RULES AND REGULATIONS
OF THE
MEDICAL STAFF
OF
SWEDISH HEALTH SERVICES
EDMONDS

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PREAMBLE

These Rules and Regulations are adopted pursuant to Article XIX of the Medical Staff Bylaws. They supersede, as of the date of adoption, all the previous Rules and Regulations. Terms used herein shall have the meaning given or applied to them in the Medical Staff Bylaws unless the context clearly indicates to the contrary.

SECTION I: CONSISTENCY OF CARE (STANDARDIZATION)

1.1 Standardized, Best Evidence-Based Practice
Standardized practices and care pathways are expected to be utilized and are an important foundation for quality medical care for clinicians practicing at Swedish Edmonds. When a patient’s clinical needs warrant deviating from standard practices, it is the clinician’s responsibility to document the rationale. Adherence to Hospital Standards and the Medical Staff Bylaws, Governance Documents and policies is an expectation of Practitioners.

SECTION II: ADMISSION AND DISCHARGE OF PATIENTS

2.1 Attending Practitioner Roles

Admitting Practitioner means the Physician, Oral and Maxillofacial Surgeon, or Podiatrist who is responsible for coordinating the care of a hospitalized patient.

2.1.1 Only Practitioners who hold admitting privileges may admit patients to the Hospital and serve as a Attending Practitioner. A plan of care and admission orders must be instituted within four hours of admission, and all patients admitted to the Hospital must be seen by a Physician within 24 hours of admission.

2.1.2 Attending Practitioner are responsible for admitting the patient; documenting a history and physical; providing an admitting diagnosis, an anticipated length of stay, initial inpatient orders and a plan of care. “The practitioner who admits the patient must assure that the name of the Attending Practitioner of record is entered in the medical record. This may be either the name of the practitioner who admits the patient or the name of a practitioner for whom he/she is providing coverage.

2.1.3 An Attending Practitioner shall at all times be designated for each patient receiving care in the Hospital. Any Practitioner referring a patient to the Hospital for direct admission shall be responsible for identifying a primary Attending Practitioner for the hospital stay, and for directly communicating and obtaining agreement from that accepting Practitioner to attend the patient.

2.1.4 Attending Practitioners are in charge of the care of a hospitalized patient. Attending Practitioners may share coverage with similarly privileged colleagues with the understanding that during such coverage the colleague assumes full responsibility of the Attending Practitioner.
2.1.5 A physician member of the Medical Staff shall be the attending physician responsible for the medical care and treatment of each patient in the Hospital. Whenever these responsibilities are transferred to another Medical Staff member on a permanent basis, a note covering the transfer of responsibility shall be entered in the orders of the medical record.

2.1.6 Unless care is transferred to the Consulting Practitioner and documented in the orders, the Attending Practitioner remains responsible for the orders, documentation and plan of care for the patient.

2.2 Availability
Each Practitioner attending a patient in the Hospital must be available at all times except when he/she has made arrangements for another qualified Practitioner to fulfill those requirements. If a Practitioner is unavailable and has not arranged for alternate coverage, the Chief of his/her Service or the President of the Medical Staff shall have the right to appoint another appropriately qualified Practitioner to provide such coverage.

2.3 Handoff Communication
Handoff communication from one practitioner to another is required and necessary to provide sufficient information for the care of a patient. The primary objective of a handoff is to provide accurate information about a patient’s care, treatment, and services, current condition, and any recent anticipated changes. The information communicated during a handoff must be accurate in order to meet patient safety goals.

2.3.1 Handoff communications must include:

(a) Interactive communication allowing for the opportunity for questioning between the giver and receiver of patient information.

(b) Up-to-date information regarding the patient’s care, treatment and services, condition and any recent or anticipated changes.

(c) A process for verification of the received information, including read-back, as appropriate.

(d) An opportunity for the receiver of the information to review relevant patient historical data, which may include previous care, treatment, and services.

(e) Limited interruptions to minimize the possibility that information would fail to be conveyed or would be forgotten.

2.4 Call Coverage
Each Practitioner must provide a list of his/her covering Practitioner or group. Each Practitioner is responsible for updating coverage information if there has been a change in coverage. Coverage must be provided by Physicians with comparable privileges. Covering Practitioners must assume full responsibility for patients to which they are assigned.

2.4.1 Each member of the Medical Staff shall provide appropriate and reliable coverage for the care and treatment of his or her patients, whether admitted at the Hospital or presenting themselves at the emergency room, whenever he or she is absent or unavailable. In case
of failure to provide such coverage, the Administrator, the President of the Medical Staff, the Chief of the Service concerned, or any physician on duty in the emergency room shall have authority to call any member of the active staff to attend when medically necessary or desirable.

2.5 Provisional Diagnosis
No patient shall be admitted to the Hospital until after a provisional diagnosis or valid reason for admission has been stated.

2.6 Necessary Information
It is the duty of the Admitting Practitioner admitting a patient to give such available information as may be necessary to assist in the protection of the patient from self harm and the protection of others whenever said Practitioner is aware that his/her patient might be a source of danger from any cause whatsoever.

2.7 Patient Consents

2.7.1 General Consent
In accordance with Hospital Standards, Hospital staff shall be responsible for obtaining a completed Condition of Admission form. The Condition of Admission form must be signed by or on behalf of every patient. The Manager of Patient Access should notify the Attending Practitioner whenever such consent has not been obtained. In this circumstance, except in emergency situations, treatment shall not be ordered until proper consent has been obtained with the assistance of the Attending Practitioner.

2.7.2 Informed Consent
It shall be the responsibility of the Practitioner to assure (a) that each patient is provided such information including the proposed treatment and procedures, the significant risks, benefits, and the alternatives available and (b) that the written consent of the patient (or surrogate decision-maker as described in Section 11.3) has been obtained. When a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker is required. The role of the Hospital staff shall be to verify that such consent has been obtained. If informed consent cannot be obtained for reasons of emergency or if, in the medical judgment of the Practitioner, it is not advisable to delay treatment or procedures to allow for the obtaining of such consent, the Practitioner shall note this in the patient’s medical record.

2.8 Emergency Admissions
Practitioners admitting emergency cases shall be prepared to justify to the Chief of Service and the administration of the Hospital that the said emergency admission was a bona fide emergency.

In cases of a physician declared emergency, medical record documentation requirements are not applicable however, said documentation must be completed within following 24 hours.

2.9 Transfers

(a) In House Transfers
No patient will be transferred without such transfer approved by the Attending Practitioner or his/her delegate. However, the Chief of Service shall have authority to
make the final decision regarding patient placement when there is a difference of opinion between the Practitioner and nursing concerning transfer to a more acute level of care.

