



DEPARTMENT OF THE NAVY

BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

BUMEDINST 6320.80
BUMED-311
17 Feb 94

BUMED INSTRUCTION 6320.80

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Personnel

Subj: EMERGENCY MEDICAL SYSTEMS

Ref:

- (a) Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Current Edition
- (b) DoD 6025.12-STD, Joint Healthcare Manpower Standards (JHMS)
- (c) NAVMEDCOMINST 6700.9
- (d) BUMEDINST 6320.66A
- (e) NAVMEDCOMINST 6550.5A (NOTAL)
- (f) BUMEDINST 6550.10
- (g) Ambulatory Health Care Standards Manual, JCAHO, Current Edition
- (h) NAVMEDCOMINST 6320.3B
- (i) Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985
- (j) Emergency Medicine: A Comprehensive Study Guide, American College of Emergency Physicians, Current Edition
- (k) BUMEDINST 6010.13
- (l) SECNAVINST 5212.5C

Encl:

- (1) Definitions
- (2) Classification of Naval Medical Center and Naval Hospital Emergency Medical Systems
- (3) COBRA Transfer Guidelines
- (4) Supplemental Instructions for Emergency Care and Treatment Record (SF 558)
- (5) Emergency Department Log (Control Register)

1. Purpose. To set forth guidance concerning organization, staffing, professional qualifications of personnel assigned, and triage procedures mandated for the safe and efficient operation of emergency medical systems (EMS). To complement the requirements for health care providers in references (a) through (l). To detail accepted procedures for documenting emergency care and treatment given to patients at naval medical treatment facilities (MTFs) under standards established by the JCAHO.

2. Cancellation. NAVMEDCOMINST 6320.9A.



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3. Applicability. Applies only to MTFs with a JCAHO level I, II, or III emergency department. All other MTFs shall meet JCAHO standards for acute care.

4. Records. Emergency Care and Treatment Record (SF 558) and the Emergency Department Log (Control Register) are the two primary records for documenting emergency care and treatment. SF 558 is only authorized for use in a level I, II, or III EMS. Those MTFs which have the Automated Quality of Care Evaluation Support System (AQCESS) capability and software may use the automated SF 558 and log available through this system. In the event a civilian ambulance service is used, copies of all medical documents completed should be acquired when feasible and retained by the command covering the beneficiary population.

5. Definitions. See enclosure (1).

6. Policy. Beneficiaries shall have access or referral to an EMS for treatment. All naval MTFs shall have the capability to determine if a patient care emergency exists and to initiate life and limb saving measures before transporting the patient or providing definitive treatment to a civilian or military MTF.

7. EMS Capability

a. Hospital-based EMS are classified as level I, II, or III, following standards established by reference (a).

b. Level I EMS. A level I emergency medical department or service offers comprehensive emergency care 24 hours a day with at least one physician experienced in emergency care on duty in the emergency care area. There shall be in-hospital physician coverage by members of the medical staff or by senior-level residents for medical, surgical, orthopedic, obstetrical, gynecological, pediatric, and anesthesiology services. When such coverage can be demonstrated to be met suitably through another mechanism, an equivalency shall be considered to exist for purposes of compliance with the requirement. Other specialty consultation shall be available within approximately 30 minutes. Initial consultation through two-way voice communication is acceptable. The hospital's scope of services shall include in-house capabilities for managing both physical and related emotional problems on a definitive basis.

c. Level II EMS. A level II emergency department or service offers emergency care 24 hours a day with at least one physician experienced in emergency care on duty in the emergency care area. There shall be specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. Initial consultation through two-way voice communication is acceptable. The hospital's scope of

services shall include in-house capabilities for managing both physical and related emotional problems with provision for patient transfer to another facility when needed.

d. Level III EMS. A level III emergency department or service offers emergency care 24 hours a day with at least one physician available to the emergency care area from within the hospital, who is available immediately through two-way voice communication. Specialty consultation of the attending medical staff member shall be available by request or by transfer to a designated hospital where definitive care can be provided. In addition to JCAHO requirements for an EMS designated as level III, a physician shall be physically present in the MTF. The physician does not have to remain in the emergency care area, but shall be available immediately by two-way voice communication.

