MEDICAL STAFF RULES & REGULATIONS

03/29/2013
SECTION ONE - GENERAL

1.1 PATIENT ADMISSION, TRANSFER, DISCHARGE & RESPONSIBILITY OF CARE

Swedish Medical Center (SMC) accepts acute medical, surgical, obstetrical patients for care and treatment within the limitations stated here and in other policies and procedures.

1.1.1 Assignment of Patients to Service

All patients are assigned when possible to the service concerned in the treatment of the problem or disease which necessitated admission. Emergency patients requiring admission will be admitted to the service most clearly indicated by the patient's condition.

When available, persons requiring admission who do not have a private attending Practitioner may be admitted to a teaching program. The patient shall be assigned an attending Practitioner who may also be a teaching attending, if appropriate, under the policies and procedures of the teaching program. All such patients admitted to a teaching program are “teaching cases” unless otherwise specified by the private attending Practitioner. Such patients may be transferred to a non-teaching unit or service with the approval and at the direction of their attending Practitioner.

1.1.2 General Responsibility of Care

The attending Practitioner is responsible for the medical care and treatment of each patient, except when transfer of responsibility is affected pursuant to Section 1.2 hereafter.

The attending Practitioner is the admitting physician. This can be changed with the agreement of both the current attending or covering physician, and the accepting physician in accordance with Section 1.2.

All consultations for general medical/surgical admissions (including Telemetry) shall be completed within 24 hours of request by a licensed independent practitioner with appropriate clinical privileges.

If emergent consult is necessary, the requesting physician shall personally communicate such to the consulting physician. Requests for routine (non-urgent) consultations may be documented in the progress notes/orders by using the prescribed Request for Consultation Form. The ultimate responsibility for securing the necessary consultation is upon the requesting physician.

If a physician cannot be found in a timely manner to perform an essential inpatient consultation and the patient’s medical care is compromised because of this, then transfer to a facility where a consultation can be obtained should be considered.

Practitioners must respond to calls from nursing units within 30 minutes or less.

1.1.3 Alternate Coverage

Whenever a member of the Medical Staff will be out of town or otherwise unavailable to provide for the continuing care of his hospital patients, he must indicate, or have his designee indicate, the name and telephone number of the Practitioner with whom the Medical Staff member has made prior arrangements for assuming responsibility for the care of his/her hospital patients during his/her absence. The covering physician shall also be a member of the Active Staff. Such indication may consist of a written order in the patient's record of who will be providing care to the patient during the Medical Staff member's period of unavailability or it may be given to the nursing staff by other means.

It will, however, be the responsibility of the Medical Staff member to ensure that this information regarding coverage is documented and available to the nursing staff. If there is no indication that proper coverage for the patient has been provided, it will be assumed that the Medical Staff member is available. If the Medical Staff member thereafter does not respond to calls, he/she may be subject to corrective action under the Bylaws of the Medical Staff. In the absence of designation of alternative coverage, and when the Medical Staff member does not respond to calls, the following have the authority to call any member of the Medical Staff qualified to care for the patient: Section Chair; Medical Staff President; Department Chair; Hospital Administration; any Emergency Department physician.
1.2 TRANSFER OF RESPONSIBILITY BETWEEN PRACTITIONERS

When primary responsibility for a patient's care is transferred from one attending practitioner to another, a note covering the transfer of responsibility and acceptance of the same by the receiving Practitioner must be entered on the order sheet. For transfers from the Emergency Department to an inpatient unit, the Emergency Department Physician must write a brief summary of the patient's diagnosis, treatment and document the name of the accepting practitioner.

1.2.1 Internal Transfers

A Practitioner's order is necessary prior to any internal transfer between patient care units. The Practitioner shall write a brief summary of the patient's care in the progress notes prior to the patient's transfer.

All previous orders are cancelled when a patient is transferred to/from a critical care area, PACU, or another hospital. In such cases, all orders must be rewritten. “Continue previous orders” is not acceptable. There may be exceptions to the general rule stated above. Any such exceptions must be approved by the Governing Board. Also, as provided in the Hospital’s Do Not Resuscitate/CPR Directive Policy & Procedure, DNR orders are not cancelled when a patient is transferred to/from a critical care area or special care unit.

1.2.2 Transfer to Another Facility

(a) No patient shall be transferred to another facility, unless a Practitioner has examined the patient and determined whether an emergency medical condition exists. Any such determination shall be made and documented in accordance with the hospital's policy defining an emergency medical condition.

(b) When the responsible Practitioner is not personally present to make the decision to discharge an outpatient surgery patient or does not sign the order, the name of the Practitioner responsible for the discharge is recorded in the patient's medical record and relevant discharge criteria approved by the Medical Staff are rigorously applied to determine the readiness of the patient for discharge.

(c) After a determination has been made concerning the presence or absence of an emergency medical condition, any subsequent transfer of the patient to another facility shall be made and documented in accordance with the hospital's policy governing Outbound Transfers.

1.3 DISCHARGE OF PATIENTS

1.3.1 Required Order

A patient may be discharged only on the order, written or verbal, of the attending Practitioner or his designee. The discharge order must be timed, dated and signed. The attending Practitioner or his designee is responsible for documenting the discharge diagnosis on the patient's medical record and signing the record at the time of discharge.

1.3.2 Leaving Against Medical Advice

The Hospital's written policies regarding leaving against medical advice should be consulted and followed whenever a patient desires to leave the hospital, including the Emergency Department, against the advice of any Practitioner.

1.3.3 Discharge of Minor or Incompetent Patient

a) **Minor Patient** - An unemancipated minor or a minor who was not authorized to consent to his treatment shall only be discharged to the custody of the minor's parent(s), legal guardian(s) or to a person authorized in writing by the parent(s) or legal guardian(s), to accept the minor upon discharge. Any such written instructions concerning a minor's discharge should be made a part of the patient's medical record.

b) **Incompetent Patient** - An incompetent patient shall be discharged only to the custody of the patient's authorized representative and/or appropriate family member, as set out in the medical record, or to the legal guardian or other individual/agency appointed by a court of competent jurisdiction. Where no authorized representative, family member, legal guardian, other court appointee is available, a qualified Hospital designee can coordinate the discharge with the appropriate county, state or federal agency, and/or with the courts.
SECTION TWO - MEDICAL RECORDS

2.1 OWNERSHIP AND ACCESS

All patient medical records, including radiographic studies and pathological specimens or slides, are owned by and are the property of Swedish Medical Center. No patient record will be removed from the Hospital except pursuant to court order, subpoena or with the express permission of Swedish Medical Center’s Administration. Unauthorized removal of all or any portion of a medical record by a Practitioner may result in the initiation of disciplinary action.

Patient medical records are confidential and access to and release of such records is limited. Swedish Medical Center’s policies on use of and access to such records should be consulted and followed. Practitioners may only access patient information if they are the current providers of healthcare to the patient. All other practitioner access requires the explicit consent and authorization of the patient. In the case of a patient’s readmission, all relevant information of the patient shall be made available upon request of the attending practitioner.

