such wastes such as those provided with automated laboratory equipment.

(3) Containerized and transporting to storage areas will be accomplished by the waste generator (i.e., lab, x-ray, public works, etc.).

2. Transport and storage.

(a) Infectious waste.

(1) Ward personnel will deliver properly sealed sharps containers and double bagged infectious waste, to the laboratory temporary holding area, on a regularly scheduled basis. Ideally, this area will be one of low traffic and prohibitive to patient care, smoking, eating, and food or medicinal handling.

(2) Ideally, ward personnel will store and transport multiple bags of infectious waste in large, covered containers (i.e., "GI" cans with tight fitting lids). These containers shall be scrubbed with a germicidal solution at least once per shift or more often if grossly contaminated.

(3) Laboratory personnel will handle and routinely autoclave waste under steam pressure for a minimum

of fifteen (15) minutes. After proper autoclaving, these wastes may be handled as noninfectious depending on host nation requirements.

(b) Hazardous waste.

(1) As noted in paragraphs 3-1 b.2, hazardous waste will be stored in their original containers or those designed for collection of such wastes.

(2) Waste generating personnel will containerize waste according to its chemical grouping such as lubricants, fuels, acids, alkalines, chlorinated hydrocarbons, etc. Containers will be tightly sealed and labeled.

(3) Storage areas will be at least 100 yards from the hospital compound and actual or potential potable water sources. Ideally, these areas will be elevated with natural drainage away from the hospital and water sources. Waste containers should be protected from the elements and the area clearly marked as "Hazardous Waste Storage".

### 3. Disposal

(a) General. It must be understood that, in an operational situation, the methods of waste disposal range from ideal to undesirable. The following disposal methods are intended to guide the hospital command towards utilization of the best disposal method for any given situation.

(1) Host Nation Agreement - Under the Status of Forces Agreement the cognizant Commander-in-Chief (CINC) will negotiate with the host country for disposal services.

(2) The cognizant CINC will provide disposal services utilizing established logistical support channels within the theater of operations such as the Supply Battalion of the Force Service Support Group, or supply ships.

(b) Methods. In the absence of the preferred, above mentioned disposal methods, the following may be utilized.

(1) Nonhazardous/noninfectious waste (including properly autoclaved infectious waste).

a Burial in a pit as deep as organic equipment will allow and covered with at least two feet of earth. Burial pits should be at least 100 yards from the hospital compound and potable water sources.

b Burning by mixing with fuel oil until only ash remains. Ash should then be buried as above. Tactical consideration must be given to open burning as smoke may give away the hospital's location.

(2) Hazardous waste.

a Laboratory chemical waste which contains infectious, organic matter, is to be treated as hazardous as autoclaving of liquids in closed containers is not authorized.

b Burial in sealed, marked containers, as deep as organic equipment will permit. Burial sites should be lined with plastic sheeting, covered with at least four feet of earth and conspicuously marked. Sites should be at least 100 yards from the hospital compound and potable water sources.

F. RESPONSIBILITY:

1. The Commanding Officer is responsible for ensuring the proper management of the overall infectious and hazardous waste program and to interface with the host nation to ensure local regulations are satisfied.

2. Nursing Service via the clinical staff is responsible for the handling of all wastes generated in clinical spaces. This includes ensuring that adequate supplies of hampers, bags, tapes, sharps containers and protective clothing are maintained in these spaces.

3. Laboratory Service is responsible for handling hazardous infectious wastes once it is delivered to or generated by the laboratory. The service is also responsible for proper autoclaving of such wastes to render it free from pathogens.

4. Surgical Service is responsible for handling wastes generated within the operating room giving special attention to surgically removed human tissue.

5. Operating Management is responsible for the removal of waste from the central collection points, including the laboratory, and delivery to the designated pickup area such as the "back loading dock".

6. Public Works Department is responsible for the removal of wastes from the hospital compound and ensuring its proper disposal as outlined in this SOP.

TAB C-9

PROCEDURES FOR RELEASE OF  
MEDICAL INFORMATION

A. **PURPOSE:** To provide procedures of release of medical information within the hospital.

B. **DEFINITION:** Medical Information - Information contained in the health or dental record of individuals who have undergone medical examination or treatment.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:** N/A.

D. **STEPS:**

1. Upon presentation of requests for medical information refer to procedures contained in the following references:

(a) Manual of the Medical Department.

(b) Freedom of Information Act, BUMEDINST 5720.8.

(c) Personal Privacy and Rights of Individuals Regarding Records, SECNAVINST 5211.5.

(d) Availability of Navy Records, Policies, SECNAVINST 5720.42.

E. **GENERAL GUIDELINES:**

1. Information contained in health care records of individuals who have undergone medical or dental examination or treatment is personal to the individual and is therefore considered to be of a private and confidential nature. Information from such health care records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, should not be made available to anyone except as authorized by the patient or as allowed by the provisions of Manual of the Medical Department and the Privacy Act of 1974 as implemented by SECNAVINST 5211.5 series.