e. The MTF commander or commanding officer shall determine the level of EMS that can be provided. Each MTF shall be responsive to the health care needs of the population served; however, the designated EMS level cannot exceed the resources of the MTF and shall conform to JCAHO standards. Each MTF shall provide the highest EMS level of care consistent with its overall capability and comply with reference (a) and this instruction. A current classification of EMS is contained in enclosure (2). Approval to change the existing designation of a level I, II, or III EMS shall be obtained from Chief, Bureau of Medicine and Surgery (BUMED) 60 days before making any changes.

f. In situations where the availability of MTF resources does not justify establishing a level I, II, or III EMS, the commander, commanding officer, or officer in charge shall provide alternative methods of meeting emergency patient care requirements. Such arrangements will include providing for initial first aid and arranging transportation or referral of patients to other facilities with emergency care services.

g. An MTF which cannot provide a minimal JCAHO level III EMS cannot use the word "emergency" when advertising its medical and health care services availability. Information that EMS is not available at the MTF and the alternatives which are available for emergency care shall be widely disseminated to the beneficiaries served by that MTF. Signs indicating an emergency care area or emergency services capabilities can only be displayed at an MTF that operates EMS at level I, II, or III, as defined by JCAHO and the requirements of this instruction. In addition, the Emergency Care and Treatment Record (SF 558) and the emergency department log are restricted for use only at an EMS designated as level I, II, or III. Acute care facilities will use the Chronological Record of Medical Care Form (SF 600) for treatment of the acute care patient.

8. Organization of the EMS Department

a. The EMS department head shall be designated in writing by the commander or commanding officer. In a level I and II EMS, department heads shall either have: (1) completed an emergency medicine residency; (2) their application accepted to sit for emergency medicine specialty boards; or (3) board certification in emergency medicine. A level III EMS may be directed by a multidisciplinary medical staff committee, with the chairman serving as department head. The head of a level III EMS shall have experience, as determined by the commander or commanding officer, in the care and treatment of emergency patients.

b. An alternate department head shall be appointed in writing. The alternate shall be a qualified physician who is authorized to perform the functions of the department head when the department head is unavailable.

c. Medical staff assigned to the EMS department shall report to the EMS department head.

9. Staffing

a. The EMS shall have a permanently assigned staff. The staff shall include an adequate number of physicians, registered nurses, and hospital corpsmen qualified to manage all types and volumes of patients. Other personnel such as physician assistants (PAs), nurse practitioners (NPs), and medical clerks may be assigned to enhance productivity. Reference (b) contains the standard for the number and mix of staff for various ranges of emergency department visits. These numbers may be adjusted by commanders or commanding officers to accommodate additional training and operational requirements, as well as capabilities afforded by contracts in place in the EMS.

b. Clinical privileges for physicians, PAs, and NPs assigned to the EMS shall be compatible with the capabilities of the facility and based on demonstrated competence. The EMS department head shall use predetermined criteria, observation, medical record review, and personal review of credentials as the basis for recommending individuals for clinical privileges. Clinical privileges shall define those patient care activities and procedures that nonphysician health care providers can perform independently and those which require consultation or direct supervision.

c. All EMS health care personnel shall receive orientation training, including course work qualifying for current registration in basic life support (BLS), before assignment in the EMS. The EMS department head shall encourage all EMS health

care personnel to complete an advanced life support (ALS) course and pediatric advanced life support (PALS) course to supplement those personnel for whom ALS is a requirement.

d. Physician Staff

(1) For EMS designated as levels I and II, the physician staff shall be permanently and exclusively assigned to the EMS. Physicians shall have: (1) a current emergency medicine board certification; or (2) completed an emergency medicine residency; or (3) at least 3 years of emergency medicine experience and at least 3 years of residency training in another specialty appropriate to the care and treatment of emergency patients.

(2) For EMS designated as level III, physicians assigned shall have a minimum experience of 1 year in primary care. This requirement may be satisfied at the entry level by a physician who has completed the first year of post-graduate training in a specialty involving direct patient care. Physicians are then required to work under the close supervision of an EMS physician for a minimum of 3 months.