(b) Transfers to an acute care facility
Practitioners are required to complete written documentation as required by EMTALA before a patient may be transferred to another acute care facility

(c) Transfers to other facilities

(d) Practitioners are required to complete written documentation as required by Washington State before a patient may be transferred to another facility

2.10 Discharge Orders
Patients shall be discharged only on order of the Attending Practitioner or designee. If a patient wishes to leave the Hospital without an order, the Attending Physician shall be notified to discuss with his/her patient and may decide to discharge the patient AMA. Patient will be requested to sign AMA form. A notation of the incident and the surrounding circumstances shall be made in the patient’s medical record.

2.11 Procedures Regarding Death
In the event of a death in the Hospital, the patient shall be pronounced dead within a reasonable time by the Attending Practitioner or designee or a registered nurse employed by the Hospital, who shall also promptly notify the Attending Practitioner. Authority to release the body from the Hospital shall be noted in the medical record of the deceased.

(a) Only physicians may pronounce a patient who has planned organ donation, who suffers cardiac death, or who suffers brain death.

(b) Registered nurses may pronounce patients who are admitted for terminal/palliative care and where the death is expected.

(c) A death note by the attending practitioner, designee or RN will be documented in the progress notes and at a minimum shall include: time of death, and if applicable, time attending physician was notified. RNs are also required to document whether the patient was admitted for terminal/palliative care.

(d) Only physicians may complete a certification of death.

2.12 Organized Health Care Arrangement: Notice of Health Information Practices
Effective April 14, 2003, the Hospital and Medical Staff are an Organized Health Care Arrangement (OHCA) in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA). The OHCA includes all members of the Medical Staff. Members of the Medical Staff agree to use and disclose Protected Health Information about patients seen in the Hospital's facilities only in accordance with the Hospital's Notice of Health Information Practices. The OHCA exists to facilitate the exchange of Protected Health Information between the Hospital and members of the Medical Staff and to avoid burdening patients with multiple notices of privacy practices. The OHCA does not and should not be interpreted as creating any employment, partnership, joint venture, agency or contractual relationship between the Hospital and members of the Medical Staff, beyond any that may otherwise exist.
SECTION III: ORDERS AND GENERAL CONDUCT OF CARE

3.1 Orders

All orders for treatment, performance of tests, or other procedures shall be entered into EPIC. All entries into the medical record must be signed, dated, and timed. Referral orders from physicians not on staff may be scanned.

Texting order is prohibited.

3.1.1 Persons Authorized to Give Orders:

(a) MD, DO Physicians and Oral Maxillofacial Surgeons who are on the medical staff and have privileges are authorized to order services and medications for the general care of inpatients and outpatients.

(b) Dentists who are on the medical staff and have privileges are authorized to give orders as they pertain to dental care rendered to inpatients and outpatients.

(c) Podiatrists who are on the medical staff and have privileges are authorized to give orders as they pertain to podiatric care rendered to inpatients and outpatients.

(d) Under the supervision of their sponsoring physician, and as privileged, physician assistants (PAs) and ARNPs are authorized to give orders for services and medications for the general care of inpatients and outpatients.

3.1.2 Referring Providers

(a) MD, DO Physicians, Oral Maxillofacial Surgeons, Dentists, Podiatrists or other licensed independent practitioners NOT on the medical staff are only authorized to order outpatient labs and diagnostic exams.

(b) MD, DO Physicians, Oral Maxillofacial Surgeons, Dentists, Podiatrists or other licensed independent practitioners NOT on the medical staff are not authorized to order medications, infusions, blood and/or interventional radiologic procedures.

3.1.3 All verbal and telephone orders shall be taken and read back by an appropriately authorized person, as defined by hospital policy and in accordance with law or regulation.

3.1.4 Personnel Authorized to Take Verbal/Telephone Orders from a Physician or his/her Authorized Registered Nurse or Certified Physician Assistant:

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>AUTHORIZED</th>
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<tbody>
<tr>
<td>Cardiopulmonary Function Lab</td>
<td>Licensed Respiratory Therapist</td>
</tr>
<tr>
<td>Dietary</td>
<td>Registered Dietitians – are authorized to take verbal/telephone orders for diets, tube feeding and TPN only</td>
</tr>
<tr>
<td>Neurodiagnostic Lab</td>
<td>EEG technicians</td>
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<td></td>
<td>Evoked Potential Technicians</td>
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<tr>
<td>Nursing</td>
<td>Registered Nurses (RNs)</td>
</tr>
<tr>
<td></td>
<td>Licensed Practical Nurses (LPNs)</td>
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3.1.5 Authentication of Orders
All orders including verbal orders, must be dated, timed and authenticated by either the ordering practitioner or another practitioner who is responsible for the care of the patient and who is authorized to write orders by Hospital policy in accordance with state law.

Verbal and telephone orders for medications and restraint must be authenticated by the Practitioner within 24 hours. All other orders will be authenticated as per the medical record completion process.

3.1.6 Physician counter-signatures are not required for orders written by pharmacists for therapeutic interchanges, renal medication dosing, nicotine prescribing, TPN dosing (electrolytes and insulin), and lab test ordering for monitoring drugs when using protocols approved Pharmacy & Therapeutics Committee and Medical Executive Committee.

3.1.7 Orders after transfer are as follows:

(a) Patients returning to any unit following a procedure OR, Transfer to or from a unit of a Higher or Lower intensity of Care

Patients returning to a unit following a surgery or invasive procedure or when transferred from a unit of certain intensity of care to another of higher or lower level, each order must be reviewed and continued, modified or canceled by a qualified practitioner.

(b) Patients transferred to a unit of the same level of care
When a patient is transferred directly from one unit to another at the same level of care, orders are not required to be re-documented by a qualified Practitioner; the nurse is to conduct an extensive patient report adequate to assure continuation of patient care.

3.2 Order Priorities
Priorities for Practitioner orders are as follows:
3.2.1 STAT: Immediate, emergent, life-threatening, pre-code. Turn-around time is a maximum of 45 minutes or less.

3.2.2 Routine: Non-urgent, repetitive or initial diagnostic order or treatment; something that can be done during a shift. There is no clinical or LOS urgency. Turn-around time is a maximum of eight hours.

3.3 Medications and Drugs
All drugs and medication administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations. Drugs for bona fide investigations may be exceptions. These shall be used in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals" and applicable laws and regulations.

