



Swedish  
Medical Center

# MEDICAL STAFF ORIENTATION AND REFERENCE GUIDE

2014

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- Policies and procedures can be found on the Swedish Medical Center Intranet page.
- From any in-house computer, click on the Swedish Medical Center Intranet icon on the desktop.

Additional resources are available on the Swedish Medical Center Website under the “Physicians” Tab at the top of the page.

## Patient Care

### Abuse and Neglect

**Children:** When there is reasonable suspicion that a child under 18 years of age is being or has been physically, emotionally or sexually abused or neglected, the physician is required by state law to report it. To report, contact the departmental case manager or call the case management supervisor.

**Adults:** When there is reasonable suspicion that a dependent adult is or has been a victim of domestic violence, physically, emotionally or sexually abused, neglected or exploited, the **designated case manager** shall be notified. If a case manager is not on duty the house supervisor shall be notified and he/she will notify the security department. The case manager or security officer will notify Adult Protective Services.

Dependent adult is defined as an individual 18 years of age or older who is unable to protect his/her own interest. Abuse includes neglect by omission or willful deprivation of services by others; the intentional infliction of physical or mental injury; unreasonable confinement; financial exploitation; cruel punishment; mental anguish; rape or sexual assault; harassment; and domestic violence.

### Advance Directives

Physicians need to be aware of their patient's intent regarding a living will and/or durable power of attorney for healthcare decisions. If a patient has provided these documents to the hospital, copies will be in the chart. If a patient has not completed these documents, nursing and/or case management will make them available upon request by patient, at admission, and at any point during their care.

### Blood Transfusions

Transfusion of blood products requires the following:

- An order to transfuse in the patient's chart
- A valid informed consent

Rationale for the transfusion should follow the hospital's transfusion guidelines.

**Remember: Transfusions require informed consent.**

### Body Fluid Exposure and Needle Sticks

If you sustain an exposure:

- Wash and rinse wound area thoroughly with germicidal soap.
- Obtain source patient information and account number.
- Report to the employee health office immediately (3rd Floor, Swedish Medical Center, from 8 a.m. to 4:30 p.m.). If employee health is closed, report to the emergency department for treatment.
- Treatment for individuals who have an HIV-positive exposure must occur within two hours.

### Catheter-Associated UTIs

We have taken several steps toward decreasing catheter-associated urinary tract infections (CAUTIs), including general education to all staff who handle urinary catheters. Measures can be taken to reduce CAUTIs. Indications for indwelling Foley catheters include:

- Relief of urinary tract obstruction
- Prostatic hyperplasia
- Acute or chronic urinary retention
- Drainage of hypotonic bladder
- Neurogenic bladder
- Critically ill patients
- Pre- and post-pelvic surgery
- Accurate measurement of output
- Empty bladder during labor
- Clot retention
- Chemotherapy intervention
- Cytotoxic therapy for papillary carcinoma

#### **Measures to be taken:**

- Assess need for catheter frequently
- Remove the indwelling catheter when no longer indicated
- Do not routinely change the catheter at regular intervals. There is little to no research regarding changing the catheter once a UTI is identified.
- Do not irrigate unless medically necessary. If urinary retention is suspected, scan the bladder first. If patient is retaining urine for unknown cause, a catheter change should be considered before irrigation due to the high probability of biofilm.
- Ensure the catheter is placed using sterile and

appropriate technique.

- Do not write “Foley PRN.” Indicate why an indwelling catheter should be placed and write parameters for use of an indwelling catheter. Infection Control staff and clinical nurse specialists are working with nursing to ensure these guidelines are followed.

When a CAUTI has been identified, the physician will be accountable to agree or disagree with the decision. If the physician agrees, he or she must make note of this in progress notes and at dismissal so that this event can be coded correctly for billing purposes.

## Caring Model

We support a culture that revolves around patient-centered care and service.

## Central Line Infections

Studies show that hospital-acquired central line infections can be prevented by utilizing a set of guidelines developed by the Centers for Disease Control. The central line insertion bundle has five components: hand hygiene, maximum barrier precautions, chlorhexidine skin antisepsis, optimal catheter site selection (the subclavian vein is the preferred site for non-tunneled catheters in adults), and daily review of line necessity with prompt removal of unnecessary lines.

Emergency catheterization, blood coagulation disorders, severe hypoxemia, temporary dialysis catheter access, and inability to access IJ or subclavian sites are reasons for femoral line insertion. The reason should be documented in the provider's procedure note.

## Communication

### Handoffs

We seek to improve transitions and handoffs in care with standard processes and communication techniques:

- Establish huddles for transitions or around specific issues, such as safety, that are important in many transitions.
- Enact structured handoffs, including use of tools

like SBAR.

- Require a verification process (repeat back or read back) for critical elements of communication.
- Limit interruptions in handoff communication,
- Perform standardized change-of-shift reports at the bedside (Nurse Knowledge Exchange).
- Communicate the most up-to-date information.
- Communicate interactively in briefings, huddles, and debriefings – both sender and receiver use active communication skills.

### SBAR

To provide guidelines for effective communication among health-care providers and enhance patient safety and quality of care, we have adopted the SBAR communication tool. We prepare the following information prior to communicating regarding patients:

- Identify self, unit, patient.
- **S:** Situation: Brief statement of the key issue(s) that need(s) immediate attention.
- Describe what is happening with the patient; highlight issues that need immediate attention.
- **B:** Background: Pertinent information related to the situation; could include:
  - Admitting diagnosis; date of admission
  - Medications, allergies, IV fluids
  - Vital signs (current and trend, if applicable)
  - Lab results
  - Clinical information (cardiac, respiratory, neuro, skin, GI/GU, etc.)
  - Pain status
  - Code status
- **A:** Assessment: Your conclusion of the critical situation
- **R:** Recommendation: Your recommendation for addressing the issue
  - Patient needs to be seen now
  - Physician order (consult, transfer, medication, treatment, diagnostic test, etc)
  - Peer-to-peer: Follow up needed; what to watch for

## Critical Results Received Timely

You should be notified of critical lab/exam results within 30 minutes. Per hospital policy, the staff calling results will read back any order given and document in the medical record that you were notified.

## Cultural Diversity

Population appropriate care refers to our ability to meet the distinct needs of patients and families with respect to cultural, spiritual and developmental needs. Knowledge and considerations for each population include communication approaches, personal space, time orientation, social organization, spirituality, education, safety, and environmental interventions. Incorporate the patient's beliefs into the treatment plan when possible.

If you have questions, contact the unit's case manager or the case management supervisor.

## Death and Dying

We support the following Colorado Medical Society declaration on physician involvement in the dying process:

- The principle of patient autonomy requires that physicians must respect the decision to forego life sustaining treatment by patients who possess decision-making capacity.
- There is no ethical distinction between withdrawing and withholding life sustaining treatment at the patient's request.
- Physicians who care for patients with terminal illnesses should seek to educate themselves about end of life care and to promote the dignity and autonomy of dying patients in their care, including providing palliative treatment even though it may foreseeably hasten death.
- When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should not decrease.