2. Release of information will be coordinated by the Patient Affairs Officer.

3. Personal information of non-medical nature will not be released.

4. personnel in the patients chain of command may be provided with information required to conduct command business but will be referred to the Patient Affairs Office.

5. Release of information will conform to local command and superior command policy.

6. All Department Heads shall ensure wide dissemination of this information and compliance with procedures outlined herein.

F. **RESPONSIBILITY:**

1. Director of Administration.
2. Patient Affairs Officer.
3. Charge Nurse or Assistant.

TAB C-10

PROCEDURE FOR PICK-UP AND DELIVERY OF HOSPITAL LAUNDRY

A. **PURPOSE:** It will be logistically impossible to pick up and deliver laundry at each individual ward and CSR. Therefore, this procedure establishes central collection points and the methodology for preparing laundry for turn-in.

B. **DEFINITIONS:** N/A.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Canvas laundry bags.
2. Request for clean linen/laundry.

D. **CRITERIA:** N/A.

E. **STEPS:**

1. Designated Laundry Petty Officer will:

(a) Set up laundry bags, tagging one for bed linen, one for clothing (including patient clothing), and one for contaminated laundry.

(b) Daily at 0800, take the soiled laundry to the nearest Clinical Work Space along with a request for the next day's linen/laundry supply.

(c) Distribute cleaned patient clothing.

2. Linen Control Clerks.

(a) Pick-up and receipt for hospital laundry at each Clinical Work Space.

(b) Collect Requests For Clean Linen/Laundry.

(c) Fill requests submitted the previous day and return cleaned patient clothing.

TAB C-11

PROCEDURE FOR HANDLING AND LAUNDERING CONTAMINATED LINENS

A. **PURPOSE:** The Combat Zone Fleet Hospital will generate a significant amount of contaminated linen within the operating rooms and treatment wards. These items will require special handling and laundering to prevent the spread of infection.

B. **DEFINITION:** Contaminated laundry is defined as those items requiring special disinfection and laundering to preclude the spread of infection.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Chlorine bleach solution.
2. Latex gloves.

D. **CRITERIA:** N/A.

E. **STEPS:**

1. Hospital ward personnel will bag contaminated laundry separate from regular laundry. Gloves are to be worn when handling contaminated laundry.

2. Contaminated laundry will be receipted by the Linen Control Clerks and delivered to the laundry.

3. At the Laundry all contaminated laundry will be segregated from that requiring only routine processing.

4. Based on the next day's requirements and current inventory the contaminated laundry will be assigned a processing priority.

5. The contaminated laundry will be processed as follows:

(a) Presoak the contaminated laundry for 60 minutes in a chlorine solution of 50 ppm.

(b) Wash the linen in hot water using a normal cycle.

6. Once laundered these items will be placed in inventory for re-issue.

F. **RESPONSIBILITY:** The Head, Environmental Health Department is responsible for routinely monitoring the handling and laundering of contaminated items to preclude the spread of infections.

**CAUTION:** Extreme care must be taken to avoid contact with the contaminated laundry to prevent the spread of infection to laundry and other hospital personnel.

TAB C-12

PATIENT PROCEDURES FOR HANDLING  
EXPATRIATED PRISONERS OF WAR

A. **PURPOSE:**

To detail patient handling procedures for expatriated prisoners of war within the fleet hospital.

B. **DEFINITION:**

Expatriated prisoners of war (EPW) - those patients who require treatment who are prisoners of U.S. or allied combat forces.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Restraints (theater command military police or hospital issue).
2. Others as specified in admission procedures (all forms will be marked with the words "Prisoner of War" or "EPW").

D. **STEPS:**

1. Upon presentation of EPW to functional area, notify Security Department.
2. Upon admission to Casualty Receiving, Security will be responsible for the following notifications:
  - (a) Theater command military police (MP) headquarters.
  - (b) Executive Officer.
  - (c) Director of Nursing.
  - (d) Director of Administration.
3. Perform essential life saving care.
4. Inform MP that custody of patient will not be assumed by hospital staff and that MP will retain custody of EPW until relieved by appropriate MP headquarters staff or patient is transferred to EPW holding center (external to hospital).
5. After treatment, have corpsman or litter bearer escort MP and EPW to next functional area charge nurse. Admissions packet, correctly annotated will be delivered by hand to

charge nurse.

6. During course of treatment, patient will be guarded by MP and/or restrained until treatment is terminated.

7. Movement to another functional area will be reported to Security.

8. EPW's will be fed either on the ward or in the general mess. If allowed to eat in the general mess, EPW's will be accompanied by MP guards.

E. **RESPONSIBILITY:**

CMAA/Security.

TAB C-13

**CASUALTY WITH UNEXPLODED ORDNANCE EMBEDDED**

A. **PURPOSE:** To provide guidance in admitting, processing, and treating a casualty who has unexploded ordnance embedded in a body part.