2.2 REQUIRED MEDICAL RECORD CONTENT

The Medical Record shall contain the elements as described below for the various types of patients treated at Swedish Medical Center:

<table>
<thead>
<tr>
<th>Data Elements:</th>
<th>Inpt</th>
<th>Ed Pt</th>
<th>Obs Pt</th>
<th>Op With Reg or IV</th>
<th>Op With Moderate or Deep Sed/Analgesia</th>
<th>Op With Local Anes.</th>
<th>Op with GA/Aws.</th>
<th>Outpt</th>
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<tr>
<td>Identification Data</td>
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<td>X</td>
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<td>Medical history, including the chief complaint; details of present illness; relevant past; social/family histories; inventory by body system</td>
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<tr>
<td>Current meds, allergies &amp; abnormal drug reactions</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Summary of patient's psycho-social needs as appropriate to the patient's age</td>
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<td>A report of relevant physical exams</td>
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<tr>
<td>A statement on the conclusions or impressions drawn from admission history &amp; physical exam</td>
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<tr>
<td>A statement on the course of action planned for the patient for this episode of care and of its periodic review, as appropriate</td>
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<td>X</td>
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<td>Diagnostic &amp; Therapeutic orders (if ordered)</td>
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<td>X</td>
<td>X</td>
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<td>Evidence of appropriate informed consent, or if not obtainable, the reason documented in accordance with SMC’s policies on informed consent</td>
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<td>Clinical observations, including the results of therapy</td>
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<td>Progress notes made by medical staff &amp; other authorized staff</td>
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<td>Consultation Reports</td>
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<tr>
<td>Reports of operative &amp; other invasive procedures, tests &amp; their results (if performed)</td>
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<td>X</td>
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<tr>
<td>Reports of any diagnostic &amp; therapeutic procedures, such as pathology and clinical lab, radiology, and nuclear medicine exams &amp; treatments</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Records of donation &amp; receipt of transplants or implants</td>
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<td>Conclusions at termination of hospitalization</td>
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<td>Clinical resumes/discharge summaries</td>
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<td>Discharge instructions to the patient or family</td>
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<td>When performed, results of autopsy</td>
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<td>Treatment provided</td>
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<td>Evidence of known advanced directives in accordance w/ SMC's policies on informed consent</td>
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<tr>
<td>Documentation of patient leaving against medical advice if appropriate, in accordance w/ SMC's policies</td>
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<tr>
<td>Discharge Order</td>
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<td>Admitting/provisional diagnoses</td>
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<td>Specific Admitting Order or outpatient order</td>
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</table>

### 2.3 AUTHENTICATION

All orders and clinical entries (transcribed, handwritten or computer generated) in the patient’s medical record must be accurately dated, timed and authenticated. The acceptable methods for authentication include the following:

- Practitioner’s written signature or initials (facsimile or photographic copy is acceptable)
- An ED practitioner may time and date admission orders using a time/date stamp
- Rubber signature stamps are not an acceptable form of authentication at Swedish Medical Center
- Electronic authentication is acceptable only under the following conditions:
  - The Practitioner uses a unique PIN number and password;
  - The Practitioner whose signature the electronic signature represents is the only individual who has possession of or knows the password; and
  - The Practitioner has provided the Information Systems Department with a signed statement to the effect that he/she is the only one who has possession of, knows of, or will use this password.

### 2.4 USE OF SYMBOLS AND ABBREVIATIONS

“Unsafe abbreviations” as defined by the facility are not to be used by practitioners in the patient record. The Professional Review Committee will be informed of any trends in which practitioners repeatedly use unapproved abbreviations in the patient record.

### 2.5 HISTORY AND PHYSICALS

2.5.1 Completeness and Timeliness of History and Physicals

The attending practitioner must document a comprehensive history and physical examination to be filed in the medical record within 24 hours of patient admission or the registrations outlined in section 2.2. The attending practitioner may delegate this to a consultant when appropriate. However, it is the
ultimately the responsibility of the attending physician to assure that a complete and accurate H&P is completed within 24 hours and available. The history and physical examination may be dictated or legibly handwritten. If the history and physical is not recorded within 24 hours, a statement must be written explaining the deferral or omission. Any such deferrals or omissions may be referred for review to the appropriate Hospital review committee.

A History and Physical must be completed on all patients admitted to the facility within 24 hours after admission. For a medical history and physical examination that was completed within 30 days prior to admission, an update documenting any changes in the patient's condition must be completed within 24 hours after inpatient admission.

The history and physical examination report must include the following:

- chief complaint
- secondary diagnosis
- details of the present illness, including, when appropriate, an assessment of the patient's emotional, behavioral and social status
- all relevant past medical, social and family histories
- allergies
- current medications
- all pertinent findings resulting from a current assessment of all body systems, unless deferred in the Practitioner's judgment

A history and physical examination performed and recorded by a House Staff officer, an appropriately credentialed Advanced Practice Professional or non-physician Hospital employee must be authenticated by the attending Practitioner before any major diagnostic or therapeutic intervention or within 24 hours, whichever is earlier. The Emergency Room report for the current admission may be used as the History and Physical if co-signed by the admitting or attending physician and all elements above are present.

2.5.2 Surgical History & Physical

Surgery shall not be performed until after the history and physical examination has been performed, unless the operating surgeon states in writing that the patient has an emergency medical condition and a delay would constitute a hazard to the patient. The history and physical shall include the elements required under Section 2.5.1 as appropriate, and shall include the patient's preoperative diagnosis, the procedure anticipated and diagnostic studies which support the decision to operate. In emergency situations, the operating surgeon shall record a brief note, including the patient's preoperative diagnosis.

A History and Physical examination, results of indicated diagnostic tests and any appropriate updates documenting any changes in the patient's condition through out the admission must be completed in the medical record prior to the operative or other high-risk procedures.

2.5.3 Current/Recent History and Physical

A history and physical that is older than 30 days will not be accepted. If a Practitioner has obtained a complete history or has performed a complete physical examination within 30 days prior to the patient's admission to the Hospital, a durable, legible copy of the report may be used in the patient's Hospital medical record in lieu of the admission history and physical. For medical history and physical examination that was completed within 30 days prior to inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after inpatient admission or prior to surgery. The history and physical must be prepared by an appropriately credentialed Practitioner. H&Ps submitted by physicians not on this Medical Staff will be co-signed by the attending physician.

2.5.4 Obstetrical Record

The current obstetrical record must include a complete prenatal record. The prenatal record must be a durable, legible copy of the attending Practitioner's office or clinic record transferred to the appropriate Obstetrical Department before admission. An interval admission note must also be written that
includes pertinent additions to the history and any subsequent changes in the physical findings. All obstetrical patients undergoing major surgery must have a history and physical examination recorded as required by these Rules and Regulations, Section 2.5.4 or 2.5.1.

Observation: A physician exam note is required when the patient is seen and evaluated by the attending physician. If the patient is evaluated by the labor and delivery nurse and the patient is discharged after consultation with the physician, then a physician exam note is not required. Physician co-signatures are not required on any procedure reports, orders, or discharge summaries that are initiated by a Certified Nurse Midwife. Co-signatures are required for history and physicals performed by CNMs.

2.5.5 Rehabilitation Unit History and Physical

For patients discharged from an acute unit to the Rehabilitation Unit, the Rehabilitation Medical Director must complete the history and physical within 24 hours. For patients discharged from the Rehabilitation Unit to an acute unit, a history and physical must be documented within 24 hours of transfer. The history and physical may be recorded in one of the following methods:

- Practitioner may dictate a new history and physical;
- Practitioner may hand write an addendum on designated form or in the physician progress notes; or
- Practitioner may write an addendum on a copy of the history and physical from the acute stay.

2.6 ORDERS

2.6.1 Writing Orders

All orders for treatment, diagnostic tests, admission or discharge must be clearly written, legible and complete, dated, timed and signed by the ordering Practitioner or assigned House Staff Officer. An order by a medical student must be entered as a medical student order and co-signed by the attending or responsible Practitioner or House Staff before being executed.

In some instances, Advanced Practice Professionals are credentialed to write certain orders without having the order co-signed by a Practitioner. If the Advanced Practice Professional is not credentialed to write orders without having the order co-signed by a Practitioner, such orders also must also be co-signed by the attending or responsible Practitioner or House Staff before being executed.

Before issuing orders for a patient, the attending or responsible Practitioner must review and be familiar with the patient's current condition and all other orders in effect for the patient.