## EMTALA

When an individual presents to a HealthONE hospital and the individual or his/her representative makes a request on his/her behalf for an

examination or treatment for a medical condition, or a prudent layperson observer would believe that the individual presented with an emergency medical condition, an appropriate medical screening examination, within the capabilities of the hospital's Emergency Department (including ancillary services routinely available and the availability of on-call physicians), shall be performed by an individual qualified to perform such examination to determine whether an emergency medical condition (EMC) exists.

With respect to a pregnant woman having contractions, the examination is performed in Labor and Delivery to determine whether the woman is in labor and whether the treatment requested is explicitly for an EMC. If an EMC is determined to exist, the individual will be provided necessary stabilizing treatment, within the capacity and capability of the facility, or an appropriate transfer as required by Emergency Medical Treatment and Active Labor Act (EMTALA). Such stabilization treatment shall be applied in a nondiscriminatory manner (e.g., no different level of care because of diagnosis, financial status, race, color, national origin, or handicap).

Each HealthONE facility maintains a list of physicians on the Medical Staff who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual receiving treatment for an EMC.

The cooperation of the Medical Staff members with this policy is vital to our success in complying with the on call provisions of EMTALA.

## Fall Reduction

Every year an estimated 35 to 40 percent of patients aged 65 and older fall. Unintentional injury is the fifth leading cause of death in older adults, and falls constitute two-thirds of these deaths.

Our nursing staff performs a fall risk assessment on all patients on admission and then on every shift or upon change in condition.

Interventions should be based on the assessment results, as well as individualized to the patient. Physicians should consider the need for assistive devices, a change in medications, orders for physical therapy or other orders that can reduce fall risk.

A yellow sock on a patient's door frame and a yellow gown identify the patient as at high risk for falls.

Medications such as sedatives, antipsychotics, antidepressants and other central nervous system agents increase the fall risk in elderly patients, with the risk of falling doubling for each psychotropic added to the drug regimen.

As part of the HCA corporate fall prevention initiative, Swedish Medical Center's pharmacy department implemented a pharmacist fall prevention program in March 2011. Pharmacists evaluate every patient aged 65 and older currently receiving two or more fall risk medications, and provide evidence-based recommendations to decrease patient fall risk. Pharmacists check to see that medications are dosed appropriately for the patient's age, renal function and hepatic function.

Physicians are to be notified if their patient experiences a fall, and all falls and precautionary measures should be documented. The physician is accountable for the assessment following a fall.

## Frequency and Timeliness of Physician Visits

(a) Patients admitted to a general medical/surgical/pediatric unit must be seen initially:

### *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
Well Newborn:	24 hours
Newborn Admitted to NICU:	1 hour
NICU Level II:	8 hours
NICU Level III:	2 hours if stable, 30 minutes if unstable
PICU	2 hours if stable, 30 minutes if unstable
Peds Admission	8 hours

(b) The admitting physician must see their patient daily.

(c) 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.

## Health Care Associated Infections (HAIs)

Surgical site infections, central line related blood stream infections, ventilator associated pneumonia, healthcare associated pneumonia, multi-drug resistant organisms, clostridium difficile, and Foley related urinary tract infections are all HAIs. Each is defined by the Centers for Disease Control through the National Healthcare Safety Network (NHSN). HAIs appear 48 hours after admission with no sign of incubation of the infection on admission. Consumers express concern that health-care professionals don't take these infections seriously enough, and government agencies now refuse payment for infections acquired during a hospital stay.

The most important way to prevent any HAI is by **practicing hand hygiene — every patient, every contact, every time.**

## Hold Hours

“Hospital hold hours” is a throughput metric used to track the flow of patients out of the Emergency Department into hospital beds. The goal is to move patients within 59 minutes of the time a disposition to admit has been made. If you need to go to the Emergency Department to assess and evaluate your patient, please be mindful of the 59-minute goal and work with the emergency department team to move the patient as soon as an inpatient bed becomes available. Inpatients occupying emergency beds prevent waiting patients from being seen by a physician.

## Influenza

Every patient over the age of 6 months should receive an influenza vaccination.

The State of Colorado mandates influenza vaccinations for all health care workers.

Physicians and advanced practice professionals will be required to submit proof of vaccination to the Medical Staff Office annually. Physicians and DHPs declining to be vaccinated must submit a medical exemption for declination of vaccine and must wear a mask when in patient care areas from November 1 through March 31 annually.

### Lab Testing Reimbursement

Physicians are advised by CMS to order only those tests and/or services which are medically necessary. A specific diagnosis, sign, symptom, or ICD-9-CM code must be provided when ordering tests or services.

When ordering tests or services that do not meet criteria for medical necessity, physicians should explain to the beneficiary why the test is being ordered and that Medicare may not pay for the test.

To limit the potential risk for both physicians and ancillary departments, we have adopted the OIG Model Compliance Plan for Laboratories and several policies related to Medicare billing. We offer only laboratory panels which are approved by the CMS or order sets (profiles) requested by and approved by the executive committee of our medical staff. There are instances when abnormal values for specific tests warrant additional testing. Therefore, we have created reflex-testing guidelines.

### Labels Required

On and off the sterile field, all syringes must be labeled when drawing up medications; all basins must be labeled as to contents.

### Level of Care/Status

All HCA facilities are adopting the following language for patient status:

- Admit to inpatient status
- Place patient in outpatient status (for a procedure)
- Place patient in outpatient status and begin observation services

Patients must meet medical necessity for the level of care ordered. If InterQual criteria are not met for the order written, the RN case manager will contact the attending physician. For questions about status requirements, speak to an RN case manager or

contact the case management supervisor or director.

Observation services cannot be routinely written following an outpatient procedure. This can only occur when a complication arises following the normal 4-6 hours expected recovery time. The reason for observation must be documented in the context of the order at the time the complication develops or in the progress notes.

### Medication Reconciliation

All patient medications must be reconciled upon admission, inpatient transfer, and dismissal. Reconciliation involves comparing the patient's list of medications to the physician's admission, transfer, and/or discharge orders.

We have a computerized system that captures all three components and produces a printed list for the patient at discharge. Discharge dictation and computerized discharge patient medication instructions should always match.

### Organ and Tissue Donation

Our policy is to request staff from Donor Alliance to provide the initial approach to families of all potential organ and tissue donors. Physicians should not approach the patient or family.

The physician notifies the nurse or case manager to contact Donor Alliance after the patient and/or next-of-kin, along with the attending physician, have made the decision to terminally wean and/or disconnect a ventilator in order to allow death to proceed unobstructed by medical measures. The referral to Donor Alliance shall be made prior to disconnection of the patient from the ventilator and/or initiation of the terminal weaning process.

Appropriate candidates for donation:

- The patient has a non-recoverable neurological injury and the attending/consulting physician has determined that the patient's medical condition is inconsistent with life and the patient's family has begun discussion to withdraw life support/ventilation.
- Cardio respiratory death will likely occur within one hour following withdrawal of life support.

The attending physician or designee continues full responsibility for the patient until the patient's death

is pronounced, and is the individual who pronounces death in the operating room at the discontinuation of ventilator support and/or removal of the ET tube.