3.3.1 Drugs brought into the Hospital by a patient shall be stored and administered in accordance with Hospital policy.

3.4 Patient Rights
The Attending Practitioner shall abide by Hospital Standards regarding patient rights. Such policies shall consider the rights of the patient with respect to such matters as:

3.4.1 Reasonable responsiveness to his/her requests and needs for treatment or service within the Hospital’s capacity, its stated mission, and applicable laws and regulations, consistent with Hospital Standards and Medical Staff policies;

3.4.2 Considerations of the psychosocial, spiritual, and cultural variables that influence the perceptions of illness in the provision of considerate and respectful care;

3.4.3 Optimizing the comfort and dignity of a dying patient through treatment of primary and secondary symptoms, effective pain management, and acknowledgment of the psychosocial and spiritual concerns of the patient and his/her family;

3.4.4 The need for sufficient information to make informed decisions and the right to be collaboratively involved with the Practitioner in the decision-making process regarding his/her care;

3.4.5 The right to information at the time of admission about the Hospital’s patient rights policy and procedures for the initiation, review, and when possible, resolution of patient complaints concerning the quality of care;

3.4.6 Access to the information contained in the patient’s medical record, within the limits of law;

3.4.7 Information regarding experimentation and research, if applicable; and

3.4.8 The rights of the patient, within the limits of law, to personal privacy and confidentiality of information.
3.5 Non-Discrimination
No patient shall be denied medical care within Swedish Medical Center by any member of the Medical Staff in a manner prohibited by applicable state or federal nondiscrimination law. Medical care may only be denied on the basis of professional justification.

3.6 Health Care Agreements for Behavioral Management of Patients
Recognizing the importance of creating a safe environment in the Hospital for patients, staff, and visitors, the Medical Staff may initiate an individualized Health Care Agreement in patients who display the following behaviors: history of unsafe behavior; non-compliance with treatment, active chemical dependency issues; verbal assault; threatening behavior; physical assault. Patients must be prevented from engaging in behaviors that are in conflict with his or her treatments and procedures, or present a risk to the safety of other patients, visitors, or staff. The Medical Staff supports the enforcement of the provisions in such an agreement whether or not the patient signs it, in order to maintain a safe environment. Patients who violate the Conditions of Admission and/or exceed the boundaries of behaviors negotiated in the Health Care Agreement may be discharged from the Hospital.

3.7 Specimen removal
Except as otherwise indicated by Medical Staff policy, all tissues removed during any procedure shall be sent to the Hospital pathologist, who shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis. His/her authenticated report shall be made a part of the patient’s medical record.

SECTION IV: PODIATRIST/DENTIST RESPONSIBILITIES

4.1 Patients of Dentists
A patient admitted for care by a Dentist who is not an Oral and Maxillofacial Surgeon is the dual responsibility of such Practitioner and a Physician or Oral and Maxillofacial Surgeon member of the Medical Staff, and those responsibilities shall be allocated as follows:

4.1.1 Dentist’s responsibilities shall include:
(a) Arranging for the medical history and physical by an MD or DO,
(b) Documenting a detailed dental history and examination;
(c) Completing an operative report;
(d) Ordering services and medications as they pertain to the dental care rendered;
(e) Recording progress notes pertinent to the oral condition;
(f) Requiring additional consultation when indicated;
(g) Completing the discharge summary as outlined in 8.17.
(h) Ordering the patient’s discharge
4.1.2 MD or DO Physician’s or Oral Maxillofacial Surgeon’s responsibilities shall include:

(a) Documenting a medical history and physical exam pertinent to the patient’s general health;

(b) Supervising the patient’s general health care while hospitalized;

(c) Ordering services and medications for the general care of the patient.

4.2 Patients of Podiatrists
A patient admitted for care by a Podiatrist shall have responsibilities allocated as follows:

4.2.1 DPM Physician's responsibilities shall include:

(a) Podiatric physicians may perform complete history and physicals for their outpatient podiatric procedures if privileged to do so by the medical staff.

(b) Podiatric physicians without the privilege to perform a medical H&P will arrange to have a medical H&P performed by an MD or DO who is a member of the medical staff of Swedish Edmonds. This H&P must meet the same requirement as any other medical H&P for their outpatient procedures.

(c) When a patient is admitted to inpatient status, the podiatric physician will arrange for a medical history and physical to be completed by an MD or DO who is a member of the medical staff of Swedish Edmonds with admitting privileges.

(d) Completing an operative report;

(e) Ordering services and medications as they pertain to the podiatric care rendered;

(f) Recording progress notes pertinent to the patient's podiatric condition;

(g) Requesting consultation with a qualified consultant when indicated;

(h) Completing the discharge summary as outlined in 8.17;

(i) Ordering the patient's discharge

4.2.2 MD or DO Physician's responsibilities shall include:

(a) Documenting medical history and physical exam pertinent to the patient's general health;

(b) Performing a physical examination.
SECTION V: NEWBORN AND PEDIATRIC PATIENTS

5.1 Newborn Assessment
Newborns must be assessed within 24 hours after delivery and within 24 hours prior to discharge. Height, weight and head circumferences and percentile will be measured on all infants admitted to Swedish Edmonds Hospital.

5.2 Pediatric patient(s) defined for medical record purposes includes any patient age 28 days through 12 years.

5.2.1 Age-specific considerations for care and treatment of pediatric/adolescent patients are further defined as:

- Infant – 28 days to 1 year of age
- Toddler – 1 year to 3 years of age
- Preschooler – 3 years to 5 years of age
- School Age – 6 years to 12 years of age
- Adolescent – 12 years to 18 years of age

5.3 Immunization status will be assessed on all pediatric and adolescent inpatients.

5.4 Infants seen in the Emergency Department and/or receiving outpatient services will have head circumference and immunization status assessed when relevant to their disease process.

5.5 Pediatric and Adolescent patients seen in the Emergency Department and/or receiving outpatient services will have immunization status assessed when relevant to their disease process.

SECTION VI: RESTRAINT USE

Swedish Edmonds is committed to providing a safe environment for all patients. Swedish Edmonds seeks to provide a safe environment by first ensuring that care has been given to resolve physiologic, psychological, and environmental factors that might place patients at risk for harm to themselves or others. The patient has the right to be free from restraint of any form that is imposed for coercion, discipline, convenience, or retaliation by staff, including drugs that are used as restraint. The use of restraint is not based on a patient’s history or solely on a history of dangerous behavior. All appropriate alternative and least restrictive options are implemented before the use of restraint. Application of restraint must be in accordance with federal and state regulations and standards. Restraints are to be used for as short a time as possible and used at all times with respect to the patient’s rights and dignity.