B. **DEFINITION:** An explosive device (most often from a rifle grenade fired at close range) which has not travelled sufficient distance for fuse detonation and explosion, and is embedded in the body of a casualty.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

Sandbags.

D. **CRITERIA:**

1. Sandbags will be stored outside Casualty Receiving Area.

2. Ordnance removed from the casualty's body without detonation.

3. Ordnance removed from the hospital environment without detonation.

4. Ordnance disposed of safely.

E. **STEPS:**

1. Prepare sandbags.

(a) Casualty Receiving Senior Corpsman is responsible for filling bags with sand and storing bags in a sheltered area outside Casualty Receiving.

(b) Prepare sandbags when setting up area.

2. Care of casualty with unexploded ordnance.

(a) Place casualty in area removed from other casualties and personnel.

(1) Keep casualty outside, if possible.

(2) If inside, stack sandbags around the casualty.

(3) Have absolute minimum of personnel near

casualty.

(b) Call Security and have them summon an explosive ordnance disposal expert.

(c) Upon determination of what the ordnance is, take additional safety precautions as determined by the attending surgeon in conjunction with the explosive ordnance disposal expert.

(d) Prepare casualty for removal of ordnance as soon as practicable. If in the OR, stack sandbags around the casualty and immediate operating personnel. All other personnel remain outside the perimeter of sandbags.

(e) Tag inpatient record chart to alert other personnel to the presence of unexploded ordnance prior to transfer from initial intake point.

(f) After removal of the unexploded ordnance, give it to the explosive ordnance disposal expert, who will then dispose of the ordnance in a safe and appropriate manner.

F. **RESPONSIBILITY:**

1. Casualty Receiving Senior Corpsman.
2. Admitting clerk.
3. Surgeon.
4. Explosive ordnance disposal expert.

**TAB D**  
**CLINICAL POLICIES/GUIDLELINES**

**INDEX**

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## TAB D-1

### GENERAL CLINICAL POLICIES

#### A. General.

1. Austere but adequate health care will be adhered to in the Deployable Medical Systems (DEPMEDS) and is defined as:

(a) Austere Health Care. Equipment limited to strictly need to have simple, high Reliability Availability Maintainability (RAM) materials that augment the physician's basic ability to render medical care or make a medical decision.

(b) Adequate Health Care. Support is sufficient to provide a level of care that will give a mortality and morbidity rate no greater than 5% of Wounded in Action (WIA), 1% mortality, and 5% morbidity non-battle casualty rate in the Echelon 3 health facility.

2. Initial resuscitation should be prompt, adequate and at the site of injury or as far forward as possible. These resuscitation efforts should follow Advanced Trauma Life Support/Advanced Cardiac Life Support (ATLS/ACLS) standards.

3. Those soldiers capable of returning to duty must be evaluated and treated at the lowest possible level of care.

4. Wounded in action and non-battle injuries will be evacuated expeditiously to the appropriate level of treatment for initial wound therapy.

5. Initial wound surgery will consist of those procedures necessary to stabilize a patient sufficiently to save life and limb as well as those required to stabilize neurological, vascular, bone and joint wounds and injuries.

6. Individuals wounded in action will be provided initial surgery as soon as possible, ideally within six hours.

7. The patient being moved from NATO Echelon 3 to Echelon 4 must be stable enough to tolerate a 6-hour bed-to-bed move. This stabilization time is from the aeromedical staging facility to the next echelon hospital bed. A patient in the strategic aeromedical evacuation system should tolerate a 24-hour bed-to-bed move. A stable patient is one who, in the best clinical judgement of the responsible physician, can withstand a bed-to-bed evacuation of 6-24 hours duration with a high probability of not sustaining complications requiring invasive treatment or intervention beyond the scope of general

nursing care during evacuation.

8. All patients who will return to duty within the 30 days will be kept at Echelon 3. The patient returning to duty between 30 and 60 days will remain at Echelon 4.

9. When a surgically wounded patient in warfare is not progressing well, particularly with evidence of sepsis, reoperation should be prompt.

## TAB D-2

### INFECTIOUS DISEASE POLICIES

#### A. General.

1. Infectious Disease as a specialty will be available in a consultative role in the theater. This provision will be serviced specific function.

2. The Infectious Disease specialist will provide consultation and liaison with preventive medicine personnel at all echelons within the theater of operations.

3. In general, a medical specialist will be responsible for follow-up care on all patients with infectious disease problems that have been consulted on by an Infectious Disease specialist.

4. The theater surgeon will develop and publish a fever evacuation policy based on the threat of the area, the tactical situation, time of year, and overall preventive medicine aspects of the force.

5. Patients with sustained fever of greater than 103o F (39.1o C) (without an obvious infectious disease process, such as, tonsillitis) on two separate occasions which is cyclic in nature and where malarial diseases are endemic, will be assumed to have a serious febrile illness, and will be evacuated to echelon 3.