2.6.2 Carrying Out Orders

Orders that are illegible, improperly written, or which the nursing staff has difficulty interpreting, may not be carried out until rewritten or understood by the nurse. Orders for diagnostic tests that necessitate the administration of test substances or medications will be considered to include the order for such administration unless otherwise specified.

2.6.3 Telephone and Verbal Orders

All telephone and verbal orders will be verified by read back procedures, whereby all information regarding the order is read back to the prescriber including the patient identification information and critical patient data, who shall immediately verify that the read back order is correct. The individual receiving the order shall record in writing that the order was read back and verified. If the read back and verify process is followed, the verbal orders shall be authenticated within thirty days after the date of the patient’s discharge. Verbal order cannot be given for IV Chemotherapy agents.

All verbal orders must be authenticated within 48 hours after the time the order is made unless a read back and verify process has been initiated in accordance with Section 2.3 Practitioners within the same coverage group may authenticate the order in the absence of the ordering practitioner.
2.6.4 Automatic Cancellation of Orders

All previous orders are cancelled when a patient is transferred to or from a Critical Care Area, PACU, or other Hospital. In such cases, all orders must be rewritten. “Continue previous orders” is not acceptable. There may be exceptions to the general rule stated above. The Medical Executive Committee must approve any such exceptions. In accordance with Swedish Medical Center’s “Do Not Resuscitate/CPR Directive Policy & Procedure”, DNR orders are not canceled when a patient is transferred to or from a Critical Care area or Special Care Unit.

2.6.5 Pre-printed Orders

Pre-printed orders for each Department, Section or other clinical unit may be formulated by the Department Chair, Section Chair or Medical Director of the unit in consultation with the Medical Staff, the nursing service, and appropriate representatives of Administration. Additional pre-printed orders may be formulated by a member of the Medical Staff subject to the approval of the applicable Department Chair, Section Chair, unit Medical Director and appropriate representatives of Administration.

All pre-printed orders shall be listed on an "Instructions and Orders” sheet that must be included in that patient's medical record and signed, dated and timed by the attending Practitioner. Pre-printed orders shall be implemented only upon the order of the attending Practitioner for that patient in accordance with Hospital policy.

Physician specific pre-printed forms must be approved by the Hospital’s Forms Committee prior to use. Protocols/Pathways require approval by the appropriate Department, as well as the Quality Management Executive and Medical Executive Committees.

All pre-printed orders must be reviewed and revised as necessary in accordance with Hospital policy.

2.6.6 Potentially Hazardous Orders

The ordering physician must sign potentially hazardous orders within 24 hours of issuance, unless there are unusual situations in which the covering physician would authenticate the order. Potentially hazardous orders have been identified as orders that may carry a greater risk to the patient. The Medical Staff has defined potentially hazardous orders as: 1) restraint and seclusion; 2) Do Not Resuscitate; and 3) Oncology drugs for chemotherapy.

2.6.7 Admit Order

A patient must have a clear admission order as to the patient’s status which must be dated, timed and signed at the time the order is written. The attending physician must write one of the following orders:

- For observation patients going into an inpatient status: Admit to inpatient.
- For outpatient surgery patients going to inpatient status: Write “admit to inpatient”.
- For an observation patient: Write “outpatient with observation hours”.

Anytime there is a change in patient status from outpatient to inpatient, an order by the attending Practitioner must be documented.

Physicians will complete the initial attending physician assessment in accordance with the following timeline:

**Adult:**
- Direct Admit: 8 hours
- Admit from ED or Office: 12 hours
- CCU: 2 hours if stable, 30 min if unstable

**Pediatrics:**
- Direct Admits: Within 2 hours or send to ED
- Admit from ED: 8 hours
<table>
<thead>
<tr>
<th>Condition</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Newborn</td>
<td>24 hours</td>
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<tr>
<td>Newborn Admitted to NICU</td>
<td>1 hour</td>
</tr>
<tr>
<td>NICU Level II</td>
<td>8 hours</td>
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<tr>
<td>NICU Level III</td>
<td>2 hours if stable, 30 minutes if unstable</td>
</tr>
<tr>
<td>PICU</td>
<td>2 hours if stable, 30 minutes if unstable</td>
</tr>
<tr>
<td>Peds Admission</td>
<td>8 hours</td>
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</tbody>
</table>

2.6.8  ICU to Inpatient Transfer Order

When a transfer out of the Intensive Care Unit is appropriate, the intensivist/attending will submit an order requesting a transfer. When a bed is available, ICU staff will advise the surgical/medical intensivist or attending to write formal transfer orders. If orders are written at the time of transfer request and there is a delay in bed availability, the attending or intensivist will review the orders for accuracy and update as appropriate at the time of transfer. Documentation of the review will state “orders verified” with physician signature, date, and time or updated orders will be provided.

2.6.9  Discharge Order

A patient may be discharged only on the order, written or verbal, of the attending Practitioner or his designee. The discharge order must be timed, dated and signed. If not discharged by the next calendar day, the attending physician must be notified. An order to discharge a psychiatric patient shall not be made over the telephone or by any other means unless the discharging Practitioner has seen and evaluated the patient within 23 hours preceding the time the discharge order is given.

2.6.10 Progress Notes

The primary attending physician or his/her physician coverage is expected to examine patients daily with corresponding daily documentation in the progress notes. When a consulting service is involved in the management of an active problem such that daily visits are warranted, these encounters should be documented daily in the progress notes. When a consulting service uses APPs to extend care for any patient, a physician member of that service must personally examine the patient and review the APPs assessment and orders at least every other day with corresponding documentation in the progress notes.

Pertinent progress notes should be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending Practitioner. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

House Staff may write the daily visit note if permitted by the policies of the teaching program.

The attending surgeon (or his/her same-specialty on call coverage) shall personally perform the post-operative examination and document such in the progress notes.

2.7  CONSULTATION REPORTS

Each consultation report must be written or dictated and include the opinions and conclusions reached, and where appropriate, documentation of an actual examination of the patient and a review of the patient’s medical record.

2.8  OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS

Any Operative and Special Procedures, performed under general anesthesia, regional block, or moderate or deep sedation, regardless of procedural location, require reports that must contain as applicable, the following:

- Name of procedures performed
- Specimens removed, if any
- Detailed account of the findings
- Complete description of the procedure
- Pre- and Post-operative diagnosis
- Estimated blood loss
- Name of the Practitioner performing the procedure and any assistants.

The complete report must be written or dictated immediately following the procedure and filed in the medical record. When the Operative Report is not placed in the medical record immediately, the Practitioner must enter a brief operative progress note in the medical record immediately after the procedure, providing sufficient and pertinent information for use by any Practitioner who is required to attend the patient.

The brief written operative note must include:

- Name of procedure
- Specimens removed
- Findings
- Diagnosis
- Estimated blood loss
- Name of practitioner performing procedure and assistants.

The complete dictated operative report must be dictated within 24 hours of the procedure.

2.9 TISSUE EXAMINATION AND REPORTS

The Practitioner performing the procedure is responsible for seeing that all tissues, foreign bodies, artifacts and prostheses removed during a procedure are properly labeled and sent to the Pathology Department. The determination as to whether to send specimens to the pathologist shall be made by the Practitioner and if certain specimens are not sent, it shall be noted in the medical record. The pathologist shall document receipt of the specimen and make any examination as is necessary to arrive at a pathological diagnosis. It is the duty of the Practitioner performing the procedure to be aware of the status of the pathological diagnosis as incorporated into the medical record and to resolve any discrepancies between the final and the pathological diagnosis.