SECTION VII: CONSULTATIONS

7.1 Responsibility for Requesting Consultations
Practitioners are responsible for requesting consultations with other qualified Practitioners when indicated. A Practitioner must communicate directly with the Consulting Practitioner to convey the nature and urgency of the consultation.

7.1.1 Recommended Consultations
Except in an emergency, consultation is recommended in the following situations:
(a) When the patient is not a good risk for operation and treatment;
(b) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
(c) Where there is doubt as to the choice of therapeutic measures to be utilized;
(d) In unusually complicated situations where specific skills of other Practitioners may be needed;
(e) In instances in which the patient exhibits severe psychiatric symptoms and is not being attended by a psychiatrist;
(f) When requested by the patient or the patient’s family.

7.1.2 Other Requests for Consultation
If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, such nurse shall call this to the attention of the nursing supervisor. If warranted, the nursing supervisor shall bring the matter to the attention of the attending physician, the Chief of the Service to which such Practitioner is assigned, the President of the Medical Staff or the Administrator. Where circumstances are such as to justify such action, the Chief of the Service, the President of the Medical Staff or the Administrator may request a consultation.

7.2 Consulting Practitioner
Consulting Practitioner means a Practitioner who advises the requesting Practitioner on the care of the patient to the extent agreed upon with the requesting Practitioner.

7.2.1 Consulting Practitioners may provide advice, information and consultation regarding the patient’s plan of care at the request of another Practitioner. Consulting Practitioners may assume all or a portion of the patient’s care in collaboration with the Attending Practitioner.

7.2.2 Consulting Practitioners may share coverage with similarly privileged colleagues. The covering colleague assumes full responsibility of the Consulting Practitioner during such coverage.

7.2.3 A preliminary consultation should be recorded in the medical record within 24 hours of consultative request.

7.3 Content
A satisfactory consultation shall consist of:

7.3.1 Examination of the patient and his/her records; and

7.3.2 A written opinion signed by the consultant, which shall become a permanent part of the patient’s medical record.
SECTION VIII: MEDICAL RECORDS

All documentation of patient care will be done in EPIC. Documentation must be legible, searchable text. Scanned documents are supplementary only.

8.1 Responsibility for Completion
The Attending Practitioner shall be responsible for the preparation of a complete and legible medical record for each patient in EPIC.

Unless care is transferred to the Consulting Practitioner, the Attending Practitioner remains responsible for the orders, documentation and plan of care for the patient.

8.2 Content
The complete Swedish medical record should include the following information as appropriate for an individual episode of care:

- Patient Identification data
- History and Physical
- Information that supports the diagnosis
- Consults
- Labs (reports, pathology, autopsy if performed)
- Radiology (reports, scans, etc)
- Operative reports, procedural and anesthesia related documentation
- Multidisciplinary Progress notes (Justification for care, treatment, service, course of care and results of treatment)
- Nursing notes
- Consent for treatment
- Discharge summary (Summary of the episode, disposition and instructions to the patient)

8.3 Texting orders
It is not acceptable for physicians or licensed independent practitioners to text orders for patients to the hospital or other healthcare settings. This method provides no ability to verify the identity of the person sending the text and there is no way to keep the original message as validation of what is entered into the medical record.

8.4 Admission Note
An admission note stating the reason for admission and plan of action shall be entered into the medical record by the Admitting Practitioner at the time of initial contact with the patient at the Hospital.

8.5 History and Physical Requirements
(See Bylaws, Article XIII)

8.5.1 Updates
(a) History and physicals completed up to 30 days prior to admission may be used but will require an updated examination of the patient including any changes in the patient’s condition.
(b) The update must be completed and documented within 24 hours after admission or registration and prior to surgery or a procedure requiring moderate sedation or anesthesia.

(c) Proceduralists accepting a history and physical from a referring physician who is a member of the medical staff are responsible for the update including examination of the patient as necessary for the procedure and documenting any changes in the patient’s condition.

8.5.2 Obstetrical Record
The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the Attending Practitioner’s office record transferred to the Hospital prior to admission. However, an interval admission note must be entered into the medical record that includes pertinent additions to the history and subsequent changes in the physical findings.

8.6 Progress Notes
Progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient’s problems shall be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily by the Attending Practitioner or designee on all patients, except in the cases of normal newborns and patients awaiting nursing home placement who shall be seen at least weekly.

A final progress note should be documented on the day of discharge.

8.7 Operative/Procedure Reports
An operative/procedure note must be dictated or entered into EPIC upon completion of the procedure or no later than 24 hours following the procedure. Operative reports not entered into the medical record or dictated within 24 hours of surgery will result in immediate suspension of privileges.

The following elements are required for both the dictated operative report and the post operative progress note:

- Pre and post operative diagnosis
- Name of primary surgeon
- Assistants
- Findings
- Technical procedures used
- Specimens removed
- Post op diagnosis
- EBL

8.7.1 Immediate post operative/procedure note
Because the dictated report might not be immediately available, a post-procedure note must be written and entered in the record immediately following surgery including C-sections to provide pertinent information for anyone required to attend to the patient. The patient may not be moved to the next level of care until this note is done.
8.8 Pre-Sedation Assessment
The Proceduralist is responsible for recording the ASA status and airway assessment on the record prior to a procedure.

8.9 Patients Admitted for Interventional Radiology Procedures
A patient admitted as an outpatient for an interventional radiology procedure requiring moderate sedation or general anesthesia will require the following documentation:

8.9.1 The physician performing the interventional radiology procedure is responsible for performing and documenting a history and physical examination. Alternately, an H&P performed by the referring physician may be accepted but must be reviewed and co-signed by the proceduralist prior to the procedure.

8.9.2 If the patient’s ASA status is I or II, an H&P performed by an MD or DO other than a medical staff member is acceptable. If the patient’s ASA status is III or greater, then the MD or DO performing the H&P must be a member of the medical staff. In either case, an update of the H&P will be done in accordance with section 8.5.1.

8.9.3 A post-procedural progress note and a detailed operative report in accordance with Section 8.6.

8.10 Pre-Anesthesia Evaluation
A pre-operative evaluation shall be made and positive findings shall be recorded by the Anesthesiologist within 24 hours prior to surgery or a procedure requiring anesthesia services. The extent of the assessment is dependent on the underlying condition of the patient and the complexity and invasiveness of the procedure. At a minimum, the evaluation and documentation shall include:

(a) notation of anesthesia risk
(b) anesthesia, drug, and allergy history
(c) any potential anesthesia problems identified
(d) patient’s condition prior to induction of anesthesia

The Anesthesiologist shall obtain informed consent to include the type, administration, and plan of anesthesia and explain risks, benefits and alternatives involved.