Comfort measures are to be provided as deemed appropriate by the physician per hospital policy and guidelines.

## **Pain Management**

We are committed to achieving optimal pain management. Pain is assessed and documented at admission, every shift, and PRN, to include location, quality and intensity. Pain assessments are to be done on all patients at all levels of care. A plan of care with the goal of patient comfort and reduction of complications should be implemented.

## **Patient Identification**

It is our policy to verify the identification of all patients during communication about patients and prior to the provision of care, including diagnostic testing and treatment. A minimum of two identifiers are used to identify patients. The primary patient-specific identifier is the patient's first, middle and last name as stated on the patient's armband. If this identifier is correct, a second identifier - patient birth date on the armband - can be compared with orders, labels, requisitions, etc. Prior to the start of a procedure, ask the patient to state his/her name and date of birth. If the patient is unable to participate in the identification process, ask a relative or another caregiver to identify the patient. Never use a room number.

## **Patients at Risk of Suicide**

All inpatients, outpatients receiving observation services, outpatient procedure patients and Emergency Department patients are to be screened upon admission for risks concerning suicide or harm to self.

## **Personal Protective Equipment**

Standard precautions protect you from infections. Use personal protective equipment (PPE)—gloves, mask, gown and/or eye protection—whenever needed

to prevent exposure to blood, body fluids, excretions or secretions. Always perform hand hygiene before and after seeing each patient.

Contact precautions require that you put on a pair of gloves and gown EVERY time you enter the contact precaution room and remove them every time you exit the room. Always use alcohol hand sanitizer or wash your hands after you remove and dispose of your gloves and gown. Gloves should not be worn in the hallway.

Remember, C. Difficile is not removed from the hands with alcohol hand sanitizer. The friction from washing hands with soap and running water is required.

Droplet precautions require that you put on a procedure mask whenever you are within three feet of a patient that is infectious or potentially infectious. We encourage staff to wear a mask whenever they enter the patient room.

Airborne precautions require that the patient be in a negative pressure room and that everyone entering the room wear an N-95 mask. Fit testing is available at the Employee Health Office. It is imperative to remember to close the door to the room and keep it closed at all times.

## **Physician Notification/Chain of Command**

This policy outlines a formal line of communication for hospital staff that has concerns regarding a prescribed treatment plan (or the lack thereof) or a medical decision or act.

If unable to contact physician, or there are concerns about the physician's orders or treatment plan, staff are to contact their immediate supervisor for consultation and support.

If staff remains uncomfortable with the plan of care after consultation with their immediate supervisor, they are to progressively activate the following chain of command: notification of department manager, department director or director on call, administrator on call.

Management staff will assist with activation of the physician chain of command by progressively notifying the following: attending physicians or designee, medical director of the department, chief medical officer, and chair of section.

## Point-of-Care Testing (Waived Testing)

The only people who can perform waived tests or any point-of-care tests are those who have successfully completed a competency assessment within the last 12 months. Therefore, physicians may not perform any point-of-care lab tests, including occult bloods, vaginal pHs, and urine dipsticks, unless they have completed the annual competency assessment and this information is documented in their credentialing files.

For additional information, contact the laboratory point of care coordinator.

## Rapid Response Team

Sixty percent of inpatients who experience cardiac or respiratory arrest show signs of deterioration up to six hours beforehand. Our Rapid Response Team (RRT) helps nurses recognize these signs and take preventive action.

Available to all adult units 24 hours every day, the team is comprised of an experienced RN from the Intensive Care Unit and a respiratory therapist. They respond to a call from a nurse (through the emergency page operator, Ext. 5555). They help the nurse assess the patient, make recommendations for appropriate action, and assist with stabilization, support, or transfer if necessary. The team also contacts the admitting physician for orders and a report.

Reasons to activate the team include a drop in blood pressure, heart rate, oxygen saturation or respiratory rate; chest pain; and/or a change in neurological status.

## Restraint and Seclusion

We are dedicated to fostering a culture that supports a patient's right to be free from restraint or seclusion. Restraint use is limited to clinically justified situations, and the least restrictive restraint is used with the goal of reducing and ultimately eliminating the use of restraints.

The registered nurse performs an assessment when a patient exhibits behavior that may place the patient at risk. Patients who are found to be at risk and may need restraint will have alternative options initiated

promptly. If the RN determines that alternatives to restraint have failed and that the patient will be safer with restraint than without, management will review the need for restraint and the physician will be called.

An order for restraint must be obtained from an LIP/physician who is responsible for the care of the patient prior to the application of restraint. The order must specify clinical justification for the restraint, the date and time ordered, duration of use, type of restraint to be used and behavior-based criteria for release. A physician or licensed independent practitioner must evaluate the patient in person within one hour of the initiation of the restraints. An order for restraint may not be written as a standing order, protocol or as a PRN or "as needed" order. If a patient was recently released from restraint or seclusion, and exhibits behavior that can only be handled through the reapplication of restraint or seclusion, a new order is required.

Please note that there are maximum times according to type of restraint. For additional information refer to HCA Clinical Policy - Patient Restraint/Seclusion CSG.CSG.001.

## Sedation

Contact Medical Staff Services for information on obtaining credentials for moderate sedation, including a learning packet and information on credentialing.

Drugs that require privileges for deep sedation are identified in medical staff privileges.

## Surgical and Invasive Procedure Safety

We endorse the Universal Protocol for preventing wrong patient identity, wrong procedure, and wrong site prior to invasive procedures. Key elements include:

- Active participation with quality and effective communication among all members
- Confirmation of correct patient identity, procedure, side/site and position
- Marking the intended site prior to surgery/procedure
- Time out: a final assessment immediately before the surgery/procedure verifying that the correct patient, site, positioning, and procedure are identified and that all relevant documents, information, and equipment are available.

## Surgical Site Infections

Risk factors for a surgical site infection include diabetes, nicotine use, steroid use, obesity, malnutrition, prolonged preoperative stay, preoperative nares colonization and perioperative transfusion.

### Recommendations:

- Antimicrobial prophylaxis
- No hair removal, or hair removal by clippers only
- Control serum blood glucose levels and avoid hyperglycemia preoperatively
- Effective skin prep (require patients to shower/bathe with an antiseptic agent preoperatively)
- Surgical scrub and hand hygiene, surgical dress attire/draped
- Inspect sterile items for contamination before opening

— *Guideline for Prevention of Surgical Site Infection, 1999. SHEA/IDSA Practice Recommendation: Strategies to Prevent Surgical Site Infection in Acute Care Hospitals, 2008.*

## Transfer of Patients

To transfer a patient to a HealthONE medical center, call the RN transfer coordinator at HealthONE's access center at 1111 or 1-888-796-6378. Request either a physician consult or transfer and admission. Once physician acceptance has been verified, the transfer coordinator will request basic patient information and make a bed assignment.