Gross (macroscopic) and/or microscopic examination of a specific specimen is at the discretion of the examining pathologist. In general, the following tissue types will receive gross examination only:

- Bone
- Plastic repair
- Inguinal hernia sac
- Nasal bone/cartilage/turbinate
- Vein stripping
- Teeth
- Lens

If relevant history, clinical setting, clinical findings and/or suspicious gross findings are present, microscopic examination of these above cited tissues might also be carried out. (Gross examination information is in accordance to Pathology Section policies.)

2.10 ANESTHESIA RECORD

Prior to any form of anesthesia (except local), an evaluation of the patient will be completed and/or approved by a Physician. This evaluation shall include:

- Past and present medical and drug history
- Previous anesthesia experience(s)
- Physical status assessment
- Results of diagnostic studies, if any
- Plan (choice) of anesthesia
- Patient's appropriateness for anesthesia.

An appropriately credentialed Advance Practice Professional or SMC employee may document the evaluation, provided the physician supervises the evaluation and co-signs the note. The patient should be re-evaluated immediately before the induction of general anesthesia.

While the choice of a specific anesthetic agent or technique may be left up to the individual administering the anesthesia (if different from the individual performing the evaluation), the medical record entry should
refer at least to the use of general, spinal, or other regional anesthesia. When a Physician or Nurse Anesthetist does not conduct the evaluation, the responsible Practitioner should make reference in the medical record to the use of spinal, regional, topical, or local anesthesia. This evaluation should be performed before pre-operative medication has been administered.

The patient must be discharged from post-anesthesia as per Physician’s order.

2.11 CONCLUSION OF HOSPITALIZATION

2.11.1 Discharge Diagnosis

The discharge diagnosis or diagnoses must be written or dictated in full at the time of the patient's discharge.

2.11.2 Discharge Summary

A Discharge Summary must be recorded for all patients. The Discharge Summary must be dictated for admissions greater than 48 hours. The summary must include the following:

- The precise reason for hospitalization
- Significant findings
- Procedures performed and treatment rendered
- Condition of the patient on discharge stated in a manner allowing specific comparison with the condition on admission
- Specific discharge instructions given to the patient

Additional documentation may be required by Department policies.

A final progress note may be substituted for the discharge summary in one of the following cases:

- Patients with problems of minor nature who require less than 48 hours of hospitalization (minor nature defined as admissions less than 48 hours, with the exception of an expiration);
- Normal newborn infants; and
- Patients with uncomplicated vaginal deliveries.

2.11.3 Discharge Instructions

Specific discharge instructions shall be provided to the patient or to their significant other at the time of departure. The instructions shall include information regarding physical activity, specific medications and dosage, diet, and follow-up care to include instructions on when to return to the office. These instructions shall be documented in the medical record.

2.11.4 Discharge Disposition

The condition of the patient at discharge must be stated in a manner allowing specific comparison to the condition of the patient upon admission.

2.12 MEDICAL RECORDS COMPLETION

2.12.1 Medical Records

The patient’s medical record should be completed at the time of discharge. A record is considered complete when its contents are assembled and authenticated by the responsible Medical Staff member. This includes recording of all progress notes and dictated discharge summary.

2.12.2 Delinquent Medical Records

Records are considered delinquent when they remain incomplete 30 days after the patient’s discharge date. Failure to complete medical records after appropriate notification from the

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Health Information Management Department (HIM) will result in the loss of admitting and procedure scheduling prerogatives. The HIM Department provides appropriate notice to Practitioners by notifying them two weeks in advance regarding any record becoming delinquent.

a. Operative reports will be dictated within immediately after the procedure. Immediately is defined as prior to the patient being transferred to the next level of care. If the report is not dictated within 48 hours from the date of procedure, the physician will be notified of the loss of scheduling surgical privileges.

b. History and physical report will be completed and/or updated within twenty-four (24) hours of admission and/or prior to a procedure as outlined in section 2.2-2.5.5.

c. Incomplete/delinquent medical records will be noted on a biweekly basis each month.
   a. Practitioners will be notified two weeks prior to their pending suspension each month of their incomplete medical records.
   b. Notifications of the Practitioners with the last name A-K shall be distributed first, followed by notifications of the Practitioners with the last name L-Z throughout the month.
   c. Chart Completion Notification 15 day Notice will be sent to the Practitioner’s offices via email informing them as to which records are incomplete and which records will become delinquent in the next two weeks. If an email address cannot be obtained, a fax will be sent to the office.
   d. Chart Completion Notification 7 day Notice will be sent to the Practitioner’s offices via email one week prior to their scheduled suspension date for all Practitioners who do not respond to the Chart Completion Notification 15 day Notice. If an email address cannot be obtained, a fax will be sent to the office.
   e. Upon completion of the 15th day following the initial Chart Completion Notification email notice practitioners eligibility for suspension will be assessed to determine activity to resolve delinquent medical records.

d. The Practitioner shall be notified of the actual loss of admitting and procedure scheduling prerogatives via email notification. The President of the Medical Staff and Director of the HIM Department shall sign the letter. A copy of the loss of admitting and procedure scheduling prerogative letter will be maintained in the HIM Department. HIM will notify the Medical Staff Office in order that this information may be maintained in conjunction with other credentialing information.

e. The third loss of admitting and procedure scheduling prerogatives (within the previous rolling calendar year) will result in a $250 fine. Reinstatement will only occur after medical records are complete and the fine is paid. The fourth loss of admitting and procedure scheduling prerogatives (within the previous rolling calendar year) will result in a $350 fine. Reinstatement will only occur after medical records are complete and the fine paid. The fifth loss of admitting and procedure scheduling prerogatives (within the previous rolling calendar year) will result in voluntary relinquishment of Medical Staff appointment and privileges.

Failure to complete medical records after medical record suspension will result in the following:

- If not complete in 2 weeks = $250 fine
- If not complete in 4 weeks = voluntary relinquishment of Medical Staff appointment and privileges

f. Practitioners will regain their admitting and procedure scheduling prerogatives upon completion of all delinquent medical records and fines paid.

g. Practitioners should notify the Director of Health Information Management, or designee, to relay any justifiable reason for failure to complete medical records according to the time
frames established. Justifiable reasons include, without limitations, if the Practitioner is ill or otherwise unavailable prior to the suspension date.

2.12.3 Practitioners who are deemed to have voluntarily resigned Medical Staff appointment and clinical privileges are not entitled to the procedural rights and processes outlined in Article VIII of the Credentials and Hearing & Appellate Review Manual of the Medical Staff. Practitioners who so resign may immediately submit an application for appointment. Any such application shall be treated and processed as an application for initial appointment. All information relating to the Practitioner’s actions and conduct during his previous appointments to the Medical Staff may be considered.

2.12.4 Filing of Incomplete Medical Records

No medical record shall be filed until it is complete and properly authenticated. In the event that a medical record remains incomplete by reason of death, resignation, or other inability or unavailability of the responsible Practitioner to complete the record, the Medical Executive Committee or its designee shall consider the circumstances and may enter such reasons in the record and order it filed.

Resignation, termination, or suspension from the Medical Staff does not relieve the Medical Staff member of his obligation to complete all medical records.

SECTION THREE – PHARMACY

3.1 PRESCRIPTION ORDERS

A pharmacist processing a prescription order for a drug by brand or proprietary name may substitute an equivalent drug product if the substituted drug is considered pharmaceutically equivalent and bioequivalent by the Pharmacy Department.

3.1.1 Formulary System: The formulary system is the accepted method whereby the Medical Staff, working through the Pharmacy and Therapeutics Committee evaluates, approves, and selects from among the numerous medicinal agents available, those that are considered most useful in patient care. Under the formulary system, each member of the Medical Staff agrees that in each instance in which he prescribes a drug by proprietary (trade) name, he expressly authorizes the pharmacist to dispense, and the nurse to administer, the same drug under its “therapeutic equivalent” irrespective of whether it is or is not the same brand referred to in the prescription or order.