8.11 Anesthesia Record
Documentation of the administering and monitoring of anesthesia, shall include at a minimum, the following elements:

(a) name and hospital identification number of the patient
(b) name of practitioner who administered anesthesia
(c) name, dosage, route and time of administration of drugs and anesthesia agents
(d) IV fluids
(e) blood or blood products, if applicable
(f) oxygen flow rate
(g) timed-based documentation of vital signs as well as oxygenation and ventilation parameters
(h) any complications or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient’s response to treatment.

8.12 Post-Anesthesia Note
A post-anesthesia evaluation shall be completed and entered into the medical record for each patient within 48 hours after surgery or a procedure requiring anesthesia services. At a minimum, the evaluation shall include:
(a) respiratory function, including respiratory rate, airway patency, and oxygen saturation
(b) cardiovascular function, including pulse rate and blood pressure
(c) mental status
(d) temperature
(e) pain
(f) nausea and vomiting
(g) postoperative hydration

8.13 Post-Anesthesia Discharge
A patient shall be discharged from the post-anesthesia recovery unit in accordance with protocol approved by the medical staff.

8.14 TNM Staging
The charts of all newly diagnosed cancer patients must contain complete clinical or pathologic Tumor Node Metastases (TNM) staging and group information as defined by the American Joint Committee on Cancer. A TNM staging form must be completed: dated, timed and signed by the patient’s managing practitioner.

8.15 Use of Symbols, Abbreviations, Acronyms and Dose Designations
Symbols and abbreviations may be used only when they have been approved by the appropriate committees, and are maintained by the Medical Records/Utilization Review Committee. A current list of DO NOT USE–Dangerous Abbreviations may be found on the Swedish Edmonds Intranet under “References”.

8.16 Discharge Summary
A discharge summary by the attending practitioner or their designee (unless they have transferred care to another practitioner who shall then be responsible) is required for patients with a
hospitalization of greater than a two-day length of stay, with a complicated hospital course, or for inpatients transferred to another facility.

8.16.1 A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a 48 hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note should include any instructions given the patient and/or family.

8.16.2 Regardless of the length of stay, a death summary is required for all patients who expire.

8.16.3 At a minimum, a final progress note is required for patients who are admitted for “palliative” care, i.e. hospice.

8.16.4 Elements of a discharge summary include:

(a) a concise summary that includes the reason for hospitalization
(b) the procedures performed
(c) the care, treatment and services provided
(d) the patient’s condition at discharge
(e) information provided to the patient and family, including discharge medication

8.17 Authentication
Appropriate authentication shall consist of the recording of the signature, date, and time by the Practitioner. This is required for all entries in the medical record.

8.18 Prescription Legibility
All prescriptions must be legibly hand printed, typewritten, or electronically generated pursuant to Washington State law. Prescriptions written in cursive are considered illegible. In the event the pharmacist, nurse, or other practitioner cannot read or understand a handwritten medication order, the prescriber shall be contacted in order to obtain clarification of the illegible order.

8.19 Release of Information
Written authorization from the patient is required for release of medical information to persons not otherwise authorized to receive this information. Any disclosure of medical information shall comply with Washington State law, Federal Law, and Hospital Standards that protect patient confidentiality and right to privacy.

8.20 Removal of Records
Records may be removed from the Hospital’s jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the Hospital and shall not otherwise be removed from the Hospital. In case of re-admission of a patient, all previous records shall be made available for the use of the Attending Practitioner. This shall apply whether the patient shall be attended by the same Practitioner or by another. Unauthorized removal of medical records is forbidden and may be grounds for disciplinary action.
8.21 Access to Medical Records
Access to medical records shall be afforded to members of the Medical Staff for bona fide patient care, and study and research contingent on preserving confidentiality of individual patient information. All projects shall be approved by the Institutional Review Board. Former members of the Hospital’s Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital subject to the discretion of the President of the Medical Staff. Unauthorized access of medical records is forbidden and may be grounds for disciplinary action.

8.22 Filing
A medical record shall not be permanently filed until it is completed by the responsible Practitioner, except by order of the Medical Records/Utilization Review Committee.

8.23 Completion
Except as otherwise provided, the record must be completed within 21 days after discharge and is considered delinquent if not completed on or before the 22nd day.

8.24 Delinquent Records

8.24.1 Notification of Delinquent History and Physicals and Operative Reports
A history and physical or operative/invasive procedure report is not dictated within required timeframes, it will result in the automatic-suspension of privileges. Practitioners will be notified immediately of a suspension. If suspended, the practitioner’s privileges will be reinstated according to the suspension process.

8.24.2 Notification of Delinquent Records
If the record remains incomplete at the end of the 21-day period after discharge, the Chief of Service and President of the Medical Staff will be notified and the Practitioner’s admitting and clinical privileges will be automatically suspended until records have been completed.

8.25 Suspension of Privileges
Suspension of privileges for failure to complete medical records within the timelines defined in these Rules and Regulations will include the denial of all elective Hospital privileges and outpatient procedure privileges except bona fide emergencies until the records are complete. It is the responsibility of the Practitioner to notify his/her patients of the canceled cases.

8.25.1 Written Notice
The Practitioner shall receive prompt written notice of the suspension of privileges from the President of the Medical Staff through Health Information Management. Receipt of the notice shall not be necessary in order for suspension of privileges to become effective.

8.25.2 Vacation or Illness
Notification of a bona fide vacation or illness shall be considered during any suspension period. It is the responsibility of the Practitioner to complete all available incomplete medical records prior to an expected absence. It is also the responsibility of the Practitioner to notify Health Information Management of an absence.
8.25.3 Removal from Staff—Exception
A Practitioner’s privileges will not be suspended under this subsection if he/she is on
vacation or leave of absence.

8.25.4 Reappointment
Recommendations for reappointment and privileges shall not be made if a Practitioner
has any incomplete medical records that are greater than 30 days old. This may result in a
delay in reappointment. Should a current appointment expire due to suspension of
privileges, the Practitioner shall not be able to practice until such time as the records are
brought current and the Department Chief and President of the Medical Staff have
approved the reappointment. At that time, interim privileges may be granted, if the
application is not required to have full Credentials Committee and MEC review pursuant
to credentialing policies.