## Unacceptable Abbreviations

<u>Unacceptable</u>	<u>Correct</u>
I.U. or IU	International Unit
U or u	Unit
Q.D. or QD	Every Day
Q.O.D or QOD	Every Other Day
MgSO4	Magnesium Sulfate
MS	Morphine Sulfate
MSO4	Morphine Sulfate
<b><u>Dose expressions</u></b>	
Zero After decimal (1.0 mg)	1 mg
No Zero Before decimal (.5 mg)	0.5 mg

## Vaccine Assessment

Adult influenza and pneumococcal vaccine assessment is automatically performed by nursing. If the patient is eligible for the vaccines, an order is entered electronically by Pharmacy.

## Vancomycin Dosing and Monitoring

To initiate vancomycin therapy, it is recommended that the prescriber consult "pharmacy to dose."

Vancomycin dosing will be adjusted by pharmacy based on the desired trough for each specific indication. In your order for "pharmacy to dose vancomycin," please be sure to specify the indication and site of infection.

In order to properly dose vancomycin, serum creatinine (SCr) will need to be drawn on a regular basis (usually every 1-3 days depending on the patient's condition and the protocol being used.)

## Ventilator-Associated Condition

**On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, the patient meets both of the following criteria:**

1) Temperature > 38 °C or < 36°C, OR white blood cell count ≥ 12,000 cells/mm<sup>3</sup> or ≤ 4,000 cells/mm<sup>3</sup>.

AND

2) A new antimicrobial agent(s) is started, and is continued for ≥ 4 calendar days.

### **Infection-related Ventilator-Associated Complication (IVAC) -- Possible Ventilator-Associated Pneumonia**

**On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, ONE of the following criteria is met:**

- 1) Purulent respiratory secretions (from one or more specimen collections)
  - Defined as secretions from the lungs, bronchi, or trachea that contain >25 neutrophils and <10 squamous epithelial cells per low power field [lpf, x100].

- If the laboratory reports semi-quantitative results, those results must be equivalent to the above quantitative thresholds.
- 2) Positive culture (qualitative, semi-quantitative or quantitative) of sputum, endotracheal aspirate, bronchoalveolar lavage, lung tissue, or protected specimen brushing.

**Infection-related Ventilator-Associated Complication (IVAC) -- Probable Ventilator-Associated Pneumonia**

**On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, ONE of the following criteria is met:**

- 1) Purulent respiratory secretions (from one or more specimen collections—and defined as for possible VAP) AND one of the following:
- Positive culture of endotracheal aspirate,  $\geq 105$  CFU/ml or equivalent semi-quantitative result
  - Positive culture of bronchoalveolar lavage,  $\geq 104$  CFU/ml or equivalent semi-quantitative result
  - Positive culture of lung tissue,  $\geq 104$  CFU/ml or equivalent semi-quantitative result
  - Positive culture of protected specimen brush,  $\geq 103$  CFU/ml or equivalent semi-quantitative result
- 2) One of the following (without requirement for purulent respiratory secretions):
- Positive pleural fluid culture (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube)
  - Positive lung histopathology
  - Positive diagnostic test for *Legionella* spp.
  - Positive diagnostic test on respiratory secretions for influenza virus, respiratory syncytial virus, adenovirus, parainfluenza virus.

**VTE Core Measures**

**VENOUS THROMBOEMBOLISM NATIONAL HOSPITAL INPATIENT QUALITY MEASURES**

Set Measure ID #	Measure Short Name
VTE-1	Venous Thromboembolism Prophylaxis
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
VTE-4	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram
VTE-5	Venous Thromboembolism Warfarin Therapy Discharge Instructions
VTE-6	Hospital Acquired Potentially-Preventable Venous Thromboembolism

Failure to prevent VTE can result in delayed hospital discharge or readmission, increased risk for long-term morbidity from post-thrombotic syndrome, and recurrent thrombosis in the future. Like other core measures, the VTE Measure set is endorsed by the National Quality Forum and is publicly reported on CMS Hospital Compare website. The VTE measures assess:

- The number of patients at risk for VTE who received VTE Prophylaxis on the day of or day after admission.
- The number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).
- The number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.
- This measure assesses the number of patients diagnosed with confirmed VTE that are discharged on warfarin with written discharge instructions that address all four criteria. Written information given

to the patient is required to address each and every one of the educational components.

- The number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.
- Patients diagnosed with VTE have 5 days overlap of parenteral anticoagulation and warfarin therapy or documented reason why not.

## Medical Staff Responsibilities

### Advanced Clinicals/CPOE

In early 2014, HealthONE implemented the Advanced Clinicals portion of Meditech and the Electronic Health Record (EHR). This includes Computerized Physician Order entry (CPOE), Provider Documentation (pDOC) and Electronic Medication Reconciliation. All new medical staff providers will be trained on the use of these electronic documentation methods and related technologies supporting their use as part of routine practice. It is the expectation that these electronic documentation systems are utilized by all providers (with some exceptions to be discussed during training). The use of EHR for documentation and CPOE has been supported by all MEC's as a condition of securing and maintaining privileges.

### Adverse/Sentinel Event Reporting

If a significant event is reported to the Risk Management Department, an investigation is initiated. When the event occurs, the priority is to take care of those affected by the event, i.e. the patient, employees, physicians, and family. Once all immediate patient-care needs have been addressed, an occurrence report must be submitted. Nursing staff submits all notifications through Meditech. Physicians have the opportunity to submit any occurrence that they desire to be investigated further. Notification of such occurrences can be done by contacting a member of the risk management department.

TJC defines sentinel event as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious

injury specifically includes loss of limb or function. The phrase 'or the risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome."

TJC Standard LD.04.04.05, EP7 requires each accredited hospital to define sentinel event for its own purposes and to communicate this definition throughout the organization. While this definition must be consistent with the general definition of sentinel event as published by TJC, accredited hospitals have some latitude in setting more specific parameters to define unexpected, serious, and the risk thereof. For additional information, go to: [http://www.jointcommission.org/sentinel\\_event.aspx](http://www.jointcommission.org/sentinel_event.aspx)

Often, events occur that do not meet the sentinel event definition but are considered significant; these events necessitate thorough analysis and require an investigation or a RCA. Following a RCA, an action plan is developed and each plan is evaluated through its established measure of success (MOS). The continual monitoring of MOS is imperative to the patient safety processes. All Risk Management activities are protected pursuant to Colorado Law. For additional information, go to:

[http://www.jointcommission.org/Framework\\_for\\_Conducting\\_a\\_Root\\_Cause\\_Analysis\\_and\\_Action\\_Plan/](http://www.jointcommission.org/Framework_for_Conducting_a_Root_Cause_Analysis_and_Action_Plan/)

### Continuing Medical Education

We offer many continuing education conferences for members of the medical staff; the calendar and more detailed information are available at:

[www.swedishmedicalcenter.com](http://www.swedishmedicalcenter.com) under "For Physicians." You may also contact the HealthONE Continuing Medical Education department at (303) 788-8839.

### Computer Support

For assistance with computer issues, call the dedicated physician information systems help desk line at 720-612-6022. This is a dedicated physician line which receives high priority.