(3) Physicians assigned to facilities in the continental United States (CONUS) levels I and II EMS departments shall have successfully completed approved advanced trauma life support (ATLS) and ALS courses, and are encouraged to complete a PALS course. In level III EMS departments, assigned physicians shall have successfully completed an approved ALS or ATLS course.

(4) Clinical privileges of physicians for EMS practice shall be based on specific education, training, and experience.

(5) All interns and residents assigned to the EMS department shall be under the direct supervision of an EMS physician per reference (c).

(6) Civilian or contract physicians employed as EMS physicians shall meet the minimum training and experience requirements as active duty military EMS physicians.

(7) Any physician who is assigned temporarily to clinical duties in the emergency department shall possess clinical privileges and the minimum experience and training requirements as the EMS physicians permanently assigned to that emergency department.

(8) The assigned EMS physician is responsible for evaluating and managing the care rendered to any patient who comes to the EMS.

(9) Staff coverage for a level I, II, and III EMS is on a 24-hour-a-day basis, 7 days a week. Facilities providing only

acute care services shall have qualified physician coverage during all designated working hours.

e. Registered Nurse Staff

(1) Permanently assigned registered nurses are required in levels I, II, and III EMS. The registered nurses shall be assigned exclusively to the EMS department and are not available to be reassigned ("pulled") to support other clinical areas.

(2) A written job description for the EMS registered nurse staff shall include standards of practice, functions, responsibilities, specific qualifications, and limitations.

(3) The registered nurse responsible for the direct supervision of emergency nursing care for a level I or II EMS department shall: (1) have a master's degree in either emergency trauma nursing or critical care nursing; or (2) meet all requirements for certified emergency nurse. At level III EMS, the registered nurse responsible for the direct supervision of emergency nursing care shall have: (1) a minimum of 2 years emergency nursing experience; or (2) a nursing subspecialty code of 1945X.

(4) Registered nurses assigned to the EMS in levels I, II, and III shall have: (1) successfully completed an approved ALS course; (2) maintained current ALS registration; and (3) a minimum of 1 year of critical care inpatient hospital experience. In addition, it is strongly recommended that registered nurses successfully complete the Trauma Nursing Core Course (TNCC). Registered nurses who have not successfully completed an approved ALS course shall be assigned with a registered nurse who meets all the above requirements, and shall successfully complete an ALS course within 1 year of initial assignment.

(5) Civilian or contract nurses employed as EMS nurses shall meet the minimum equivalent training and experience requirements as active duty military EMS nurses.

f. Hospital Corpsmen Staff

(1) Before assignment, hospital corpsmen working in EMS or assigned to ambulance attendant duty shall have current certification by the National Registry for Emergency Medical Technicians (NREMT) as an emergency medical technician-basic (EMT-Basic). Current certification by the NREMT as EMT-Intermediate or EMT-Paramedic fulfills this requirement. Reference (c) provides additional guidance and training information.

(2) General duty hospital corpsmen E-5 or below ordered to outside continental United States (OCONUS) locations that do

not have an approved EMT-Basic training program shall have taken the NREMT certification examination before detaching CONUS.

g. Physician Assistants and Nurse Practitioners

(1) PAs, NPs, and other health care personnel in EMS may augment physician services, following guidance established in references (d) and (e).

(2) PAs and NPs assigned to an EMS shall have: (1) successfully completed an approved ALS course; and (2) maintained current ALS registration.

(3) PAs shall meet the minimum training requirements of the Committee on Allied Health Education Accreditation (CAHEA) and shall successfully pass the National Commission on Certification of PAs.

(4) The individual credentials files of PAs and NPs who work in the EMS shall include documentation of supplemental clinical privileges for EMS per reference (d). Utilization guidelines for NPs is provided in reference (f).

(5) NPs and PAs shall refer to an EMS physician any patient who:

(a) Requires schedule II controlled drugs.

(b) Requests to see a physician.

(c) Has a life-threatening problem.

(d) Has a multisystem injury.

(e) Has an unscheduled repeat visit for the same complaint.

(f) Has a problem beyond the scope of their clinical privileges or clinical judgement.

(g) Requires EMS physician referral, in their judgement.