SECTION IX: EMERGENCY SERVICES DEPARTMENT

9.1 Physician Staffing
The Emergency Services Department of the Hospital shall be staffed by Physicians in accordance
with the provisions of contractual arrangements with the Hospital. Any Practitioner may provide
care for his/her own patients and/or consult on Emergency Department patients.

9.2 Evaluation
All patients who present for emergency services will receive a Medical Screening Examination
and appropriate evaluation performed by a credentialed and appropriately privileged licensed
independent professional, or by a Physician Assistant under the supervision of an Emergency
Medicine physician. This exam may also be performed by a physician or OB triage nurse for
complaints related to labor.

9.3 Treatment

9.3.1 Immediate care will be rendered as necessary. All patients will be treated until their
emergency medical condition is stabilized within the capabilities of the staff and
activities available at the Hospital or until they are transferred in accordance with
applicable legal regulations.

9.3.2 If a patient’s Physician has notified the Emergency Services Department that he or she
will evaluate the patient in the Department, the Physician will be contacted when the
patient presents for evaluation unless the patient’s condition warrants immediate
intervention by Emergency Department physician.

9.4 Call Coverage
The Medical Staff of the Hospital will provide emergency call coverage for urgent and emergent
requests from the Emergency Department and for inpatient hospital consults. Emergency call
rotation is mandatory for Active Medical Staff members with 10 or more patient contacts per year
where there is at least four physicians within that specialty group. As long as departmental
coverage is adequate, reduction or elimination of call coverage responsibilities for any member of
a specialty group (for reasons of age, health, etc.) may be recommended by the Chief of that
Service with the approval of a majority of the specialty group members and/or authorization by
the MEC.
When an on-call Physician is contacted for an emergency consultation, the physician must respond by telephone or in person within 30 minutes.

Medical Staff members must respond to emergency call requests regardless of a patient’s insurance status or ability to pay.

It is the responsibility of the on-call Physician to arrange for other coverage if he/she is unable to be on-call as scheduled. The coverage MUST be by another Physician who is privileged to practice at Swedish Edmonds with like privileges.

SECTION X: RESUSCITATIVE MEASURES

10.1 Resuscitative Measures
If a patient is classified as “Do Not Resuscitate,” (DNR), the attending Physician will document the resuscitation status order. Resuscitation orders must be signed, dated, and timed by the Practitioner within 24 hours. Until the resuscitation status order is obtained, all patients will be considered full code.

10.1.1 Efforts should be made to resuscitate patients who suffer cardiac or respiratory arrest except in the following circumstances:

(a) The patient or a surrogate decision-maker has decided that resuscitation should not be attempted.

(b) In the judgment of the attending Practitioner and following a formal Ethics Committee consult, the patient’s underlying medical condition is so far advanced that resuscitative effort would be futile.

10.1.2 The Practitioner is expected to verify advance directives with the patient or surrogate decision-maker and assure that they are appropriately documented in the patient’s medical record. If the patient arrives into the facility and provides a completed Physicians Order for Life-Sustaining Treatment (POLST) form, these orders will be honored for up to 24 hours or until the content can be reviewed and converted into order by the practitioner.

10.1.3 The Practitioner has an ethical obligation to honor the resuscitative preferences expressed by the competent patient or those of an incompetent patient expressed previously while competent through advance directives or otherwise.

10.1.4 If the patient is incapable of rendering a decision regarding the use of resuscitative measures and has not previously expressed a preference, the decision must be made by a surrogate decision-maker in accordance with Washington State law.

Washington State law sets the following order of priority for people to make decisions on behalf of a patient who is unable to make decisions for himself/herself:

(a) Guardian, if one has been appointed;
(b) The person named in the patient’s Durable Power of Attorney for Health Care;
(c) Spouse or registered domestic partner;
(d) Adult children (decisions must be unanimous);
(e) Parents (decisions must be unanimous);
(f) Adult brother and/or sisters (decisions must be unanimous).

In the event a unanimous decision is unable to be made, an Ethics Committee consult will be obtained.

10.1.5 If the patient who has not previously expressed a preference is not competent, and no surrogate is available to assist in making the decision, then the patient is assumed to be a full code. If the Practitioner believes that attempting resuscitation would be futile, the Practitioner must obtain a formal Ethics Committee consult prior to initiating any change in the patient’s code status.

10.1.6 A progress note outlining a DNR order is essential and should document the underlying rationale, the persons with whom the decision has been discussed, any disagreements, and any intended changes in other aspects of the patient care plan.

10.1.7 DNR orders shall be rescinded in the event of surgery for the immediate perioperative period, from arrival in surgery to 24 hours post-surgery, unless the patient or surrogate decision-maker specifically informs the Surgeon and Anesthesiologist that the DNR should be honored throughout the operative period.

SECTION XI: END-OF-LIFE ISSUES

11.1 Policy
It is the policy of the Medical Staff to encourage open and productive communication among the patient, the Practitioner, and the family. Patients or family members expressing the desire to discuss end-of-life issues with their Practitioner are encouraged to do so.

11.2 Right to Issue Directives
Patients who are competent or a surrogate decision maker for that of an incompetent patient have the right to enact end-of-life directives. These directives will be honored by the Medical Staff and personnel of the Hospital. If applicable, the Ethics Committee will be made available to assist with conflicts that may arise specifically with patient directives or with end-of-life issues in general.

11.3 Death with Dignity
The Medical Staff and Hospital have elected not to participate in physician-assisted suicide as allowed under Washington State law under the Death with Dignity Act.
SECTION XII: CRITERIA FOR CONFIRMATION OF BRAIN DEATH

12.1 Diagnosis
To determine brain death, the attending physician shall request and document consultation for this purpose with a neurologist or neurosurgeon who is board certified or board eligible. Brain death is a clinical diagnosis. A repeat clinical evaluation 6 hours later is recommended, but this interval is arbitrary. The date, time and criteria used for determination of brain death shall be documented in the medical record.

12.2 Clinical Criteria
The criteria utilized to determine the presence of brain death is outlined in the Brain Death Policy.

SECTION XIII: ORGAN DONATION

13.1 Notification
Federal Law requires that all deaths (20 weeks gestation and up) be reported to an organ tissue procurement agency. A representative from the organ procurement agency, LifeCenter Northwest, will be the first person to approach the legal next of kin. This may be done together with the Physician if appropriate. The procurement coordinator will obtain written or telephone consent from the legal next of kin for organ/tissue donation.

The process for this option is outlined in “Solid Organ, Eye and Tissue Procurement” procedure. The Physician maintains responsibility for the patient’s medical plan of care until death is pronounced.