## Device/Product Malfunction or Failure

Any member of the Medical Staff who suspects that any piece of medical equipment, device or product is not working correctly is obligated to report his/her suspicion to an employee and/or to the Bio Med department for follow-up and verification that the equipment is functioning correctly.

## Disaster Response

In the event of a community disaster, communication regarding the disaster's scope and the response of the Medical Staff must be timely. If you are in the hospital, at your office or home and become aware of a pending or an in progress disaster impacting our community, you can acquire timely information and instructions by doing any of the following:

- If you need to speak with someone, call the Swedish Medical Center Main Operator and ask the operator to connect you to the Swedish Medical Center Incident Command Center if it is activated. Otherwise, the operator can connect you to an administrator; or
- Go directly to the physician's lounge report to the Chief Medical Officer or designee.
- Do not report directly to the Emergency Department unless you are instructed to do so.

## Disruptive Physician Behavior

It is our policy that all individuals be treated courteously, respectfully, and with dignity. To that end, we require all individuals, employees, physicians, and other independent practitioners to conduct themselves in a professional and cooperative manner in the medical center. Inappropriate behavior should be reported to the clinical service department chairperson, the chief medical officer (CMO) or the chief executive officer (CEO).

## Documentation Requirements

Failure to maintain timely records can be detrimental to patient care, compensation, and legal issues, and it endangers the physician's privileges.

Failure to complete medical records within the specified time frame shall result in a delinquent episode.

A delinquent episode is the failure to complete one or more medical records within 30 days from date of discharge. Delinquent episodes can lead to placing the physician on automatic suspension of privileges, intensified monitoring, or automatic voluntary resignation of repeat offenders.

## Ethics and Compliance

### Business ethics:

The HCA Code of Conduct provides guidance and assistance with carrying out daily activities within appropriate ethical and legal standards.

To view the HCA Code of Conduct, go to <http://hcaethics.com/CPM/Code%20of%20Conduct%20Booklet%20w.%20HCA%20logo.pdf>

This site can also be accessed from the Intranet page on Ethics and Compliance.

If you have questions about business ethics or the Code of Conduct, call the Ethics and Compliance Officer at your facility or the HCA Ethics Line at 800-455-1996.

### Physician Relationships:

Health care facilities like those owned and operated by HCA reflect collaboration between those who are part of HCA and those who have been credentialed and privileged to practice in HCA facilities. As in any collaboration, each party has important roles and responsibilities. Federal and state laws and regulations govern the relationship between hospitals and physicians who may refer patients to the facilities. The applicable federal laws include the Anti-Kickback Law and the Stark Law. If relationships with physicians are properly structured, but not diligently administered, failure to administer the arrangements as agreed may result in violations of the law. Any arrangement with a physician must be structured to ensure compliance with legal requirements, HCA policies and procedures and with any operational guidance that has been issued. Most arrangements must be in writing and approved by the Legal Department.

If you have any questions related to physician relationships please contact the facility Ethics and Compliance Officer.

### **Clinical ethics:**

For assistance with ethical concerns related to patient care, contact a Case Manager who will assist in arranging a consultation with the Ethics Committee. HCA Clinical ethics information can be found at:

<http://hcaethics.com/introduction/clinical-ethics.dot>

### **HCAHPS Hospital Survey Questions**

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The purpose of this survey is to provide comparable data on the patients' perspectives of care. After their hospital stay patients are randomly selected by a contracted company to complete the survey. The data comparing hospital results is available at [www.hospital-compare.hhs.gov](http://www.hospital-compare.hhs.gov). Most questions are answered using the following scale: never, sometimes, usually, and always. The "always" response is what is reported on the comparative data. The questions are:

- How often did nurses treat you with courtesy and respect?
- How often did nurses listen carefully to you?
- How often did nurses explain things in a way you could understand?
- After you pressed the call button, how often did you get help as soon as you wanted it?
- How often did doctors treat you with courtesy and respect?
- How often did doctors listen carefully to you?
- How often did doctors explain things in a way you could understand?
- How often were your room and bathroom kept clean?
- How often was the area around your room quiet at night?
- How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

- How often was your pain well controlled?
- How often did the hospital staff do everything they could to help you with your pain?
- Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
- Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
- Did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
- Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
- Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
- Would you recommend this hospital to your friends and family?

### **Ill and Impaired Licensed Independent Practitioners**

Physicians may encounter challenges that impair their ability to practice medicine, such as drug or alcohol addiction, mental or physical disability, or even the aging process. The Colorado Physician Health Program (CPHP) is designed to help physicians travel the road to recovery. The program, founded in 1986, is grounded in a fundamental philosophy of confidentiality for its participants and for those who report physicians. Except in a criminal action, any information acquired is confidential and may not be disclosed without written consent. To contact Colorado Physician Health Program, call 303-860-0122. All requests for information are held in strict confidence.

#### **Our process**

We have a process to address practitioners and others with clinical privileges that have physical, psychiatric or emotional illness that requires confidential diagnosis, treatment, and rehabilitation.

Concerns regarding a practitioner can be relayed to

the house supervisor, a director or administrator on call, chief medical officer or other member of the senior management team. Confidentiality must be maintained at every step.

The credibility of the complaint will be evaluated. The practitioner will be informed that a concern regarding impairment has been received.

If the concern is substantiated, the practitioner will be referred for evaluation. He or she may then be asked to voluntarily enter a rehabilitation program and request medical leave of absence or restrict his or her privileges pending completion of rehabilitation. A monitoring program will be initiated and followed upon the practitioner's return.

Any practitioner who is not safe to practice or refuses help will be referred to the medical executive committee for corrective action, and precautionary suspension may be initiated.

## **In-Hospital Emergencies**

### **Fire, smoke, or suspected fire:**

Move patients from immediate danger. Call 5555, to activate a "Code Red" give location and identify yourself. If no phone is available, pull the closest fire alarm.

### **Cardiac or respiratory arrest:**

Call 5555, say "Code Blue", give location and identify yourself.

### **Infant/Child Abduction:**

Call 5555, say "Code Pink", give Unit, location and identify yourself.

### **Security emergency:**

Call 5555 to activate a "Code PAUL BUNYAN" and give the operator the location of the emergency (Department, Floor and Room Number).

### **Hazardous material spill:**

Call 5555 to activate a "Code Orange", give the location and identify yourself.

### **Severe Weather Plan enacted:**

Move patients to interior rooms and corridors; if unable to do so, cover patients with blankets or mattresses and move them as far from windows as possible. Close all doors and windows, pull down window shades and blinds. Move to interior rooms. Do not leave the building.

Further information about emergency procedures, emergency conditions and systems failure can be found in the back pages of the Swedish Medical Center telephone directory.

## **Joint Commission and Physicians**

The Joint Commission (TJC) is a private, not-for-profit organization dedicated to continuously improving the safety and quality of care provided to the public. TJC is the nation's principal standards setter and evaluator for a variety of healthcare organizations.

TJC's Board of Commissioners has identified enhancing physician engagement in accreditation and other quality improvement initiatives as some of its top strategic priorities.

With an ability to serve as a bridge between patients and staff, and staff and management, physicians play a unique leadership role in fostering improvements in care.