6. There will be an attempt to identify specific etiological agents within the limits of theater resources.

#### B. Antibiotic Policies.

1. Antibiotic use. The Defense Medical Standardization Board (DMSB) will publish, at appropriate intervals, a list of patient conditions in which antibiotics should or should not be used. Generally, all open trauma cases will receive antibiotic therapy and closed injuries will not. The preferred route of administration will be parenteral in all cases of major open injuries.

2. Specific antibiotic schedules. A quad-service panel of consultants will review and publish annually a schedule of antibiotics to be used in the defined patient conditions. The panel will consider military scenarios, antibiotics in the current supply system, causative agent risk, and list choices by rank. The panel will also make recommendations to the Defense Medical Standardization Board (DMSB) in the

introduction of new antibiotics (and deletion of old) in DEPMEDS.

3. In the management of the conditions defined, the decisions of the DMSB and panel will be mandatory unless an individual circumstance of the patient contraindicates this management.

4. Publication. Each service will develop its own procedures for disseminating and implementing the current antibiotic policy.

## TAB D-3

### INFECTION CONTROL POLICIES

- A. Aseptic techniques (with each hand gloved) will be maintained when the patient's condition requires an invasive procedure (i.e., operator procedure, dressing change, ET/Tracheostomy care).
- B. Handwashing is essential before and after each patient contact. This should be accomplished with running water and an antimicrobial soap. An alcohol-based cleanser is acceptable in the absence of soap and water.
- C. Disease specific isolation procedures will be accomplished as best as possible within the theater of operations. The rationale for utilizing disease-specific precautions rather than an alternative isolation system (category-specific) is conservation of supplies and reduction of expenses. See Table I.
- D. Intravascular Access Therapy will follow in Table II, remember also to:
1. Change all IV fluid containers every 24 hours.
  2. Handle all intravascular devices with aseptic techniques.
  3. Change, at the earliest opportunity, all IVs started under dirty conditions. It will be assumed that all patient IVs initiated at echelon 2 will have been performed under aseptic conditions.
- E. All open fluid containers will be changed and/or discarded after 24 hours (IV, irrigation, respiratory therapy).
- F. All laboratory specimens, blood and body fluids, obtained on patients with potential infectious diseases, are to be considered infectious.
- G. Linen and trash must be removed from patient care areas at a minimum of every 12 hours.
- H. Reusable equipment will be cleaned and disinfected between each patient. Disposable equipment will not be reused.
- I. The isolation standards for infectious diseases will be according to the Center Disease Control (CDC) guidelines, in so far as possible. For further guidance and elaborated details, consult "Communicable Diseases in Man" (editor, Abram

S. Benanson).

**Table I**  
**Isolation Policies**

A. The following diseases would require as much isolation as possible. However, the preferred method of isolation would include private room, gowns, gloves, and masks:

<u>Disease</u>	<u>Length</u>
1. Chicken Pox	Until lesions are crusted 7-10 days/persons not susceptible, need not wear a mask
2. Diphtheria	Two negative cultures after cessation of antibiotics
3. Echovirus Disease	Seven days after onset.
4. Epiglottitis due to H. influenza	Twenty-four hours after initiation of effective therapy.
5. Erythema Infectiosum	Seven days after onset.
6. German Measles, Rubiola	Seven days after onset of rash.
7. Hemorrhagic Fevers	Duration of illness.
8. Herpes Zost	Until lesions crusted, people not susceptible, need not wear a mask.
9. Lassa Fever	Duration of illness.
10. Marburg Virus Disease	Duration of illness.
11. Hemophilus Influenza Meningitis	Twenty-four hours after initiation of effective therapy.
12. Neisseria Meningitis initiation	Twenty-four hours after initiation of effective therapy.
13. Meningococcal Pneumonia	Twenty-four hours after initiation of effective therapy.
14. Meningococemia initiation	Twenty-four hours after initiation of effective therapy.

- |  |   |
|--|---|
| 15. Multiply Resistant Organism Infection or Colonization GI tract, respiratory and skin | Until cultures are negative.  |
| 16. Mumps swelling.  | Nine days after onset of  |
| 17. Pertussis  | Seven days after initiation of effective therapy.                       |
| 18. Plague, Pneumonia  | Three days after initiation of effective therapy.                       |
| 19. Pneumonia, Staph Aureus Steptococcus, Group A  | Twenty-four to forty-eight hours after initiation of effective therapy. |
| 20. Rabies   | Duration of illness.  |
| 21. Ritton Disease (Staphylococcal scalded = kin syndrome                                | Duration of illness.  |
| 22. Smallpox   | Duration of illness.  |
| 23. Tuberculosis   | Two-to-three weeks after chemotherapy.                                  |

B. For patients with draining wounds or lesions, with diarrheal diseases/conditions, gloves should be worn by hospital personnel. When splashing or soiling is likely, gowns should be worn.