After certification of patient death, if organs are to be donated for transplantation, mechanical and pharmacological support of organ function shall be continued under the direction of the organ procurement agency until organ retrieval has taken place.

SECTION XIV: POSTMORTEM EXAMINATIONS

14.1 Postmortem Policy
It shall be the policy of the Hospital and Medical Staff that a postmortem examination will be actively utilized as a quality management mechanism.

14.2 Consent
The Attending Practitioner or designee is expected to obtain consent for an autopsy in the event of a death that meets the criteria. The consent form “Authorization for Autopsy” will be completed and kept within the medical record. If permission cannot be obtained from the family (or legal guardian) in such death, that fact will be documented in the medical record.

14.3 Criteria for Autopsies
Autopsies may be performed in conjunction with Washington State law requirements according to the Medical Examiner’s jurisdiction at the request of the Attending Practitioner or legal guardian.
14.4 Autopsy Reporting
The Pathology Department will report annually to the Medical Staff’s Quality Committee regarding Postmortem Examination activities.

SECTION XV: ALLIED HEALTH PROFESSIONAL

A Practitioner who uses the services of an Allied Health Professional in the Hospital shall do so only in conformance with the Allied Health policies and within the limits authorized by the Hospital and applicable laws and regulations.

SECTION XVI: PRACTITIONER HEALTH AND WELL-BEING

The Medical Staff is committed to maintaining a healthy environment for Practitioners. Qualifications for membership in the Medical Staff and the criteria entitling a Practitioner to exercise clinical privileges in the Hospital include demonstrated competence and judgment, current satisfactory physical and mental condition, and the ability to work harmoniously with others. These qualifications and criteria must be sufficient to assure the Medical Staff and the Hospital’s Board that any patient treated by the Practitioner in the Hospital will receive quality care and that the Hospital and the Medical Staff will be able to operate in an orderly manner. The Medical Staff provides a process to help Practitioners maintain health and well-being, which includes but is not limited to the following components:

(a) education about recognizing illness and impairment issues specific to Practitioners;

(b) opportunities for confidential self-referral and referral by others;

(c) access to internal and external resources for evaluation, diagnosis, and treatment;

(d) thorough evaluation of the credibility of complaints, allegations, or concerns;

(e) monitoring Practitioners and the safety of their patients during and, as necessary, after rehabilitation;

(f) encouraging the reporting of concerns of unsafe treatment to Medical Staff leaders.

The Practitioner’s assistance process is overseen by the Medical Staff Quality Oversight Committee.

SECTION XVII: PROFESSIONAL BEHAVIOR CONCERNS

17.1 The Medical Staff is committed to providing quality patient care and a work environment that fosters teamwork and respect for the dignity of each patient, visitor, employee, volunteer, student, and member of the Medical and Allied Health Staff. Consistent with the philosophy of maintaining professional communication in the Hospital, and a workplace that is free of all forms of unlawful and unacceptable harassment, including sexual harassment, the Medical Staff supports professional conduct by all Practitioners. Medical Staff Members are expected to behave in a professional manner, showing respect to other individuals within Swedish Medical Center without exception. This is a basic tenet required to foster a culture of safety within the Hospital.
For behaviors that undermine a culture of safety and appropriate corrective actions, please reference the Medical Staff Professional Behavior policy.

Sexual harassment by Practitioners of anyone including other Practitioners, managers, employees, and non-employees, patients, vendors and visitors is specifically prohibited. Possible violations of this policy will be promptly investigated with the Hospital and Medical Staff taking appropriate corrective and remedial actions up to and including termination of membership and privileges. In addition, Medical Staff Members who are employees of Swedish are subject to all Hospital policies, including without limitation, the Non-Discrimination and Progressive Corrective Action policies. In cases involving Allied Health Professionals, the supervising Practitioner shall be informed of any actions taken under this policy.

17.1.1 Swedish prohibits all forms of unlawful and unacceptable harassment, including harassment due to race, color, religion, sex, national origin, age, marital status, sexual orientation and disability. Sexual harassment is a form of discrimination and is expressly prohibited. Conduct, which may constitute sexual harassment, includes repeated, unsolicited verbal comments, gestures, drawings or physical conduct of a sexual nature, which is unwelcome and damaging to the integrity of the employment relationship. Examples of such conduct include:

(a) Unwelcome or unwanted physical advances of a sexual nature. This includes patting, pinching, brushing up against, hugging, cornering, kissing, fondling or any other similar physical contact unacceptable to another individual.

(b) Requests or demands for sexual favors. This includes subtle or blatant expectations, pressures, or requests for any type of sexual favor accompanied by an implied or stated promise or preferential treatment or threat of negative consequences concerning one’s employment status.

(c) Verbal abuse or joking that is sexually oriented and unacceptable to another individual. This includes comments about an individual’s body or appearance where such comments go beyond a mere compliment; sexually oriented comments, innuendoes, or actions (“dirty jokes”) that should reasonably be known to be unwanted or offensive to others.

(d) Any type of sexually oriented conduct that unreasonably interferes with another’s work performance.

17.1.2 Pleasant, courteous, mutually respectful and non-coercive interaction between individuals that is acceptable to all the parties involved is not sexual harassment.

17.1.3 Retaliation because an individual has made a complaint of discrimination or harassment, has cooperated with the investigation of a complaint or has failed to respond to sexual advances is a violation of this policy and is strictly prohibited.

17.1.4 Procedure to investigate a complaint of behavior that undermines a culture of safety:

(a) If any individual is subject to or observes behavior that undermines a culture of safety, it is appropriate to intervene (on one’s own or another’s behalf) if at all possible, requesting that the behavior cease. It is desirable that the parties
involved speak calmly, privately, and resolve the incident between them in a positive and constructive manner on an informal basis as soon as possible.

(b) If a problem cannot be resolved informally by the individuals directly involved or if one of the parties refuses to meet to discuss the incident, the following process should be pursued:

i) An employee, volunteer or student should notify his/her immediate supervisor within 14 days of the incident, and provide a written account of what occurred. A member of the Medical Staff or allied health professional staff should notify the appropriate medical director of the service line and Medical Staff Services within 14 days of the incident and provide a written account of what occurred. Patients or visitors who experience disrespectful behavior or behavior that undermines a culture of patient safety should contact Patient Relations.