Physician leadership and involvement are critically important to the success of TJC's patient safety improvement efforts, including:

- Standards review
- National patient safety goals
- Healthcare summits
- Sentinel event alert topics

The Physician Engagement Advisory Group advises TJC on expanding physician participation in the accreditation process and broadening physician engagement in quality of care and patient safety initiatives.

For more information, see the "Quality and Safety" section of this guide or log on to [www.jointcommission.org](http://www.jointcommission.org).

## **Medical Staff Obligations –**

*— Extracted from the Model Medical Staff Bylaws 2013 – These bylaws may not have been adopted by all Continental Division facilities as of this date.*

- 2.7.2. Provide continuous care to his/her patients at the generally recognized professional level of quality and efficiency established by the Hospital; delegate

- in his/her absence, the responsibility for diagnosis and/or care of his/her patients only to a Practitioner who is a Member in good standing of the Medical Staff and who is qualified and approved by the Hospital to undertake this responsibility by the granting of appropriate clinical privileges; and seek consultation whenever necessary, and in accordance with the consultation policies of the Medical Staff.
- 2.7.3. Abide by these Bylaws, the Rules and Regulations, Medical Staff Policies, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital in force during the entire term of appointment or clinical privileges;
  - 2.7.4. Abide by all local, State and Federal laws and regulations, Joint Commission and other accreditation standards as they apply within the Hospital, and State licensure and professional review regulations and standards, as applicable to the applicant's professional practice;
  - 2.7.5 Participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as maybe assigned;
  - 2.5.6. Within the scope of clinical privileges granted, to provide on-call coverage for emergency care services within his/her clinical specialty, as required by the Hospital or the Medical Staff;
  - 2.7.7 Comply with clinical practice protocols and evidence-based medicine guidelines that are established by, and must be report to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;
  - 2.7.8 Participate in necessary training and utilize the electronic record systems or other technology in use by the Hospital to prepare a patient record for each patient;
  - 2.7.9 Complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital;
  - 2.7.10 Utilize the Electronic Health Record (EHR) system of the Hospital;
  - 2.7.11 Cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;
  - 2.7.12 Participate in peer review, quality assessment, performance improvement, risk management, case management/resource management, and other review and improvement activities as requested;
  - 2.7.13 Cooperate with all oversight activities related to utilization and medical appropriateness;
  - 2.7.14 Participate in continuing education to maintain clinical skills and current competence;
  - 2.7.22 Agree that the Hospital may obtain an evaluation of the applicant's performance by a consultant selected by the Hospital if the Hospital considers it appropriate;
  - 2.9.3.11. The individual shall specifically agree to immediately provide in writing within one business day of being officially notified of a change in status, a notice to the Medical Staff and the Hospital, with or without request, of any new or updated information that is pertinent to the individual's professional qualifications or any question on the RFC/RRFC form, including but not limited to any change in Federal Health Care Program ineligible Person status, any exclusion from a State Program, any change in licensure in any state, any change in DEA status or status with a State controlled substance regulatory agency, or any exclusion or other sanctions imposed or recommended by the U. S. Department of Health and Human Services or any state, the receipt of a Quality Improvement Organization (QIO) citation,

any change in legal status to reside and/or work in the USA, any investigation by a specialty certification board, any payer contract termination, any change in health status, any change in location of office or residence, loss of on-call coverage, any criminal investigation, termination of or notice of non-renewal of professional liability insurance coverage, initiation of any corrective action by any health care facility or professional organization, and/or a quality denial letter concerning alleged quality problems in patient care.

- 3.8 The term, “Advanced Practice Professional” (AAP) refers to individuals, other than those defined as a Practitioner, who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. Categories/types of APPs eligible for clinical privileges shall be approved by the Board of Trustees and shall be credentialed through the same processes as a Medical staff Member, as described in Article Two, and shall be granted clinical privileges as either a dependent or independent healthcare professional as defined State laws and in these Bylaws. Although APPs are credentialed provided in these Bylaws, in Article Two, they are not eligible for Medical Staff membership. They may provide patient care services only as permitted by state laws and to the extent of the clinical privileges that have been granted. The Board of Trustees has determined the categories of individuals eligible for clinical privileges as an APP are physician assistant (PA), certified registered nurse anesthetists (CRNA), anesthesiology assistant (AA), certified nurse midwives (CNM), clinical psychologist (Ph.D.), advanced registered nurse practitioners (ARNP), and clinical nurse specialists (CNS).<sup>75</sup> A medical Staff Member who fails to fulfill the responsibilities as outlined in the Rules and Regulations and/or in a sponsorship agreement for the supervision of an APP or a dependent healthcare professional shall be subject to appropriate actions provided by these Bylaws.

## Patient Privacy (HIPAA)

All healthcare providers are obligated to take reasonable safeguards to protect patient privacy. Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) regulations govern providers’ use and disclosure of health information, and grant patients rights of access and control. They also establish civil penalties for violations of patient privacy which include fines ranging from \$100 to \$50,000 for each episode. Criminal penalties for non-compliance may also be assessed. When privacy violations occur, disciplinary action will be taken.

Healthcare providers’ obligation to protect patient health information includes all formats: written, electronic and oral communication.

Protected Health Information (PHI) may not be discussed in front of a patient’s family, friends and/or visitors without the patient’s permission. There are two exceptions to this portion of the rule: professional judgment and emergency situations.

In normal situations, you should ask individuals to momentarily leave a patient’s room while you discuss the patient’s health information/condition with the patient. Other situations when you should be especially aware of protecting verbal disclosures occur with reports, educating students, voice messages and telephone conversations, and discussions in waiting rooms or semiprivate rooms. When discussing health information with another provider or the patient, use reasonable safeguards to prevent others from overhearing.

Additional safeguards should include:

**Patient Lists:** Place physician patient lists in one of the hospital shredding bins rather than the trash.

**Images or photography:** When using images for presentation, remove information that may identify the patient. Photography of patients for non-treatment purposes (e.g. education) mandates that a specific patient release be obtained. Please contact the facility privacy official (FPO) at the hospital to ensure the release has been obtained prior to photography. All treatment related photography must

be obtained utilizing a hospital camera or device. Cell phone photography is not permitted.

Texting protected health information: DO NOT send any type of sensitive data to text pagers. Text pager message traffic is very easily monitored by publically available websites. You may send text messages containing sensitive data to PDAs (cell phones that are able to use text messaging and send/receive e-mail). The frequencies that text messaging devices use are far more secure than the frequencies used by text pagers, and it is illegal to monitor the text messaging frequencies. However, to prevent a breach, delete messages as soon as possible or encrypt your memory card. The recommendation at this time is to delete the message immediately after sending or receiving the text or e-mail, to remove sensitive information from your physical device.

Hospital employees may request your medical staff identification number when questioning your identity on a telephone call requesting PHI.

Physicians may only access, use or disclose PHI when they have a legitimate need to know in order to perform their job function, regardless of the extent of access provided to them.

You can also contact the FPO at the facility.