(h) Requires transport or referral to another facility.

(6) If NPs or PAs work at an EMS designated as level I or II, the EMS physician shall be physically present in the emergency care area at all times. In a level III EMS, the NP or PA may provide emergency services only if an EMS physician is present in the MTF and immediately available by two-way voice communication.

(7) The EMS physician shall review and countersign the records of patients treated by NPs and PAs before the patients depart the emergency care area if possible or within 24 hours.

(8) All treatment by nonphysician health care providers during ambulance or helicopter dispatch shall follow protocols approved by the EMS department head. Treatment shall be documented at the accident scene and during transport. A designated EMS physician supervisor shall review all care provided by nonphysician personnel during ambulance or helicopter dispatch and not later than 12 hours after the patient departs the accident scene.

h. Consultants. Physician clinical specialty services shall provide and maintain an accurate up-to-date duty roster of specialty consultants posted in the EMS department. Specialty consultants shall be available as required by reference (g) and report to the EMS when requested by the medical officer on duty. Specialty consultants are staff physicians or senior residents, available within 30 minutes per reference (g). A method of communication that is simple, rapid, and efficient shall be maintained by the specialty consultants at all times to ensure expeditious access by the EMS physician and staff.

10. Triage and Transfer Protocols

a. Any eligible beneficiary with a stated or apparent health care emergency who arrives at an MTF emergency care area shall be evaluated by a designated EMS health care provider or EMS triage registered nurse. The designated provider is responsible for determining which patients require immediate treatment and which require referral either to an appropriate clinic within the MTF or to another health care facility. If referral to another facility is necessary, the patient shall first be evaluated by an EMS physician. When a non-active duty patient requires transfer to a civilian facility or provider, the disengagement process shall follow reference (h). Reference (i), though not specifically applicable to MTFs, is the Federal statute governing transfer of patients to other hospitals. This statute provides guidelines which shall be followed by most civilian EMS departments. Enclosure (3) excerpts these guidelines and should be considered when establishing MTF transfer protocols. All transfers shall comply with State and Federal statutes.

b. Patients ineligible for military health care services who come to an MTF seeking emergency care, shall be evaluated by an EMS physician. If the physician determines a patient care emergency exists, and it is inadvisable to transport (refer) the patient to a civilian treatment facility, the patient shall be treated and admitted, if required. The EMS shall have written guidelines for the transport or referral of ineligible patients to an appropriate civilian treatment facility.

c. Patients with non-urgent and minor-urgent health care problems shall be evaluated by the designated EMS health care provider or EMS registered nurse. These patients shall be treated within the EMS if staff is available and if non-urgent care does not disrupt the care of emergent or urgent patients. Otherwise, the non-urgent patients may be referred either to the appropriate outpatient clinic or to civilian health care facilities. Patients who are referred to civilian providers shall be disengaged following the guidelines established in reference (h) and provided with health benefits information and a list of other appropriate health care facilities where care may be obtained.

d. Each MTF shall have written working agreements with the surrounding civilian MTFs. These working agreements shall specify the requirements for patient referral and transfer, the mutual support disaster plan, and the means of communication among facilities.

e. A written plan shall exist at each MTF to transport or refer emergency patients for definitive treatment. The plan shall establish responsibility for the patient during transfer and set forth procedures for conveying pertinent patient care documents, such as x-rays and laboratory test results, which shall accompany the patient, as well as documentation of care already provided. The patient shall be transferred only on the order of the physician and only after the receiving hospital's consent to accept the patient. All transfers shall comply with State and Federal statutes.

f. Each ambulance dispatched shall have at least one EMT-Basic attendant. Ambulance personnel shall be under the supervision and direction of the EMS department head or their designated relief. All State and local requirements for ambulance services shall be met by each EMS. Reference (c) provides detailed guidance on ambulance support.