C. For the following diseases, gloves should be worn when in contact with blood/body fluids:

1. Hepatitis-B, Non-A, Non-B.
2. HIV disease.
3. Rat bite fever (Spirillum minus disease).
4. Relapsing fever.
5. Jakob - Creutzfeldt disease.
6. Leptospirosis.
7. Colorado Tick Fever.

8. Arthropod borne viral fevers (Dengue, Yellow Fever).
9. All forms of clamydial infections.
10. Mucocutaneous (Herpes, Simplex).
11. Malaria.

**TABLE II**

**Summary**

**Intravascular Access Therapy**

Documentation	Duration of Site/Needle	Dressing Change	Tubing Change
Central	Not more than 6 days	72 Hrs	72 Hrs
Peripheral, Intravenous	72 Hrs	72 Hrs	72 Hrs
Piggyback Meds	24 Hrs	N/A	24 Hrs

## TAB D-4

### NUTRITIONAL CARE POLICIES

A. The following basic diets will be available at Echelon 3 and 4 utilizing the Hospital B Ration: regular (hospital high protein), clear liquid, full liquid, and dental liquid. The regular diet can be modified for consistency, i.e., cut meat and dental soft.

B. Nutrition care provides forced fluids and supplemental nourishments. Tube feedings will be prepared and transported to the wards three times per day if a powdered product is supplied. If canned tube feeding products are supplied, nursing personnel will obtain them directly from logistics.

C. There is a limited capability at both Echelons 3 and 4 to provide certain additional dietary modifications, i.e., low protein, low sodium, low fat, and low residue.

D. Dietitians will respond to consults for nutritional assessment and intervention.

**TAB D-5**

**PHYSICIAN'S UTILIZATION GUIDELINES**

- A. The primary physician's treater in the EMT/Pre-op is the Emergency physician. Other specialists provide consults as appropriate.
- B. There is a need to develop a secondary treater for all possible tasks.
- C. Physician's specialty follow-up on wards will be two 10-minute visits for ICU and one 10-minute visit every 3 days on the ICW. There will be no specialty follow-up on MCWs. The primary physician on the MCW is the General Medical Officer.
- D. Since there will be a great demand for surgeon's time, some surgical patients, for example, closed head injuries are followed by a neurologist or internist. Also, some surgical patients will be cared for in the immediate post-op period (first day or two) by a surgeon and then followed by a non-surgeon.
- E. Consultative time for physicians will be 30 minutes.
- F. The emergency physician in EMT will perform a complete work-up of all patients going to OR, however, patients not requiring surgery will have only those tasks performed in EMT required to validate the patient status. The patient will have a complete work-up performed by the Ward Medical Officer.
- G. All specialists consulting in EMT will perform three tasks totaling 16 minutes for each episode.

**TAB E**  
**STANDARDS AND JOB DESCRIPTIONS**  
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E-2 93	Emergency Cardio Resuscitation Kit
E-3	Job Descriptions
E-3.1 95	Director, Medical Services Job Description
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E-3.3 99	Ward Medical Officer Job Description
E-3.4 101	Treatment Team Physician in Casualty Receiving Job Description
E-3.5 102	Physicians Assistants Job Description

**TAB E-1**

**SAFETY PRECAUTIONS**

- A. **PURPOSE:** To maintain a safe, clean environment.
- B. **DEFINITION:** N/A.
- C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**
1. Needle destruction box.
  2. Sink.
  3. Bedpan washer.
  4. Cleaning materials.
- D. **CRITERIA:**
1. All broken equipment will be removed from ward for repairs as defect is discovered.
  2. Nursing personnel will be instructed on proper techniques in lifting and handling patients and equipment.
  3. Hospital procedures for disposal of wastes will be followed.
- E. **STEPS:**
1. General precautions.
    - (a) Enforce NO SMOKING regulations.
    - (b) Wipe up spills immediately.
    - (c) Display signs to denote:
      - Hazardous materials in use
      - Wet floors
      - Oxygen in use
      - Isolated areas
    - (d) Keep passageways clear of furniture, equipment, and debris.
  2. Needle precautions.

- boxes.
  - (a) Dispose of used needles in needle destruction
  - (b) Report needle stick to charge nurse immediately.
  - (c) Get medical attention IAW NAVMED P-5010.
  - (d) Store needles and syringes in an appropriate section of the ward medical locker.

3. Waste precautions.

- (a) Handle hazardous wastes (i.e., excretions, sera, blood, etc.) IAW guidelines established by Environmental Health Department.
- (b) Clean bedpans in Clinical Workspace, only.
- (c) Prepare specimens in Clinical Workspace, only.

4. Personal safety.

- (a) Use good body mechanics when transporting litters, lifting or positioning patients IAW TAB H-1, Pages 3-29.
- (b) Avoid x-ray exposure.
  - (1) If possible, leave area when x-ray is being taken.
  - (2) Wear a lead apron if you must remain with patient.
- (c) Wash hands between each patient whenever possible.
- (d) Use caution when breaking a glass ampule to avoid cutting fingers. Use a file and cover finger tips with a piece of gauze for protection.