(c) All written complaints will be recorded and all behavior that undermines a culture of safety will be investigated. The appropriate medical director of the service line will review the complaint or report of the incident and collect any additional background information necessary.

i) A first incident will be an informal communication between the staff member, the appropriate medical director or designee. The goal of this meeting would be to enhance understanding of both parties perspectives, and make it clear that behavior that undermines a culture of safety is not acceptable in the professional work environment at Swedish Medical Center.

ii) A second incident will result in a counseling session with the appropriate medical director or the Administrator or designee. The appropriate medical director will complete documentation of the behavior and develop an action plan with the Practitioner. The appropriate medical director may refer the Practitioner to an early assistance program, as appropriate. The potential need for referral to an appropriate program can be discussed with the Practitioner.

iii) A third episode will result in a meeting with the Practitioner, the appropriate medical director, and the Administrator or designee. At this meeting, referral to a professional coaching program may be required to resolve the repeated behavior concerns.

(d) A written summary of each meeting is completed by the appropriate medical director, and placed in the Practitioner’s quality file.

(e) Voluntary resolution is the preferred method. Further disciplinary action may be pursued as outlined in the Medical Staff bylaws if required. In egregious situations, a Practitioner may be removed from the Medical Staff on a temporary basis pending investigation in accordance with the Medical Staff Bylaws.
In all cases, the aggrieved individual shall be kept informed, as appropriate, of action taken to resolve the complaint. To the extent possible, the report or complaint will be handled in a confidential manner. At the corrective action stage of discipline, the aggrieved individual will be advised that further action is being taken, but due to peer review immunity statutes, no further action may be divulged.

The Hospital and Medical Staff expressly prohibit any retaliation against anyone who makes a complaint or who provides information about possible violations of this policy.

17.1.5 Procedure to investigate a complaint of harassment. Any individual working in the Hospital who believes he or she has been subjected to sexual harassment or intimidation on the job is strongly encouraged to bring the matter to the immediate attention of the Chief of Staff or the Administrator or designee. Any person who believes she or he has information suggesting that this policy has been violated is strongly encouraged to bring the matter to the attention of one of these individuals. Human Resources shall be informed of all reports of discrimination or harassment of or by an employee.

As appropriate, an investigation will be promptly initiated. Medical Staff Members alleged to have violated this policy may be required to meet with the Chief Executive Officer, Administrator, Chief of Staff, a senior medical director, and/or the appropriate medical director. The Practitioner shall be advised of the nature of the complaint and will be given an opportunity to respond. Complaints will be kept confidential consistent with this policy, and disclosed only as necessary to investigate and act on the information.

Depending on the nature of the complaint, and the close working relationship of the alleged wrongdoer and complainant, the Practitioner may be placed on administrative leave pending the conclusion of an investigation.

After the investigation has been completed, corrective action shall be taken against anyone found to have violated this policy. Corrective action recommended by the Chief of Staff or Administrator or designee in each case will depend upon the gravity and circumstances of the offense, and may include such actions as requiring an apology, issuing a warning to cease improper conduct, and/or suspending or terminating the Practitioner’s privileges and Medical Staff membership. Summary notes of the meeting will be included in the Practitioner quality/peer review file. The Hospital will take whatever action is determined necessary to prevent an offense from being repeated. Prior to any formal action, the Practitioner will be notified of his or her right to a hearing pursuant to the Medical Staff Bylaws and related policies.

At the conclusion of the investigation and identification of required corrective action, a brief explanation of the allegations, investigation and action taken will be provided to the Medical Executive Committee.

In all cases, the aggrieved individual shall be kept informed, as appropriate, of action taken to resolve the complaint. To the extent possible, the report or complaint will be handled in a confidential manner. At the corrective action stage
of discipline, the aggrieved individual will be advised that further action is being sought but that due to peer review immunity statutes, no further information may be divulged.

17.1.6 Trend of disruptive behavior. When adequate documentation is on file to support a trend of disruptive behavior, the following shall occur:

(a) The Administrator or designee, a senior medical director, or designee, shall meet with the Practitioner to discuss the issue.

(b) The Practitioner will be advised of medical staff policy which requires that one be able to work harmoniously with hospital staff and colleagues.

(c) The Practitioner will be offered contact information for an executive coach.

(d) The Practitioner will be advised of cost of the coaching program and policy relative to reimbursement.

(e) If the Practitioner satisfactorily completes the coaching program and exhibits no further disruptive behavior during the one-year period following completion of the primary coaching program, the Practitioner will be reimbursed up to one-half of the cost of the program, with a reimbursement limit of $2500.

(f) The Practitioner must provide documentation of payment of the cost of the executive coaching.

(g) The invoice shall be presented to the Manager of Medical Staff Services, 747 Broadway, A Floor West, Seattle, WA. 98122-4307.

(h) Payment shall be made one-half from hospital funds and one-half from medical staff dues funds.

(i) The executive coaching must be with an approved program. The program shall be approved by the Administrator or designee, a senior medical director, or the I-MEC.

(j) The Manager of Medical Staff Services shall be advised of the referral to executive coaching, the executive coach and the executive coach address and phone number and shall forward such information to the I-MSQOC.

(k) The Manager of Medical Staff Services shall request quarterly reports of compliance.

17.1.7 The Medical Staff and Administration strive to promote harmonious relationships between members of the Medical Staff and employees of the Medical Center. The expectation is that all members of the Medical Staff will be successful in their interactions with others. Executive coaching is one approved methodology for achieving positive results for someone who is experiencing difficulty. The Medical Staff and Administration of Swedish will not tolerate behavior that undermines a culture of safety. Further evidence of such behavior may result in corrective action.
SECTION XVIII: ATTENDANCE REQUIREMENTS

Medical Staff members are advised to attend Medical Staff meetings and Department meetings for their own benefit and to contribute to the Medical Staff decision making process, but attendance shall not be required but tracked as part of the OPPE process.

SECTION XIX: PLAN IN EVENT OF DISASTER

19.1 Plan
The Medical Staff shall follow current Emergency Operations Plan & Hospital Incident Command System Plan which outlines the duties of Practitioners in the event of an internal or external disaster. Among other provisions, the plan shall identify Practitioner roles necessary for mitigation, preparedness, response, and recovery phases of disaster management.

19.2 Participation
Practitioners shall be expected to respond in a disaster, as they are able, in accordance with their clinical capabilities and the Hospital’s Disaster Management Plan to the labor pool.
RULES AND REGULATIONS

APPROVED by the Medical Staff on January 11, 2013
APPROVED by the Board on February 27, 2013

THE MEDICAL EXECUTIVE COMMITTEE OF SWEDISH EDMONDS

[Signature]
President of the Medical Staff

SWEDISH HEALTH SERVICES

[Signature]
Chair of the Board

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