11. Diagnostic and Treatment Protocols. Written diagnostic and treatment protocols, as described in reference (j), shall provide basic guidelines for diagnosing and treating patient care emergencies. Protocols shall be developed or adopted by each EMS department head and used in each MTF to reflect the national standards described in reference (j). Recognizing that the EMS provider's primary expertise may not be emergency medicine, protocols shall be concise and convey the essential diagnostic and therapeutic measures to be rendered quickly by EMS health care providers. These protocols are intended as aids in preventing errors of omission. EMS health care providers may deviate from the established guidelines when clinical judgment dictates. The following components govern the scope and content of the required diagnostic and treatment protocols:

a. Patient care emergencies requiring written diagnostic and treatment protocols include, but are not limited to: chest pain, shock, altered level of consciousness, multiple trauma, seizure, abdominal pain, fever, shortness of breath, major injuries to the extremities, injuries to the central nervous system, attempted suicide, rape, eye injuries, burns, gunshot and stab wounds, animal bites, poisoning, and child or spouse abuse (including sexual abuse).

b. If applicable, each protocol shall address differences in treatment specific to patient sex and age, i.e., newborns, children, adolescents, or adults.

12. Quality Assessment and Improvement (QA&I). The MTF QA&I program shall include EMS QA&I activities.

a. The EMS quality assurance evaluation shall include monitoring and evaluating all EMS health care per reference (k). Indicators specific to the EMS are a part of the EMS monitoring and evaluating process. Emergency services QA&I review shall be documented in the provider's activity profile following reference (k).

b. The Emergency Care and Treatment Record (SF 558) shall be completed legibly and accurately to document treatment provided to patients. These records are used in determining followup care and as source documents in preparing reports.

c. The JCAHO requirement for the emergency department log, per reference (a), is used for documenting the unit of assignment or duty station for active duty members. The log shall be accessible in the MTF for at least 1 year. See reference (1) for retention of the log.

13. Education. All personnel assigned to the EMS shall be prepared adequately for the responsibilities of patient care.

a. Orientation. Each EMS department shall establish a written orientation program to inform assigned EMS staff of policies, procedures, equipment, and patient care responsibilities related to each individual's level of participation in providing emergency services. Watchstander orientation shall be comprehensive and under the direction of a medical officer with clinical expertise.

b. Basic Life Support

(1) BLS classes shall be conducted as often as necessary to maintain competence and current registration of EMS personnel.

(2) Cardiopulmonary resuscitation (CPR) drills shall be conducted at least monthly to maintain skills and proper management of cardiac arrest patients. The drills should include both adult and infant or child. CPR drills should undergo a written critique using predetermined criteria as part of the inservice education and quality assurance activities.

(3) Classes for ALS, PALS, ATLS, TNCC, BLS, and EMT-Basic certification shall be arranged on a regular basis.

c. Inservice Education

(1) Inservice classes should be planned, relevant, and based in part on the findings and evaluation of an ongoing assessment of the quality and appropriateness of care in the EMS department.

(2) The EMS department head or qualified designee is responsible for the inservice education of the EMS personnel.

(3) Individual participation in education and training activities should be documented in writing and kept on file.

14. EMS Department Policies and Procedures. The policies and procedures of the EMS shall be readily available to the staff. Specific areas which are to be addressed include triage, patient transfer, and records. Policies and procedures shall define the scope and method of treatment provided, including procedures for managing specific types of emergencies.

15. Records. The following records shall be maintained:

a. Emergency Care and Treatment Record (SF 558), to be completed for every patient, as outlined in enclosure (4). The first copy shall be retained for a period of 3 years.

b. An emergency department log of patient activity, as described in enclosure (5).

c. An identification and notification system for patients who require followup.

16. Action

a. Commanders, commanding officers, and officers in charge of MTFs shall:

(1) Commit the necessary resources, including manpower, funds, and equipment to ensure that the designated level of EMS is maintained.

BUMEDINST 6320.80
17 Feb 94

(2) Know about available health care resources at local, State, and other Federal health care facilities so unnecessary duplication of emergency services can be prevented. For example, a level I MTF which meets all the necessary JCAHO criteria, except cardiopulmonary bypass oxygenator capabilities, can still maintain level I status if a nearby hospital has such capability and written agreements are established.

(3) Use this instruction and the standards specified in references (a) and (g) as the basis for the provision of EMS.

(4) Ensure that personnel assigned to the EMS are sufficient in number and professionally competent through demonstrated skills and knowledge. Ensure support services and backup personnel are readily available.