5. Patient safety.

- (a) Identify patients at high risk for falls. Those who:
  - (1) Are receiving narcotics or sedatives.
  - (2) Are disoriented or debilitated.

(3) Require ambulation devices such as crutches, canes, etc.

(b) Prevent patient falls and mechanical ambulation injuries.

(1) Teach patients to use ambulatory devices correctly.

(2) Assist weak patients with ambulation.

(3) Ensure patients wear proper footwear when ambulating.

(c) Beds and examining tables.

(1) Caution patients to turn slowly in bed due to narrowness and height of table/bed.

(2) Attend patients frequently while they are are on examination table.

(3) Restrain patient as necessary using safety straps.

(4) Strap unattended patients to bed using abdominal body strap.

(d) Chairs/wheelchairs.

(1) Attend patient in chair if condition warrants.

(2) Lock wheels on wheelchair in transferring patient from chair to bed.

(3) Caution patient never to step on foot rest of wheelchair.

(e) Leather cuff restraints.

(1) Use leather cuff restraints to protect patients from self-injury and infliction of injury on others.

(2) Explain to patient that restraints are protective not punitive measures.

(3) Allow moderate movement of extremities.

(4) Check circulation on restrained extremities every 2 hours.

(5) Change patient's position every 2 hours to prevent discomfort, muscle and nerve damage, and skin breakdown.

(6) Remove restraints one at a time to do range of motion exercises every 4 hours.

(7) Provide skin care to extremities every four hours.

(f) Heat applications.

(1) Ensure that all equipment is in proper working order.

(2) Observe patient closely to prevent burns.

(3) Apply heat lamp at a safe distance from patient for 15 minutes per treatment.

6. Environmental safety.

(a) Avoid electrical shock.

(1) Use extension cords in accordance to command policy.

(2) Use only grounded electrical equipment unless cleared through Medical Repair Division.

(3) Prevent shock and fire by checking electrical cords for defects and fraying.

(b) Oxygen safety regulations.

(1) Display "Oxygen in Use" sign.

(2) Chain or support all oxygen cylinders in holders.

(3) Do not use oil, grease, or flammable liquid on equipment.

(4) Prevent static electricity by not using wool materials.

(5) Remove antiseptic tinctures and alcohol from immediate oxygen environment.

(6) Keep oxygen storage free of combustible

material.

(7) Monitor cylinder pressure readings. Change cylinder if p.s.i. is 100 or less.

(8) Keep wrench with cylinder.

F. **RESPONSIBILITY:**

1. Charge Nurse.
2. Senior Corpsman.

**TAB E-2**

**EMERGENCY CARDIO RESUSCITATION KIT**

A. **PURPOSE:** To provide appropriate supplies/equipment needed during emergency situations.

B. **DEFINITION:** N/A.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Emergency Cardio Resuscitation Kit (Sparks Kit).
2. Emergency Kit Inventory List.
3. Departmental Log.

D. **CRITERIA:**

1. Emergency Cardio Resuscitation Kit is readily accessible.
2. Kit is completely stocked and inventoried when seal is intact.
3. Oxygen cylinders, wrenches, and seals on Emergency Cardio Resuscitation Kit will be checked every watch.

E. **STEPS:**

1. Emergency Cardio Resuscitation Kit will be located in the Specialty Treatment Area at all times. It will be used only for cardio resuscitative emergencies.
2. Senior Corpsman on each watch will check to ensure seals have not been broken, and oxygen pressure in cylinders is sufficient, that is psi is not less than 500.
3. Inventory Emergency Cardio Resuscitation Kit every three months or when seals have been broken.
4. Check daily the Emergency Kit Inventory List posted on the outside of kit for drug expiration dates.
5. Make appropriate entries in the Departmental Log.
6. Senior Corpsman will be responsible for re-supplying kit during normal working hours. The Watch LPO assumes this responsibility at other times.

F. **RESPONSIBILITY:**

Senior Corpsman or his representative.

**TAB E-3.1**

**DIRECTOR, MEDICAL SERVICES JOB DESCRIPTION**

The Director, Medical Services is responsible to the Commanding Officer for the coordination and efficient operation of the medical services of the command. The Director, responsible directly to the Executive Officer, acts independently upon medical matters which do not require the personal direction of the Executive Officer or Commanding Officer but keeps them apprised of actions taken.