The following statement is found on physician orders, “Drug orders: Unless initialed P.B.O. (prescribe brand only) a generic equivalent or a formulary therapeutic alternative may be administered.” If for any medical reason, a Practitioner wants a patient to receive a specific brand name of drug, they must specifically indicate by writing on the Physicians’ Order form or the Outpatient Prescription Blank, the words, “Dispense as Written” or prescribe brand only (P.B.O.) Only then will the pharmacist dispense that particular brand. All “Dispense as Written” orders are subject to evaluation by the Pharmacy and Therapeutics Committee.

3.1.2 Additions/Deletions to Formulary: Requests for additions to or deletions from the formulary should be submitted on a Formulary Addition Request Form, available from the pharmacy department, to the Directors of Pharmacy for presentation to the Pharmacy and Therapeutics Committee. These requests are researched and evaluated by the Pharmacy and Therapeutics Committee. The criteria for formulary admission is found in Pharmacy P&P 712-10-30. The Pharmacy and Therapeutics Committee is composed of administration, nursing, pharmacists and Medical Staff members. All drugs are admitted to the formulary on a non-proprietary name basis. No drug of unknown or secret composition will be admitted.

3.1.3 When a non-formulary drug is requested from the pharmacy department, the pharmacist will inform the prescribing Practitioner of those formulary drugs which are pharmacologically similar. If the Physician has a medical reason for using the non-formulary drug, the pharmacy will obtain the medication for that particular patient. Non-formulary requests are reviewed by the Pharmacy
on a routine basis. The Pharmacy will assess medication use trends and evaluate the medication against formulary admission criteria. Medication misadventures with the medication will also be evaluated.

3.1.4 Since non-formulary drugs are not stocked within the pharmacy, there may be a time delay in obtaining the medication. The pharmacy will keep a written account of all honored requests for non-formulary drugs and will present these to the Pharmacy and Therapeutics Committee for their consideration.

3.1.5 Bioequivalent drug products are those products that display comparable bioavailability (equal rate and extent of absorption of active ingredients) when studied under similar experimental conditions.

3.1.6 Available references to be used by the Pharmacy Department in determining pharmaceutical and bioequivalence include (Approved Drug Products with Therapeutic Equivalence Evaluations and Volume III of the USPDI: (Approved Drug Products and Legal Requirements). In controversial matters, the Pharmacy and Therapeutics Committee will be consulted.

3.1.7 Therapeutic equivalents are those drug products expected to have the same therapeutic effect when administered to patients under the conditions specified in labeling (Reference – same as “A”). The designation, approval and regulation of therapeutic substitution must be conducted by the Pharmacy and Therapeutics Committee. All therapeutically substituted orders must be documented in the patient’s medication orders (chart). Therapeutic substitutions are published in the formulary.

3.2 INVESTIGATIONAL DRUG

Investigational drugs to be used for Hospital patients must be maintained and dispensed through the pharmacy. The physician ordering the drug must obtain the patient’s written consent to participate in the investigation. IRB approval is necessary for use of experimental drugs, except in the case of an emergency (e.g. compassionate need). The physician ordering the experimental drug must comply with state and federal law in using and ordering same. (Refer to the Hospital’s interdisciplinary P&P #8614.137.)

3.3 MEDICATION STOP ORDERS

When medically appropriate, the prescribing practitioner may specify the exact total dosage or total period of time (e.g., days) for specialized drugs or treatments. Such medications may include certain anti-infective and chemotherapeutic agents for which specified time intervals are necessary. All medication orders automatically stop after 60 days. The Pharmacy will notify the physician within a reasonable time of a pending discontinuation. The physician will evaluate whether to continue, change or stop the medication.

3.4 PATIENT’S OWN MEDICATIONS AND SELF-ADMINISTRATION

All medications for use by an inpatient shall be labeled, dispensed and administered in accordance with the provisions of the Hospital’s policy concerning medication administration. Inpatient requirements for allowing patients to use their own medication (from home), as well as patient self-administration, are found in the Hospital’s policy #8711.610. Allowing patients to use their own medications, as well as self administer medications, requires a specific written medication order. The use of the patient’s own medications is discouraged. As a guide, the use of the patient’s own medications is restricted to situations where there is a bona fide continuity of care issue.

The Physician or other authorized Practitioner must write or orally transmit a prescription for each medication to be given to the patient upon discharge. All such medications shall be labeled and dispensed in accordance with the Corporation’s policy concerning Take Home Medications.

3.5 DRUG THERAPY MANAGEMENT
Drug therapy management is defined as the review and evaluation of drug therapy regimens for patients undertaken by a pharmacist in order to provide drug therapy, monitor progress, and modify drug therapy. Pharmacists engaging in drug therapy management in an inpatient setting must meet State Board of Pharmacy qualifications, conduct activity pursuant to a valid order, and follow protocols set forth by the Pharmacy and Therapeutics Committee and Medical Executive Committee.

SECTION FOUR – CONSENTS

4.1 GENERAL

Upon admission, the Hospital should obtain a general consent for treatment during the hospitalization. This general consent does not, however, eliminate the need for each Practitioner to obtain informed consent from the patient or the patient's authorized representative for specific treatments or procedures. Where Hospital policies require written consents such consents must be obtained by the Practitioner. Hospital personnel, including but not limited to the nursing staff, shall not be responsible for or be asked to secure written informed consents from patients, nor shall they complete consent forms nor present them to patients for signature unless specifically allowed under a policy approved by the Board and the Medical Board.

4.2 INFORMED CONSENT

4.2.1 The Hospital has several policies outlining when, how and from whom specific consents must be obtained for surgical and medical treatments and procedures. All Practitioners are responsible for being familiar and complying with the provisions of these policies.

4.2.2 The Hospital’s policies require that informed consent be obtained and documented in writing by the Practitioner on at least the following procedures:

- Procedures usually requiring general or regional anesthesia
- All surgical or invasive procedures
- All research procedures or treatments
- AIDS and HIV testing
- Blood transfusions
- Practitioners may consent patients via telephone for blood transfusions
- All other procedures designated by the Hospital or any of its clinical Departments

4.2.3 Documentation

Evidence of the informed consent must be obtained and filed in the patient's medical record prior to proceeding with the surgery or other procedure or treatment in accordance with the Hospital’s policies.

4.2.4 Emergencies

If a patient who presents with an emergency condition is unable to give consent and no other person who is authorized to act on behalf of the patient is available for consultation, the Practitioner may elect to proceed in accordance with the Hospital’s policies with such surgery or treatment as is necessary to address the emergency. In all such cases the Practitioner will thoroughly document the patient's condition, including the immediate threat to the patient and all efforts made to obtain a valid consent.

If a minor or other incompetent patient presents with an emergency condition and the parent(s) or guardian refuses consent for a surgery, procedure or treatment which, in a Practitioner’s opinion, is necessary to address the emergency, such emergency care as may be necessary to address the emergency may be administered in accordance with the Hospital’s policies. In all such cases, appropriate judicial proceedings should be promptly thereafter initiated.

4.2.5 Inability to Obtain Consent

If a patient who is not suffering from an immediate life threatening condition is unable or is incompetent to give consent for a surgery, treatment, or procedure which a Practitioner believes
should be performed or administered, or if the parents or other legal guardians or authorized representatives of such a patient refuse to give such consent, approval for the treatment, surgery or procedure should be sought through appropriate judicial proceedings before any treatment is initiated.