(5) Ensure adequate education and training opportunities to meet recertification and registration requirements. Mandate personnel to participate in these programs.

(6) Maintain ongoing public information programs to keep local commands and beneficiaries aware of the availability and alternative sources of emergency health care and use all available modes of communication (e.g., staff meetings, health care consumer councils, wives' club presentations, newsletters, welcome-aboard packages, and orientation programs on base radio and television stations).

(7) Be responsible for all military EMS including ambulance services under command jurisdiction. Maintain liaison with non-Medical Department organizations that provide emergency systems for personnel assigned to Navy and Marine Corps activities.

(8) Coordinate educational programs for ALS, ACLS, PALS, ATLS, TNCC, BLS, and EMT-Basic to use available assets, avoid duplicating efforts and maintain standard operating procedures for such programs.

b. Chief, Bureau of Medicine and Surgery will:

(1) Monitor MTF compliance with this instruction.

(2) Ensure that the proper level of approved emergency services are maintained.

17. Forms. SF 600 (5-84), Chronological Record of Medical Care, NSN 7540-00-634-4176, and SF-558, Emergency Care and Treatment Record, NSN 7540-01-075-3786, are available from the Federal

BUMEDINST 6320.80

17 Feb 94

Supply System through normal supply procedures. The MTF shall develop the Emergency Department Log locally as described in enclosure (5).



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DEFINITIONS

1. Acute Care Services. Coordinated services related to the examination, diagnosis, care, treatment, and appropriate disposition of minor acute illnesses during designated working hours.
2. Emergency Care. The assessment, diagnosis, and treatment of physical or psychological conditions that are perceived to be, or have the potential to be life, limb, or function threatening or disabling, and which are primarily episodic or acute. These conditions may require minimal care or may involve more extensive measures such as life-support. Psychological treatment to prevent undue suffering associated with painful or acute conditions is included in this definition.
3. Emergency Care Area. The designated area in an MTF where the personnel, equipment, and supplies required to provide patient care emergency services are located.
4. Emergency Medical System (EMS). The organization of resources (including personnel, equipment, supplies, and space) available 24 hours a day to assess, treat, or refer for medical or dental treatment an ill or injured person. The level of EMS at an inpatient naval MTF shall be classified as level I, II, or III following reference (a) and the additional requirements of this instruction.
5. Emergent. Emergent or "critical patients" include those who require the attention of a medical officer for a condition that threatens loss of life or limb and who would be expected to benefit from immediate life saving procedures. These patients have the first priority.
6. EMS Provider. A staff provider assigned to the emergency department. These includes physicians, nurse practitioners, physicians assistants and independent duty hospital corpsmen.
7. EMT-Basic. Personnel who are certified by the NREMT after completing the Department of Transportation (DOT) curriculum or equivalent programs approved by Health Sciences Education and Training Command (HSETC). Local State registered civilian EMTs shall have 1 year to complete NREMT requirements.
8. MTF. A permanently established and authorized land-based Medical Department center, hospital, clinic, or other facility that provides medical, surgical, or dental care. This definition excludes ships and field units.
9. Non-urgent. This category includes the full spectrum of "non-chronic" natures in which there will be no increase in morbidity due to delay in treatment.

BUMEDINST 6320.80

17 Feb 94

10. Patient Care Emergency. A medical or dental condition threatening life, limb, or body functions or causing undue suffering to the patient.

11. Protocols. Written procedures providing basic guidelines for managing (i.e., diagnosis and treatment) specific types of medical or dental patient care emergencies.

12. Urgent. Urgent or "serious patients" are those who don't require immediate medical attention but in whom delay of evaluation and treatment could produce increased morbidity or even mortality.