THE DIRECTOR MEDICAL SERVICES WILL:

1. Provide medical officers for twelve (12) clinical areas, including nine (9) wards, Casualty Receiving Area, OR Prep and Hold, and Specialty Treatment Area.
2. Define and implement the philosophy, objective, and standards for medical practice in a combat zone hospital.
3. Ensure that the hospital's medical services comply with accepted standards of medical practice.
4. Establish an organizational plan to delineate responsibility and accountability of assigned personnel.
5. Maintain a system of records and reports which reflect the qualifications, experience, and activities of assigned personnel.
6. Continually evaluate, observe, and analyze the functions of Medical Services, and institute actions to meet the overall departmental needs.
7. Direct, plan, coordinate, implement, and evaluate activities related to medical care of patients.
8. Organize and direct education and training to assigned medical officers.
9. Co-ordinate Medical Service activities with those of other departments promoting cooperative efforts and interest in patient centered care.
10. Ensure the adequacy, security, maintenance, proper use, economy, and accounting of supplies and equipment.
11. Participate in establishing Fleet Hospital policies.
12. Perform other appropriate functions as directed by higher

authority.

QUALIFICATIONS:

1. Designator 2100/2105
2. Board Certified Internal Medicine Physician with subspecialty code 0101.
3. Fully credentialed.
4. Advanced Trauma Life Support (ATLS) certification recommended.
5. Advanced Cardiac Life Support (ACLS) certification required.
6. LMET
7. Completion of Fleet Hospital Operations and Maintenance orientation course.
8. Previous experience in senior management level position.

**TAB E-3.2**

**HEAD, MEDICAL SERVICES JOB DESCRIPTION**

The Head, Medical Department is responsible for medical care given to patients on ICU wards in the hospital. He reports to the Director, Medical Services.

THE HEAD, MEDICAL DEPARTMENT WILL:

1. Primarily be assigned to Ward ICU2 for the night watch.
2. Assist Director, Medical Services in setting policies and procedures for medical care provided by the hospital.
3. Ensure that a medical officer evaluates each new ICU admission.
  - a. History and physical exam is performed within 24 hours of admission and is recorded on SF 539.
  - b. A primary diagnosis is assigned to patient.
  - c. Doctors orders are recorded on SF 508 and are signed.
  - d. Progress notes are updated daily.
4. Assign medical specialist to a case as diagnosis warrants.
5. Make daily rounds to patients on ICU ward at beginning of watch.
6. Be on call to the Specialty Treatment Area.
7. Demonstrate expertise in performing medical emergency procedures.
8. Monitor medical care given by nurses and corpsman on ICU ward.
9. Supervise work performance of all personnel assigned to medical department.
10. Conduct weekly meeting with departmental staff.
11. Participate in orientation and training program for departmental staff.
12. Provide training lectures to ward medical officers about medical diagnoses and treatment protocols.

13. Consult with Ward Medical Officers as needed.
14. Serve on hospital committees as assigned.
15. Approve all performance evaluations prepared for assigned personnel.
16. Monitor departmental evaluative standards and initiate training as needed.
17. Prepare and submit required reports to Director, Medical Services.

QUALIFICATIONS:

1. Designator 2100/2105 Physician
2. Board Certified Internal Medicine Physician with subspecialty code 0101.
3. Fully credentialed.
4. Advanced Trauma Life Support (ATLS) certification recommended.
5. Advanced Cardiac Life Support (ACLS) certification required.
6. Intermediate leadership, management, and training certification recommended.

### TAB E-3.3

#### WARD MEDICAL OFFICER JOB DESCRIPTION

The Ward Medical Officer, is responsible for all medical care given on the nursing ward. He reports to the Head, Medical Department.

##### THE WARD MEDICAL OFFICER WILL:

1. Set policies and procedures for medical care given on the ward.
2. Orient Medical Officers to ward.
3. Receive report from Medical Officer on previous watch and make patient rounds prior to assuming the watch.
4. Enforce admission and discharge criteria for ward.
5. Communicate with the command duty officer, and register about the availability of beds.
6. Make patient rounds at 0830 daily and as needed during watch to evaluate/reassess each patient. Formulate an appropriate treatment plan. Determine suitability for discharge or transfer patient.
7. Write orders and daily progress notes on patients charts.
8. Review all laboratory data, x-rays, and other diagnostic test results.
9. Review all medications and renew antibiotics, narcotics, and other controlled drugs IAW pharmacy policies.
10. Respond to cardiac arrests on wards during his watch.
11. Sign S.L. and V.S.L. List. Pronounce patients at time of death and write death note on NAVMED 6320/5.
12. Participate in an orientation and training program.
13. Prepare and submit required reports in final form.

##### QUALIFICATIONS:

1. Designator 2100 physician.
2. Advanced Trauma Life Support (ATLS) certification recommended.

3. Advanced Cardiac Life Support (ACLS) certification required.
4. Intermediate LMET graduate.
5. Fleet Hospital Operations Course graduate.

**TAB E-3.4**

**MEDICAL OFFICER ON CASUALTY RECEIVING AREA TREATMENT TEAM**

The Medical Officer on the treatment team reports to the Head, Casualty Receiving Area.