SECTION FIVE
SURGICAL SERVICES AND OPERATING AND POST-ANESTHESIA CARE UNIT

The Department of Surgery and its Anesthesia Section are guided by policies of their Service. These policies include, but are not limited to, the practitioner’s role and responsibilities in the following:

- Pre-procedure time out verification of correct patient, site, and procedure process
- Pre-Anesthesia and Post-Anesthesia assessment

SECTION SIX - HOSPITAL DEATH AND AUTOPSY

Every member of the Medical Staff is expected to be actively interested in securing autopsies in case of unusual death or of particular medicolegal or educational interest and for other accepted professional reasons. Such clinical situations include but are not limited to:

- Unexpected, sudden death of unknown cause
- Death occurring in the first post-operative week
- Death following any invasive procedure
- Death occurring within 24 hours of admission
- Suspected fatal drug reaction
- Infectious disease of unknown etiology
- Metastatic tumor with no known primary and bleeding diathesis, with no known etiology

An autopsy may be performed by a Pathologist in the hospital Pathology Department located at SMC only if:

a. The death is a Coroner's case, the body has been released by the Coroner and an autopsy is requested by the attending Physician agreed to by the responsible Pathologist and the appropriate Next of Kin consent to the autopsy.

b. The death is not a Coroner's case, and the attending Physician requests an autopsy and the Next of Kin consent to the autopsy.

A request for an autopsy must be ordered by the attending Physician. The permit for an autopsy shall be obtained by a Physician, registered nurse, house staff, or chaplain. Permission for autopsies must be granted by the Next of Kin as stated by the patient at admission.

Autopsies performed at Swedish Medical Center shall be performed by the hospital Pathologist. The provisional anatomic diagnoses should be prepared within 3 days. The final anatomic diagnoses should be prepared within 60 days.

SECTION SEVEN - EMERGENCY MEDICAL SERVICES

7.1 SCOPE OF SERVICE

7.1.1 Emergency Department at the Hospital, shall provide services and procedures commensurate with standards and criteria outlined by the Joint Commission. Procedures requiring general anesthesia or major surgery shall not be performed in the Emergency Department except in the instance where life-saving measures are mandatory.

7.1.2 All individuals who present at the Hospital or any of the Hospital’s off site campuses, shall be provided with an appropriate medical screening examination performed by a credentialed practitioner in accordance with the Hospital’s policies and procedures to determine whether they have an emergency medical condition. Persons with such a condition shall, within the hospital's capabilities, be provided treatment designed to stabilize the condition or an appropriate transfer in
accordance with the hospital's applicable policy.

7.1.3 All admissions to, diversions, discharges or transfers from the Hospital's Emergency Department shall be accomplished in conformity with the written policies of the hospital.

7.1.4 Documentation including all important aspects of the patient encounter (including physician orders) shall be completed before leaving the Emergency Department.

7.1.5 The performance of a medical screening examination, initiation of stabilizing treatment, and disposition of the patient shall be consistent with the HealthONE Board of Governor’s EMTALA policy, EMTALA statute, and relevant federal and regional policies and guidelines. The credentialed practitioners and the Trauma Surgeons are credentialed to provide Emergency Department (ED) care. The Emergency Physician (and/or Trauma Surgeon, in appropriate cases) is responsible for the supervision and/or direct care of all patients in the ED. On Labor & Delivery, the OB physician is responsible for the supervision and/or direct care of the emergency OB patient.

a) All patients presenting to the ED shall have a timely triage assessment and a medical screening examination (MSE) to determine the presence of an emergency medical condition. The timing of the MSE shall be based on the triage assessment. There will be no delays to determine insurance status or the existence of a primary care physician (PCP) relationship. The credentialed practitioner (and/or Trauma Surgeon in appropriate cases) is responsible for the performance and/or supervision of an appropriate MSE. On Labor & Delivery, the RN may complete an MSE. This will be to rule in/out labor only according to competencies of the RN and algorithms established by the Obstetrics Section.

b) If requested by the patient or the PCP, the Emergency Physician may contact the PCP as a courtesy. A PCP, for the purposes of this guideline, shall be considered to be the patient’s personal physician with whom an established doctor-patient relationship exists.

c) If a PCP requests that he/she sees his/her patient in the ED, contingent on the conditions stipulated above, the Emergency Physician may agree to such a request, but remains responsible for the supervision of the MSE, and may or may not choose to do his/her own MSE.

d) The Emergency Physician (and/or Trauma Surgeon, in appropriate cases) is responsible for the evaluation, treatment, and disposition of all patients in the ED. Final patient disposition (e.g., discharge, transfer, or admit) shall be the decision of the Emergency Physician (and/or Trauma Surgeon, in appropriate cases).

7.2 MEDICAL STAFF COVERAGE

7.2.1 The Emergency Departments shall be staffed with appropriately credentialed emergency medicine Physicians.

7.2.2 An on-call schedule of specialists and general licensed independent practitioners representing all services routinely available at Swedish Medical Center shall be promulgated by the respective clinical Departments or services in accordance with their policies and procedures or rules and regulations and will thereafter be posted or otherwise available in the Emergency Department. All such schedules shall be updated as required by Hospital policy.

7.2.3 Licensed independent practitioners who are on call to the Emergency Department shall be available to respond to the Emergency Department Physicians by telephone or in person, as appropriate. On Call licensed independent practitioners shall respond to a call from the Emergency Department no later than 20 minutes by telephone and shall personally appear within 60 minutes or within a shorter time frame as deemed appropriate to the patient’s clinical situation per the Emergency physician assessment. If this time frame cannot be met because of other emergent patient care obligations, the licensed independent practitioner On Call and Emergency Department shall cooperate in finding an appropriate substitute who is available.

A shorter response time may be required by contract or by the Clinical Department’s policies. If a licensed independent practitioner will be unavailable to take Call, it is his responsibility to provide
for appropriate backup and notify the Emergency Department of his unavailability and to identify the licensed independent practitioner taking call. Failure to comply with this provision may result in disciplinary action in accordance with the Medical Staff Bylaws.

As long as an On Call physician has arrangements for back-up, the On Call physician may schedule elective surgery or take simultaneous call at more than one hospital. The On Call physician must be able to respond in a timely manner relative to the medical condition of the patient, or he will provide in writing to the Emergency Department a backup plan to include the name of a physician who will accept the alternate call.

7.2.4 All licensed independent practitioners who are On Call to the Emergency Department shall arrange for at least one outpatient follow-up appointment as clinically appropriate for patients referred to the licensed independent practitioner by the Emergency Department. Appointments need to be available on a timely basis. If the patient requires a followup appointment within the next 48 hours, a call notifying the followup licensed independent practitioner will be made by the Emergency Department physician.

7.2.5 Licensed independent practitioners On Call for the Emergency Department will be responsible to accept appropriate transfers of patients with an emergency medical condition from other facilities and shall accept inpatient consultation if requested.

7.2.6 As long as each Department or Section has adequate coverage for their On Call Schedule, the MEC may allow the Department/Section to exempt from call any physician age 60 or over. However, all physicians who have reached the age of 70 and have at least 5 years of service to the Active Staff may elect not to participate on any call panel.

7.2.7 The Swedish Family Medicine Clinic is the only SMC off campus center and is not a dedicated Emergency Department. Their specific policies/procedures appropriately address the process for patients who present with emergency medical conditions.

7.2.8 Active Staff Physicians appointed to Departments which have diagnostic testing that must be read and interpreted by a licensed physician may (e.g. Radiology, Cardiology, Neurology, etc) participate in reading panels as established by the Department. The applicable Department Chair or his/her designee shall prepare and post reading panel schedules for Active Staff physicians. Physicians participating on reading panel services shall read, interpret and dictate all reports within the timeframe as defined by the specific reading panel Dept/Section Chair, unless a shorter period of time is required in the Medical Staff Bylaws, Rules and Regulations or applicable Hospital policy. Physicians participating on reading panel services shall read, interpret and dictate all exams regardless of the patients’ insurance coverage. Billing for the professional component of the reading and interpretation of a diagnostic test is the responsibility of the physician reading the diagnostic test.