BUMEDINST 6320.80
17 Feb 94

CLASSIFICATION OF NAVAL MEDICAL CENTER AND NAVAL HOSPITAL
EMERGENCY MEDICAL SYSTEMS

Level I

NAVMEDCEN Bethesda
NAVMEDCEN San Diego

Level II

NAVHOSP Bremerton
NAVHOSP Camp Lejeune
NAVHOSP Camp Pendleton
NAVHOSP Charleston
NAVHOSP Jacksonville
NAVHOSP Millington
NAVMEDCEN Oakland
NAVHOSP Orlando
NAVHOSP Pensacola
NAVMEDCEN Portsmouth

Level III

NAVHOSP Beaufort
NAVHOSP Cherry Point
NAVHOSP Corpus Christi
NAVHOSP Great Lakes
NAVHOSP Groton
NAVHOSP Guam
NAVHOSP Guantanamo Bay
NAVHOSP Lemoore
NAVHOSP Long Beach
NAVHOSP Naples
NAVHOSP Oak Harbor
NAVHOSP Okinawa
NAVHOSP Patuxent River
NAVHOSP Roosevelt Roads
NAVHOSP Rota
NAVHOSP Sigonella
NAVHOSP Yokosuka
NAVHOSP 29 Palms

Enclosure (2)

COBRA TRANSFER GUIDELINES

1. Basic requirements:

a. Provide a medical screening examination sufficient to determine whether they have an emergency medical condition (EMC) as defined by the act, using all available resources of the hospital, including on-call personnel, that are routinely available to the EMS.

b. Treat and stabilize patients with EMCs to the extent of the MTFs capability.

c. Provide a medically appropriate transfer as defined by the act to those patients whose conditions exceed the ability of the hospital to treat.

2. The duty to provide a medical screening examination applies only to hospitals that maintain an emergency room (ER). But JCAHO accredited facilities that list their capabilities as "level 4" may be considered to have an ER for purposes of COBRA.

3. EMCs include life threatening emergencies plus those that might result in impairment to the organ or dysfunction to any organ or part of the body.

a. The definition of EMC expressly applies to pregnant women experiencing contractions. The only way that a pregnant female experiencing contractions can be stabilized is to deliver the fetus and placenta. This means there shall be objective criteria for uniform medical screening examinations for both the ER and labor and delivery to be able to justify any decision to send a patient home or to another facility.

b. Undiagnosed pain is an EMC unless ruled out by appropriate testing.

4. Transfer is defined as any time a patient leaves a hospital, including discharge. The exception is if the patient leaves dead or against medical advice.

5. Stabilize under COBRA means the patient is stabilized if there is no reasonable likelihood that the patient's condition shall materially deteriorate from or during transfer. A different definition as noted above applies to pregnant females. Vital signs are only one component in the determination of stability for transfer. Physicians shall project out the possible adverse turns of events during and after a transfer to ensure stability.

17 Feb 94

6. Patients who have an EMC shall be provided such additional care and treatment, within the capabilities of the hospital, as required to stabilize their condition. Once treated and stabilized, or if not suffering from an EMC after having been provided a medical screening examination, the patient can be transferred.

7. If the patient cannot be stabilized to COBRA standards, the patient may be transferred only if the benefits expected from proper treatment at the receiving facility outweigh the risks of transfer. The physician shall execute medical record documentation listing the risks and benefits the physician considered. Additionally written informed consent from the patient should be obtained.

8. A medically appropriate transfer requires that:

a. The hospital shall provide all additional care within its capabilities to minimize the risk to the patient.

b. The hospital shall locate a hospital that has the available space and personnel to treat the patient, and that hospital shall accept the patient in transfer.

c. The hospital shall send along copies of all medical records when the patient is transferred.

d. The transfer shall be effected through appropriate transfer vehicle with qualified personnel and necessary life support equipment.

SUPPLEMENTAL INSTRUCTIONS FOR
EMERGENCY CARE AND TREATMENT RECORD (SF 558)

1. Completion of SF 558. Complete an SF 558 for every patient provided emergency care or treatment in the EMS. Specific instructions for completing and filing the SF 558 are printed on the back of the form. The following are general instructions:

a. Provider's Statement. If a patient refuses to sign the SF 558, declines to follow medical instructions, or leaves the EMS against the provider's advice, document the facts and circumstances of the situation in the "Provider's Statement" block.

b. Disposition. When a patient is transferred to another hospital after being treated in the EMS, the "Other" category in the "Disposition" block shall be completed stating where the patient was transferred (i.e., Department of Veterans Affairs hospital, civilian hospital, etc.).