THE MEDICAL OFFICER WILL:

1. Serve as Team Leader on treatment team.
2. Perform primary assessment on patient.
3. Direct resuscitative measures to be implemented by other team members (nurse, Corpsman A, Corpsman B, Anesthesia staff, and Physician Assistant).
4. Perform treatment procedures as necessary IAW ATLS protocols (e.g., IV cutdown, needle thoracentesis, chest tube insertion, and/or peritoneal lavage).
5. Orient and train treatment team members to perform resuscitative measures.
6. Review and sign orders and notes on SF 600.
7. Initiate a history and physical on patient on SF 539 if time permits.

QUALIFICATIONS:

1. Designator 2100/2105 Physician.
2. Emergency Medicine, Family Practitioner, or General Surgeon physicians are recommended.
3. Advanced Trauma Life Support (ATLS) certified.
4. Advanced Cardiac Life Support (ACLS) certified.
5. Intermediate LMET graduate.

**TAB E-3.5**

**PHYSICIANS ASSISTANTS JOB DESCRIPTION**

The Physician Assistant is responsible to a physician for performing specific treatment procedures in the Casualty Receiving Area or Specialty Treatment Area.

THE PHYSICIAN ASSISTANT IN CASUALTY RECEIVING AREA WILL:

1. Assist with primary assessment and triage.
2. Perform resuscitation of patients IAW ACLS protocols including intubation assists if trained.
3. Assists in placement of central lines.
4. Initiates blood transfusions, volume expander replacement therapy.
5. Applies "M.A.S.T." trousers with orders for care.
6. Write routine inpatient orders.
7. Suture minor wounds.
8. Inserts additional IV lines.
9. Monitors patient status.
10. Inserts nasogastric tubes in patients without facial trauma.
11. Applies splints and semi-rigid casting materials.
12. Draws radial ABG's, obtains femoral ABG's when indicated.
13. Stabilizes C-Spine patients.
14. Performs percutaneous peritoneal lavage.

THE PHYSICIAN ASSISTANT IN SPECIALTY TREATMENT AREA WILL:

1. In addition to watchstanding and on the job training in casualty receiving, under the direction of a Team Leader, obtain history and inpatient physical exam, monitor patient status including post-operatively.
2. Diagnosis and primary treatment that can be done by a Physician Assistant is:

- a. Trench foot.
- b. Partial thickness burns.
- c. Frostbite.
- d. Abscess management including pyoderma.
- e. Herpes zoster.
- f. Sexually transmitted diseases.
- g. Heat stressed illnesses.
- h. Gastroenterologic dehydration.
- i. Upper respiratory tract infections requiring inpatient care (pansinusitis, pneumonia, PTA).
- j. Uncomplicated UTI.
- k. Cellulitis requiring IV antibiotics.
- l. Monitor for post-traumatic (combat) stress disorders
- m. Mononucleosis.
- n. Varicella, other infectious diseases as determined by team leader.
- o. Training of RN's and HM's in Casualty Receiving Areas

QUALIFICATIONS:

1. Warrant Officer with subspecialty code 7540.
2. ACLS certified.
3. ATLS certified.

**TAB F**

**REFERENCES**

**INDEX**

<u>TAB</u>	<u>NUMBER</u>	<u>TITLE</u>
F-1	NAVMED P-117	USN Manual of the Medical Department.
F-2		Basic Cardiac Life Support (BCLS) Interim Guidelines American Heart Association.
F-3		Advanced Cardiac Life Support (ACLS) Interim Guidelines by the American Heart Association.
F-4	NAVMED P-5010	Navy Preventive Medicine Manual.
F-5	NAVMED PUB 436	Standard "B" Medical for the Armed Forces.
F-6		Guidelines for the Prevention and Control of Nosocomial Infections, U.S. Dept. of Health and Human Services.

**TAB G**

**FORMS INDEX**

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G-2	FHCZ.3202	Cardiac Arrest Flow Sheet
G-3	SF 508	Doctors Orders
G-4	SF 509	Progress Notes
G-5	SF 512	Plotting Chart
G-6	SF 539	Abbreviated Clinical Record
G-7	NAVMED 6320/5	Serious/Very Serious Condition Or Death of Patient On Ward
G-8	NAVMED 6010/14	Incident Reporting Data Sheet
G-9	FHCZ 2606	Evacuation Flow Chart
G-10		Ward Diet Roster
G-11	DD 599	Patients Effects Storage Tag
G-12	NAVMED 6010/8	Patients Valuables Envelope

TAB G-1

WATCH EMERGENCY KIT CHECK LIST  
FHCZ-0401

WARD: \_\_\_\_\_

DATE	WATCH	PERSON CHECKING SIGNATURE/STATUS	02/PSI	DISCREPANCIES	FOLLOW-UP	CHARGE NURSE SIGNATURE
------	-------	-------------------------------------	--------	---------------	-----------	---------------------------

\_\_\_\_\_ AM

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\_\_\_\_\_ NOC

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\_\_\_\_\_ AM

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\_\_\_\_\_ NOC

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