Physicians on reading panels must demonstrate competency for the service prior to being accepted to the reading panel. The reading panel for each service must report outcomes at a minimum annually to QMEC through their respective Section/Dept meetings.

7.3 INSTRUCTIONS TO PATIENTS DISCHARGED

Patients seen in the Emergency Department and not admitted to a facility of the Hospital or transferred out shall be given written instructions regarding their follow up care (“After Care Instructions”). The patient or guardian shall sign a receipt acknowledging delivery of said instructions. A signed copy of the general instructions shall become a part of the Emergency Department record. Where additional printed, standardized or computer generated instructions are given, a notation to that effect should be entered in the record.

7.4 LEAVING AGAINST MEDICAL ADVICE

The Hospital's written policies regarding leaving against medical advice should be consulted and followed whenever a patient desires to leave a facility of the hospital, including the Emergency Department, against the advice of any Practitioner.
SECTION EIGHT - OTHER POLICIES AND PROCEDURES

8.1 SCOPE OF POLICIES AND PROCEDURES

The Clinical Departments of the Medical Staff may, with approval of the Medical Board, promulgate written policies and procedures regulating any aspect of the Department’s care of patients or operations provided that no portion of any such policy or procedure conflicts with any provision of these Bylaws. Any such policy or procedure shall have the same force and effect as these Rules and Regulations.

8.2 RESPONSIBILITIES TO SPECIFIC HOSPITAL POLICIES

8.2.1 Patient Rights

The Medical Staff shall be informed of and support the Hospital’s Patient’s Bill of Rights and Responsibilities.

8.2.2 Patient Complaints

Patient complaints forwarded by the Hospital Patient Representative will be reviewed by the Medical Staff President, with referral to the MEC or HPRC where appropriate.

8.2.3 Restraints – Physician Orders/Documentation

- The initial restraint order must be written by the physician within one hour after the patient restraint has been initiated.
- Physical restraint orders are time limited – maximum 24 hours (Exception: Behavioral Health patients – Refer to Hospital Policy 8711.600 for specific details.)
- Continuation of the order must be authorized by a physician no less than one calendar day based upon the physician’s examination of the patient.
- Physical restraint may not be ordered on an PRN basis.
- Define physical method to be used (i.e., leather, posey)
- Define specific area of the body to be restrained
- Verbal orders are co-signed within 24 hours
- Indicate any additional clinical considerations
- Orders are based on specific knowledge of the patient’s behavior
- Orders will be dated and timed
- Include criteria for early release from physical restraint
- Identify patient behavior(s) justifying the intervention

8.2.4 No Smoking Policy

Smoking shall be prohibited inside all facilities of Swedish Medical Center. All physicians are empowered and responsible to enforce this policy.

Infractions by physicians shall be reported to the Medical Staff Office. The President of the Medical Staff shall enlist the cooperation of the physician, with enforcement for physician violations being pursued in accordance with the Medical Staff Bylaws and accompanying Manuals.

8.2.5 Organ and Tissue Procurement

Medical Staff members will be expected to follow the HealthONE policy regarding organ and tissue procurement.

8.2.6 Equipment, Supplies, and Pharmaceuticals

All equipment, supplies and pharmaceuticals must be provided by the hospital to patients admitted into its care. In the rare situation that equipment or supplies are not currently available, practitioners will follow hospital Supply Chain policies and procedures.
Medications not supplied by Pharmacy should be reserved for those cases in which pharmacy cannot supply the medication and interruption of the continuity of care would compromise therapy. The medications will be sent to the Pharmacy for identification and documentation of the medication on the patient’s MAR.

8.2.7 Bedside Procedure Policy

Practitioners are responsible to this Policy which fulfills the requirements of nursing notification, nursing monitoring, documentation, and informed consent.

8.2.8 Time Out Policy

An appropriate time out must be conducted on all bedside procedures. There must be documentation of correct patient, correct site, and procedure process before initiation of the procedure.

SECTION NINE – MEDICATION DIVERSION PREVENTION

9.0. POLICY

This Section of the Rules & Regulations are taken from HCA Policy #CSG.MS.001 and reiterated within these Medical Staff Bylaws due to its extreme importance.

Swedish Medical Center is dedicated to fostering a culture that supports safe and effective patient care and provision of a healthy work environment. It is the expectation of all Active Medical Staff members and APPs to strictly adhere to processes that support the prevention of medication diversion. Active Medical Staff members and APPs who may access medication are responsible for reading this policy and understanding their role in preventing medication diversion. Diversion of medication is a criminal act punishable by local, state and federal authorities and a violation of local and corporate HCA employment policy and these Medical Staff Bylaws, Rules and Regulations.

9.1. PROCEDURE

9.1.1. Selection

DEA Controlled Dangerous Substances listed in Schedule II – V, (including 2N and 3N) will be controlled along with State-mandated controlled substances (if applicable), and additional items deemed necessary by the facility. Propofol is designated at this facility as a controlled substance.

9.1.2. Access

Controlled medications in patient care areas, pharmacy and/or designated storage areas are to be maintained in an automated dispensing cabinet (ADC) or locked in a substantially constructed cabinet (hereafter referred to as “locked box”) that is stored in a locked area. Only patient care staff members who have completed an authorization/access form and had the form approved by the individual designated to approve such forms may remove controlled medications from the ADC or a locked box that is stored in a locked area.

9.1.2.1. The following healthcare providers have the ability to request access to controlled medications based on their job description and competencies, to include: LIPs, APPs, RNs, LPNs/LVNs, Anesthesia Assistants, Registered Pharmacists, Pharmacy Technicians, and other qualified staff as authorized by the facility.

9.1.2.2. Contracted staff will receive access only to the ADC or locked box that is stored in a locked area on the unit in which they are scheduled to work. Access should be limited to only areas that are needed to perform assigned duties and for the designated time period of the contract. Access for staff working on a shift-to-shift basis is limited to the shift assigned.

9.1.2.3. During times when locked areas are not occupied, the keys to these areas must be located in a locked area.
9.1.2.4. A staff member’s, LIP’s or APP’s access to medications may be terminated at any time if policy infctions occur.

9.1.2.5. A physician may request access to controlled substances for a qualified staff member who will work under his/her direction, e.g., RN, LPN/LVN, radiology technologist, medical assistant, when working in an outpatient imaging center or physician office practice.

9.1.2.6. All staff, LIPs, and APPs will protect their access to ADCs, locked box, or combination lock. ADC pin numbers should be changed at least every 90 days, as appropriate, or when the user suspects the integrity of their access has been compromised. Other locking mechanisms will be changed routinely based on the policy of the entity. This does not apply to facilities using bioID.

9.1.2.7. Keys to locked boxes/locked areas are not to be removed from the facility or reproduced.

9.1.2.8. Unattended medication identified by staff/LIPs/APPs will be reported to the appropriate unit manager and confiscated. The individual responsible for the unattended controlled medication will be notified and may retrieve the confiscated medication. This event is documented as an occurrence.

9.1.2.9. Occurrence reports will be utilized for tracking through the facility defined QA/PI mechanism.

9.1.2.10. All identified occurrences will be tracked. The initial occurrence will result in education and/or counseling by the manager. A subsequent occurrence will necessitate a referral of a LIP or APP to the Medical Executive Committee for quality/peer review subject to the current LIP’s or APP’s term of appointment or reappointment. LIPs and APPs with Professional Service Agreements are held to the conditions of the contract, which supersedes the Medical Staff Bylaws. Staff occurrences will be addressed through their supervisor using established facility policy and procedure.

9.2. PRESCRIBING

9.2.1. Prescribing of controlled substances is limited to a LIP or APP with controlled substance prescribing privileges that have been granted in accordance with these Bylaws.