## Patient Rights and Responsibilities

Upon admission, all patients or their identified medical representative are given a copy of "Patient Rights and Responsibilities".

Patient rights include the right to accept or refuse any procedure, drug or treatment. Inpatients also have the right to appeal their dismissal.

## Physician Immunizations

Physicians and allied health professionals working at HealthONE medical centers are required to provide documentation of immunization against vaccine-preventable diseases and identification of susceptibility to infectious disease, as a condition of appointment, reappointment and continued affiliation, in accordance with TJC.

This screening, vaccination and assessment are an essential part of our infection control efforts to protect patients and safeguard coworkers from possible infection.

Our employee health department will initiate, at no cost to the practitioner, testing for antibody titers as indicated to complete these requirements. The administration of any other immunizations to practitioners will be determined according to community prevalence and by infection control.

In the event of an outbreak with new public health recommendations, an announcement will be made and education and instructions will be provided.

Annual vaccination with influenza vaccine will be offered to all practitioners working within the facility. The State of Colorado Board of Health issued a ruling which requires physicians to be immunized against influenza unless said immunization is medically contraindicated as described in the FDA product labeling, and who have a confirmed medical reason that they cannot receive the vaccine because it will be harmful to their health. **IF** a physician has a medical exemption, the policy requires that the physician wear a surgical or procedure mask during influenza season (November – March) when in direct contact with patients and in common areas as specified by the facilities policy.

## Physician Relations and Outreach Department

The physician relations and outreach department is a valuable resource for facilitating communication between Swedish Medical Center and physicians throughout the service area. The department's staff members work with our administrators, medical staff office, and Continuing Medical Education department to coordinate various services for physicians and their staff members. For more information, call the department at 303-788-6252.

## Quality and Safety

We have systems and programs in place to monitor and evaluate the quality of patient care and patient safety and to identify and address actual or potential risks.

Areas of focus are determined by hospital leadership in collaboration with the medical staff. Publically reported data include core measure performance (see below), patient satisfaction data

(HCAHPS), infection rates, and other specific project areas such as cardiothoracic surgery outcomes and care. We are committed to delivering excellent care based upon evidenced-based guidelines which are accepted at a national level.

The phone number for Swedish Medical Center Quality Department is 303-788-4807. The number for Swedish Medical Center's Safety Officer is 303-788-5560.

### **Core measures collected and reported**

#### **Outpatient procedures**

- Timing of Antibiotic Prophylaxis
- Antibiotic Selection

#### **Stroke**

- VTE prophylaxis
- Discharged on antithrombotic therapy
- Anticoagulation therapy for atrial fib/flutter
- Thrombolytic therapy received
- Antithrombotic therapy by end of day 2
- Discharged on statin medication
- Stroke education
- Assessed for rehabilitation

#### **Perinatal care**

- No elective delivery < 39 weeks
- Cesarean section rate for nulliparous women with single term infant
- Health care associated bloodstream infections in newborns
- Exclusive breast milk feeding (may be breast milk in a bottle)

#### **Surgical Care Improvement Measures**

- Prophylactic antibiotic received within one hour of surgical incision
- Prophylactic antibiotic discontinued within 24 hours after surgery
- 6 a.m. blood glucose of cardiac surgery patients <200 day 1 and day 2
- Surgery patients with appropriate hair removal
- Urinary catheter removed on POD 1 or 2 with day of surgery being zero
- Beta blocker given before surgery if patient takes beta blockers at home

- Recommended VTE prophylaxis ordered for surgery patient
- Surgery patient received recommended VTE prophylaxis within 24 hours of surgery and 24 hours after surgery

#### **Heart failure**

- Evaluation of LVS function
- ACEI or ARB for LVSD

#### **Pneumonia**

- ICU patients receive blood cultures within 24 hours prior to or after hospitalization
- Blood cultures performed before antibiotic received
- Correct antibiotic administered in the first 24 hours selected for patient health status (immunocompromised or immunocompetent, ICU or floor)

#### **Immunization**

- Immunization rate of influenza overall everyone > 6 months of age

#### **Acute myocardial infarction**

- Aspirin on arrival
- Aspirin prescribed at discharge
- ACEI or ARB for LVSD
- Beta blocker prescribed at discharge
- Median time to fibrinolysis
- Fibrinolytic therapy received within 30 minutes of hospital arrival
- Median time to PCI
- Primary PCI received within 90 minutes of hospital arrival
- Statin prescribed at discharge

#### **Children's asthma care**

- Use of relievers for inpatient asthma
- Use of systemic corticosteroids for inpatient asthma
- Home management plan for caregivers complete and accurate

### **Reporting Safety and Quality Concerns**

Any concerns about the safety or quality of care provided may be reported to the Quality and Risk

Manager at your facility. If you feel your concern has not been adequately addressed at this level, you may contact the Division Office Quality and Patient Safety Department at 303-788-2545.

## **Workplace Threats and Violence**

We strive to maintain an environment free of workplace violence, verbal and nonverbal threats, and related actions. We have an obligation to provide a safe workplace and protect employees from threats to their safety, which obligation cannot be accomplished unless we are informed about individuals who have been ordered by the courts, or other legally constituted entities, to remain away from our location.

Workplace violence is any act against a patient, employee or visitor that creates a hostile environment and which negatively affects the involved person(s), either physically or psychologically. These acts include all types of physical or verbal assaults, threats, coercion, intimidation and all forms of harassment.

## Mission Vision and Values

The people of Swedish Medical Center are committed to the highest level of patient care and employee satisfaction. They are innovative, intelligent professionals who are the best in their respective fields, and who believe in making Swedish Medical Center one of the best health care facilities in Colorado.

### Mission

**The Mission** of Swedish Medical Center is to provide compassionate, high-quality patient care that meets the caring and cost effective expectations of our patients, physicians, employees and volunteers, and to preserve and strengthen the Swedish tradition of community service.

### Vision

**The Vision** of Swedish Medical Center is to become the provider of choice for healthcare services for our community. We will differentiate ourselves through our centers of excellence:

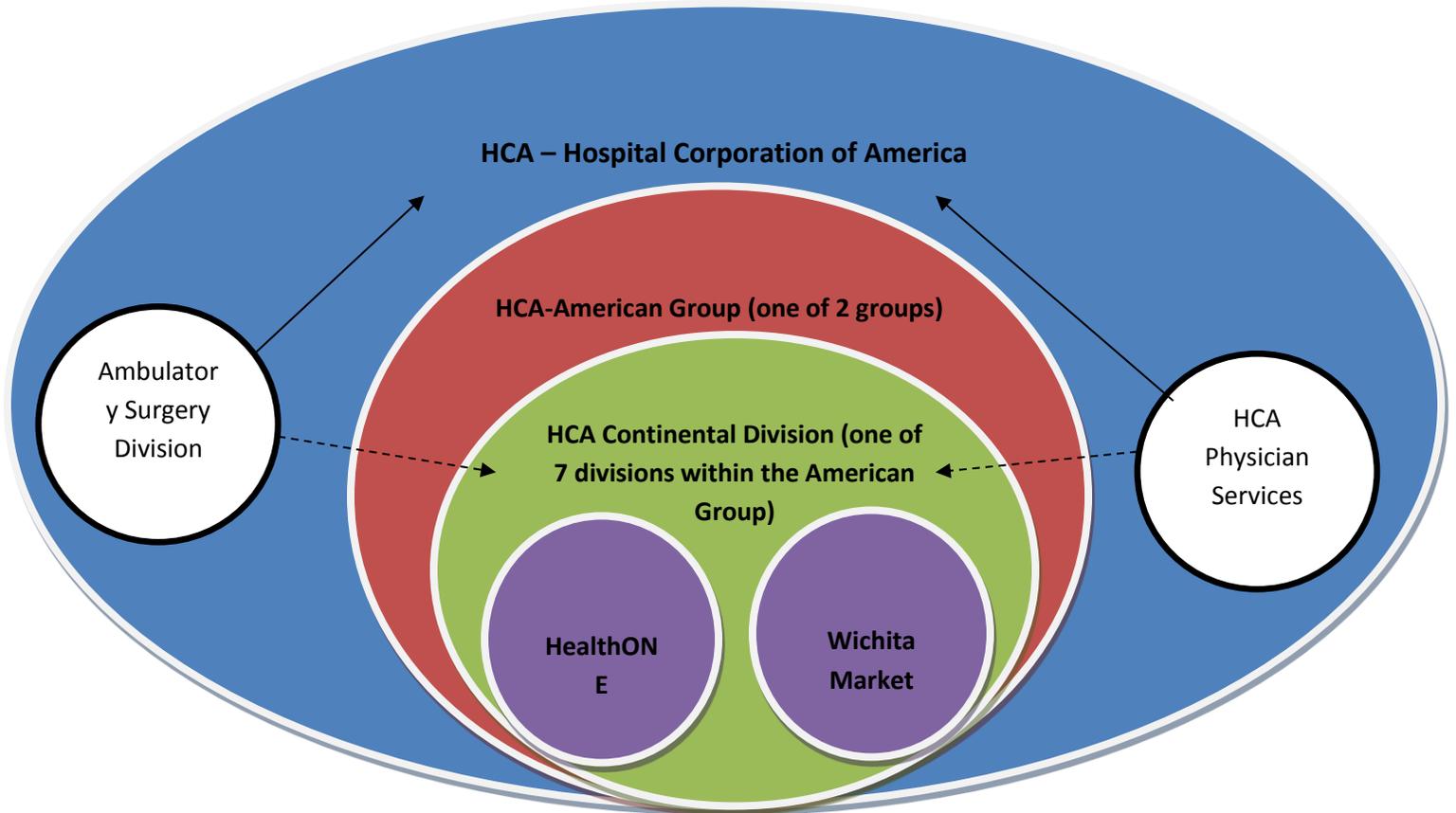
- Neurosciences, in collaboration with the Colorado Neurological Institute.
- Adult and Pediatric Trauma Services
- Cardiology Services
- Cancer Treatment Services
- Advanced Radiology Capabilities
- Women's and Children's Services

### Values

**The Core Values** guiding Swedish Medical Center include:

- Constant Courtesy
- Patient & Family Centered Care
- Teamwork & Respect
- Professionalism & Personal Responsibility

## HealthONE Corporate Structure



HealthONE is the consolidated name for the Denver Market facilities that are part of the Continental Division of HCA. The facilities included are:

- North Suburban Medical Center
- Presbyterian/St. Luke's Medical Center
- Rose Medical Center
- Sky Ridge Medical Center
- Swedish Medical Center
- Spalding Rehabilitation Hospital
- The Medical Center of Aurora

While the Ambulatory Surgery Centers and the HCA Physician Services Clinics and practices (employed physicians) carry the HealthONE name in the Denver Market, their reporting structure is through the HCA ASC Division and the HCA Physician Services Division with dotted line reporting to HealthONE Executives.

The HealthONE Board of Trustees is comprised of HCA members and Community members and carries governance responsibilities for the all hospitals of the Denver Market. The Board has delegated the approval of Credentialing and Privileging responsibilities to the Clinical Patient Safety and Quality Committee of the Board of Trustees (CPSQC). The CPSQC meets monthly to approve these documents and receive quality reporting from the facilities and reports 6 times per year to the full board.

# Leadership

## Swedish Medical Center

President and CEO .....Mary White  
 Chief Operating Officer.....Daniel Miller  
 Chief Medical Officer..... Paul Hancock, MD  
 Chief Nursing Officer .....Shari Chavez  
 Chief Financial Officer..... Kathy Ashenfelter  
 VP for Human Resources .....Lisa Morris  
 VP Physician Services & Strategy.....Lisa Ruiz  
 Associate Administrator .....David Donaldson  
 Finance Controller ..... Nathan Esparza

## Medical Executive Committee

President.....Herbert Thomas, MD  
 Vice President..... Mark Kozlowski, MD  
 Immediate Past President....Patricia Howell, MD  
 Family Medicine Chair ..... Brad Winslow, MD  
 Medicine Chair..... Ira Chang, MD  
 Surgery Services Chair .....Sue Slone, MD  
 Women’s & Children’s Chair. Nancy Germer, MD  
 Credentials Chair .....Mark Kozlowski, MD  
 Peer Review Chair.....Jeanne Seibert, MD  
 Quality Chair.....Mary Laird Warner, MD

## Medical Directors

Please refer to the Swedish Medical Center website.

## Section Chairs

Anesthesia ..... Ron Ellis, MD  
 Cardiology ..... Ira Dauber, MD  
 Critical Care... Mary Warner & Ken Lyn-Kew MDs  
 CME..... Daniel Hubbard, MD  
 Dental.....Kevin Patterson, MD  
 Emergency ..... Susan Brion, MD  
 General Surgery ..... Eric Kortz, MD  
 GI.....Eric Pieramici, MD  
 Internal Medicine .....Chris Courtney, MD  
 Neurology .....Judd Jensen, MD  
 Neurosurgery..... Paul Elliott, MD  
 Oncology ..... Lillian Klancar, MD  
 Ophthalmology .....William Richheimer, MD  
 Orthopedics .....John Woodward, MD  
 Pathology .....Jeff Truell, MD  
 Pediatrics ..... Michael Frand, MD  
 Physical Medicine & Rehab..... Elena Draznin,MD  
 Plastic Surgery ..... Terrance Murphy, MD  
 Psychiatry.....Jason Richter, MD  
 Pulmonology ..... Michelle Beutz, MD  
 Radiology ..... Matthew Fleishman, MD  
 Trauma.....Sue Slone, MD  
 Urology .....Barrett Cowan, MD

### Standardized Patient Color-Coded Wristbands

Purple- Do Not Resuscitate

Red- Allergies

Yellow- Fall Risk

Green- Latex Allergy

Pink - Restricted Extremity

Blue – Blood Bank Band

### Standardized Employee Scrub Colors

Navy- Radiology

Royal Blue - EVS

Ceil- Surgery, GI

Khaki and Black - Therapy

Caribbean- RN's

Wine- All CNA, PCT, EMT