c. Provider's Signature. If the provider of care is a non-physician health care provider, that practitioner may sign the SF 558 as the "provider of care," but a physician shall countersign the form before the patient leaves the emergency care area if possible, or within 24 hours.

d. Patient Instructions. If a special instruction sheet is provided to the patient, a completed copy shall be attached to the original SF 558 and filed in the treatment record. If a routine instruction sheet is provided to the patient, documentation shall be made in the "Patient Instructions" block, but it is not necessary to include a copy of routine instructions in the treatment record. The "Patient Instructions" block need not be completed if the patient is transferred or admitted to the hospital.

e. Log Number. Enter the number assigned to the patient on the emergency department log (see enclosure (5)).

2. Restrictions. The SF 558 is only authorized for use in a level I, II, or III EMS. There are no exceptions or waivers to this restriction.

3. Distribution of SF 558

a. The original SF 558 is the copy of record and shall be filed in the patient's treatment record. (For purposes of this instruction a treatment record refers to inpatient records, health records, outpatient treatment records, and civil service medical records.) When filed in the health, outpatient treatment

BUMEDINST 6320.80

17 Feb 94

or civil service medical record, the SF 558 shall be interfiled in chronological order with the SF 600. (See instructions on back of the SF 558 for additional information.)

(1) When a patient treated in the emergency department does not have a treatment record at the facility where treated and is not hospitalized, the original SF 558 is forwarded to the medical facility having custody of the treatment record for inclusion in the patient's file.

(2) When a patient is hospitalized, the original SF 558 is filed in the inpatient record.

(3) When a patient does not have a treatment record, one is established and the original SF 558 filed in the record.

(4) When a patient is transferred to another military facility, the original SF 558 is filed in the patient's treatment record and the record forwarded with the patient.

(5) When a patient is transferred to a civilian facility the original SF 558 shall be filed in the patient's treatment record and the record retained at the transferring facility. An extra copy of the SF 558 shall be made and forwarded with the patient.

b. First Copy. The first copy of the SF 558 is for in-house use daily. This copy of each SF 558 prepared is reviewed by the head of the EMS department. Subsequently, the MTF forwards the copy in the following sequence: (1) to patient administration to serve as a source document for initiating line of duty, accident or injury, third party liability, and other forms; and then (2) back to the ER for retention for 6 months. This copy of the SF 558 is then destroyed as a non-record copy. Clinics and other treatment facilities shall follow the above procedures that apply and as further modified or implemented by their parent command.

c. Second Copy. The second copy of the SF 558 is the patient copy and is used exclusively for this purpose. Give to the patient whenever the "Patient Instructions" block is completed. If the patient is transferred or admitted to the hospital and no instructions are provided, this copy is destroyed.

EMERGENCY DEPARTMENT LOG (CONTROL REGISTER)

1. MTFs having an EMS shall maintain an emergency department log.

2. The log shall include the data columns listed below. Complete each column for every patient treated in the EMS (including patients who are dead on arrival).

- a. Patient log number
- b. Name
- c. Age
- d. Sex
- e. SSN of member or sponsor
- f. Date
- g. Time and means of arrival
- h. Nature of complaint or diagnosis
- i. Name and type of provider
- j. Treatment
- k. Disposition
- l. Time of departure

3. The patient log item "a" above is assigned in the same manner as a register number is assigned to an inpatient. It consists of seven digits assigned sequentially as follows:

a. First Digit/Letter. This represents the month in which the patient was treated. For January through September, code as "1" through "9." For October, November, and December, code as "O," "N," or "D."

b. Second Digit. This represents the last digit of calendar year in which the patient was treated. For example, if the year was 1993, code as "3."

c. Third through Seventh Digits. These are five-digit sequential numbers starting with 00001, 00002, etc. A new series starts each month.

d. Example. The fifth patient treated in the emergency room during January 1993 would be assigned patient log number 1300005. All numbers shall be assigned. None may be skipped or left unused during the month.

4. Emergency department log entries shall be completed as soon as possible after treatment is rendered. The emergency department nursing supervisor ensures that all log entries for each patient treated, released, admitted, or transferred during their shift are completed before being relieved from duty.

5. Emergency department log records shall be retained per reference (1).