9.2.2. Verbal orders for controlled substances should be used infrequently. All verbal orders/telephone orders are to be read back or repeated back when read back is not feasible (i.e. during a code, in operative/invasive procedure setting).

9.2.3. Blank lines or spaces should not be left on forms that would allow for the insertion of an unauthorized order.

9.2.4. Only complete orders will be entered into the patient’s medication profile. The ordering LIP or APP will be consulted for unclear orders.

9.2.5. Orders shall not be processed until the ordering practitioner is identified and the practitioner’s authority to order controlled substances is verified.

9.2.6. Orders with illegible authentication will not be accepted.

9.2.7. Defaulting attribution of the order to the attending practitioner is not permitted.

9.2.8. If the Meditech pharmacy module flags an order as not being received from an authorized practitioner, then the Chain of Command Policy will be implemented to notify the appropriate facility leaders. Controlled substances will not be dispensed based on that order until the flag is resolved.

9.2.9. For areas where there is no pharmacy oversight, orders for controlled medications must be complete before they can be acted upon.
9.2.10. Only a LIP or APP can authorize refills of controlled substances. The refilling of a prescription for a controlled substance listed in Schedule II is prohibited.

9.2.11. Dispensing samples of controlled medications is prohibited.

9.3. ANESTHESIA MEDICATIONS (OR AND OTHER ANESTHETIZING AREAS)

9.3.1. A defined method for obtaining controlled medications is followed without exception.

9.3.2. Controlled medications are dispensed for individual patient use.

9.3.3. All waste must be recorded by two (2) licensed individuals.

9.3.4. Ideally, all syringes, bags, vials, etc. containing wastage are returned to pharmacy or designated controlled medication storage areas for periodic random testing with all sharps removed. All syringes should be clearly labeled. Reconciliation of the controlled medication dispensed should occur after each case, or as close to the end of the procedure as possible. Preferably, controlled substances are wasted in a secured medication vault.

9.3.5. All discrepancies will be resolved by the controlled medication manager or designee by the end of the provider’s shift.

9.3.6. Documentation must be clearly legible and correlate to usage.

9.3.7. All discrepancies will be tracked, by provider, for trending and identification.

9.3.8. No medication can be left unattended. All medications prepared for the next patient in advance must be locked and secured at all times.

9.3.9. When controlled medications are drawn up and not administered immediately, medication syringes must be labeled to include: name of medication(s), strength, quantity (if not evident), diluents and volume, date and time. (Note: Date and time are not needed for short cases, as defined by the facility.)

9.3.10. Staff, LIPs, and APPs are discouraged from bringing items such as book bags, briefcases, duffel bags or any other type of items into OR/invasive procedure settings. If items like a nerve stimulator or pocket reference book are needed it can be brought into the OR in a clear zip lock bag and kept in plain view. Other items should be stored in a locker. Items brought to the OR/invasive procedure settings are subject to search for cause.

9.3.11. The Chief of Anesthesia/designee or ASC Medical Director will assume responsibility for informing all anesthesia staff of these rules and their enforcement prior to granting of clinical privileges.

9.3.12. Consideration for use of an ADC in each OR is strongly recommended. Ideally, this ADC will have the ability to track wastage by patient and be used in concert with a secure vault for depositing of waste medications to be collected by pharmacy staff.

9.3.13. All controlled medication kits will have an independent double check prior to dispensing.

9.3.14. All controlled substances used must be documented on the Anesthesia Record.

9.3.15. Sign-out process: Standard controlled medication kits are signed out from the ADC, pharmacy department, or controlled medication storage area. When obtaining the controlled substance kit, anesthesia personnel must verify the contents of the kit and initial the designated form, eg, Controlled Substance Record, Anesthesia Administration Form, indicating that the contents are correct. Once signed, the anesthesia providers are responsible for controlled medications that they sign out.

9.3.16. The controlled medication kit will remain locked and secured at all times.

9.3.17. All controlled substances used must be documented on the Anesthesia Record or designated form should the Anesthesia Record not be utilized, e.g., Endoscopy, Emergency Department, Imaging, Cardiac Cath Lab. Anesthesia providers are responsible for reconciling all drug totals (i.e., total administered and amount returned, when applicable).

9.3.18. Hand-off of controlled medication from nursing to anesthesia providers is documented.

9.3.19. Provider relief during a procedure must have documented reconciliation of all controlled substances. The responsibility for this reconciliation will be that of the relief provider.

9.3.20. Anesthesia personnel are not permitted to dispense controlled substances to other anesthesia personnel from their kit except in a bona fide emergency as defined by Medical Staff Rules and

Swedish Medical Staff Rules & Regulations
Regulations. Any additional controlled substances needed must be checked out from the pharmacy, ADC, or controlled medication storage area. When an ADC is not used, the controlled substance removed is documented on the Controlled Substance Record.

9.3.21. Unused controlled medications: All unused controlled medications must be returned to the appropriate location for verification and destruction. Unused controlled medications must be labeled and dated appropriately with name of medication, dosage, strength.

9.3.22. Return process

- The controlled medication kit and the designated controlled medication record, or Anesthesia Record must be returned to the designated area.

- Anesthesia personnel must verify via signature, date, and time that the contents of the controlled medication kit have been verified and checked against the Controlled Medication Record or Anesthesia Administration Form.

- Any discrepancy discovered must be resolved during the return process. Failure to do so may result in loss of privileges to sign-out controlled medications.

- If a discrepancy cannot be resolved (i.e. cause of discrepancy cannot be determined), the nurse manager or designee should be notified and an occurrence report should be initiated.

9.3.23. Tracking of frequent discrepancies for trending and identification of individuals should be ongoing.

9.3.24. Auditing: Monthly, audits of the OR record vs. the Controlled Substance Record of Anesthesia Administration Form will be conducted on all anesthesia personnel who check out a controlled substance kit.

9.3.25. Testing of returned controlled substances: When applicable the Department of Pharmacy or designated person will randomly test the contents of returned syringes from the invasive procedure areas. The results will be recorded and compared against control values.

9.3.26. Review of results: When applicable, the pharmacy department will review inconsistencies found in the auditing process or toxicology testing process with the Chief Medical Officer or their designee. If there is any suspicion of diversion or other tampering, a team (as defined in the SPAE Policy) will be convened to investigate.

9.4. PROPOFOL

When using propofol, Swedish Medical Center will strictly apply all previously addressed and applicable sections of this policy and procedure to:

9.4.1. Procedures for operating room suites and other invasive procedure settings:

- All propofol is to be received and accounted for in the same manner as other controlled drugs, and stored in a secured location.

- All propofol dispensed to anesthesiologists/CRNAs/anesthesia assistants/qualified anesthesia providers is to be counted and logged as is routine with all controlled substances.

- All propofol administered is to be documented on the Anesthesia Record or other designated form.

- All propofol wastage is to be observed and documented utilizing the routine method for wastage of controlled substances.

9.4.2. Swedish will identify each setting in which propofol is utilized to include, as examples: Labor and Delivery, Endoscopy, Cardiac Catheterization Lab, Imaging, Emergency Room; adult, pediatric and neonatal ICUs.

9.4.3. Physician orders, independent review by two (2) licensed individuals of wastage, administration, documentation, tracking and reconciliation of propofol will be addressed as with all other controlled substances.
9.5. POLICY MONITORING AND AUDITING

Monitoring of the HCA Medication Diversion Prevention Policy will occur quarterly by the Division Directors of Pharmacy. Auditing of policy compliance will occur through Compliance Process Reviews by the Corporate Ethics & Compliance Department, Quality Review System Surveys by the Clinical Services Group, and Internal Audit and Consulting Services.

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