LSUHealth
INTERIM LSU PUBLIC HOSPITAL
Graduate Medical Education

LSU

PERSONAL DATA FORM

PLEASE PRINT LEGIBLY OR TYPE

Department: _____ House Officer Level: _____ (Circle One):
(Level you will be in July)

Internship Residency Fellowship

Training Program Name: _____

Name: _____
Last First Middle

Mailing Address: _____
Street City State Zip

Telephone Number: Beeper Number:

Social Security Number: _____ Citizenship: _____

Date of Birth: _____ Place of Birth: _____

National Provider Identification (NPI#): _____

Sex: Male_ Female _ Marital Status: S M W D Spouse's Name: _____

Race: (Please check one)
American Native ___Asian or Pacific Islander ___Hispanic ___White ___Black ____

List Person to Contact in case of Emergency: _____

Relationship: _____ Telephone Number: _____

PLEASE ATTACH THE FOLLOWING:

___ ACLS Certificate (If Applicable)

___ Copy of Medical License

___ Picture

LSU

LSUHealth
INTERIM LSU PUBLIC HOSPITAL
Graduate Medical Education

APPOINTMENT FORM

NAME: _____
Last First Middle Degree

SS#: _____ D.O.B. ____/____/_____ NPI#: _____

DEPARTMENT: _____ SUBSPECIALTY: _____

New Appointment: _____ Renewal: _____If Renewal, Did you Transfer from another Department? _____

Termination: _____ Transfer: _____From What Program: _____

HAVE YOU EVER WORKED WITH ANY OTHER LSU ENTITY? _____ IF SO ID# _____

EFFECTIVE DATE: _____

EXPECTED PROGRAM COMPLETION DATE: _____

APPOINTMENT LEVEL: _____

BEEPER #: _____ CELL#: _____

SUBMITTED BY: _____ DATE: _____

PHONE: _____

PROGRAM DIRECTOR: _____

THIS FORM IS TO BE COMPLETED FOR ANY HOUSE OFFICER WHO WILL BE ON CLINICAL ROTATION AT THE MEDICAL CENTER OF LOUISIANA.

LSUHealth
INTERIM LSU PUBLIC HOSPITAL

Medical Staff Services

House Officers/Fellows
Signature File

Name of Physician: _____
(Please Print)

ILH ID#: _____

School / Department: _____

Cell Number: _____ Beeper Number: _____

DEA License Number: _____

Signature of Physician: _____

SUBJECT: CODE GREY – HURRICANES	REFERENCE #2011
	PAGE: 1
DEPARTMENT: EMERGENCY MANAGEMENT	OF: 12
	EFFECTIVE: November 1, 2002
REVISED: August 10, 2006; March 15, 2007; Feb 27, 2009	

Reviewed By: Emergency Management Coordinator

Lonnie W. Hills 3/2/09

Approved. by: Medical Director

3/2/09

Clinical Chair of Emergency Preparedness Committee

Chair of Environment Care Committee: 3/2/09

PURPOSE:

The purpose of this plan is to prepare the LSU Interim Hospital for the event of a hurricane.

GENERAL:

- The Chief Executive Officer or designee, in concert with the Incident Command Team, local and state officials and Louisiana State University Health Care Services Division (LSU HCSD) officials, will determine the possible adverse impact that weather situations may have on the operations of the LSU Interim Hospital. Initiation of each phase of this plan will not necessarily coincide with reports and warnings from the National Weather Service, the Office of Emergency Preparedness or the City of New Orleans. WWL 870 AM is the official broadcast stations for LSU INTERIM HOSPITAL announcements. All phases of the LSU INTERIM HOSPITAL Code Grey Hurricane Plan will be announced on WWL-TV and radio.

- Hurricanes are classified according to the Saffir-Simpson Scale as follows:

	WIND	TIDAL SURGE	DAMAGE
Tropical Depression	< 39 mph		
Tropical Storm	39-73 mph		
Category I Hurricane	74-95 mph	4-5 feet	Minimal
Category II Hurricane	96-110 mph	6-8 feet	Moderate
Category III Hurricane	111-130 mph	9-12 feet	Extensive
Category IV Hurricane	131-155 mph	13-18 feet	Extreme
Category V Hurricane	> 155 mph	> 18 feet	Catastrophic

- There are five (5) phases to LSU INTERIM HOSPITAL Code Grey Hurricane Plan. They are:

1. Watch
2. Warning
3. Activation
4. Evacuation. The Evacuation Plan is detailed within Reference #1026.
5. Recovery.

Each phase requires specific actions by LSU INTERIM HOSPITAL management and staff. The following information for initiating the LSU INTERIM HOSPITAL Code Grey Hurricane Plan is general and allows flexibility. It is written as a plan for weather situations that provide time for preparation. In short term weather situations, like flash flooding, refer to Code Grey – Thunder Storms/Heavy Rainfall Procedure, Reference #2010 within the Emergency Management Manual.

Category 4 and 5 hurricanes will require more drastic actions than are outlines in the plan. Those decisions as well as decisions concerning unusual circumstances occurring during Category 1, 2 and 3 hurricanes will be made as needed and are not covered by this plan. Please refer to the LSU INTERIM HOSPITAL Emergency Management Evacuation Plan, Reference #1026 within the Emergency Management Manual for information regarding evacuation procedures.

The Emergency Management Coordinator or designee will:

- be an active member in the Region 1 HRSA group for healthcare organizations
- maintains an up to date resource of Region 1 HRSA members names and telephones so that effective communication can occur before, during and after an emergency incident.
- ensure LSU INTERIM HOSPITAL's active participation in the statewide patient tracking system initiated by HRSA & LHA. This tracking system will allow all hospital within the state to track patient location and status.

Physicians and staff must wear their official pictured ID badge throughout the entire emergency episode including throughout transport and work assignments at alternative treatment sites.

Incident stress debriefing will be available during the incident, if needed. Post incident staff debriefing will also be available, if needed.

Information regarding LSU INTERIM HOSPITAL's operational status and any other pertinent information for employees will be posted on hospital's website, www.LSU Interim Hospitalno.org.

TEAMS:

- LSU INTERIM HOSPITAL will use the Hospital Emergency Incident Command System for the Code Grey Hurricanes. The individual departments will staff utilizing an Activation Team and Recovery Team concept.

- The department directors are responsible for development of Activation and Recovery Teams within their areas of responsibility. All department directors are responsible for reviewing and updating their Activation and Recovery Team members as requested and submitting them upon request to the Planning Chief. See Code Grey Team Designations, Reference #2012 within the Emergency Management Manual.

- Each employee is responsible for providing two current contact telephone numbers (i.e.: pager number, cell phone number) to their department director or designee **and** the name and telephone number of a contact person that does not live within the state of Louisiana. See Reference #2011-A for the Telephone Call Tree template.

- All employees are expected to participate in the LSU INTERIM HOSPITAL Code Grey Hurricane Plan. Each employee will be required to sign a "Code Grey Acknowledgement Form" (See Reference #2013 within the Emergency Management Manual). This form will contain the employee's Activation I, Activation II or Recovery Team designation and will be maintained within the employee's departmental file.

- The Activation Team members will be given a status of 1 or 2. Status 1 employees are those who live on the West Bank of the Mississippi River, east of the Industrial Canal, or beyond the Orleans Parish line. Status 2 employees are those who live within Orleans Parish in the areas not mentioned in Status 1.

- Activation Teams should be assigned to work twelve (12) hour shifts. Staffing should be considered at 100% occupancy for staffing. Selection of Activation Team members should be based on skill mix.

- The Code Grey plan requires that we staff our facilities with sufficient staff to provide essential and support services through various stages of tropical storms and hurricanes. To that end, volunteers will be sought to serve on Activation teams. Should there be insufficient numbers of appropriate volunteer staff, staff will be assigned to the Activation teams as needed. Failure to report to duty as part of Activation or desertion after reporting for Activation will result in termination.

- When both members of a married couple are employed by LSU INTERIM HOSPITAL, special consideration may be given when both the husband and wife are assigned to the Activation team. If possible, one of the married employees may be given the option of opting out of Activation and placed on recovery, especially when dependents are involved. It is acceptable

to allow both employees to remain on Activation if they wish and are needed. If one employee is employed within one department and the other is employed within another department, department directors from each area should discuss the options and decide which of the employees is most critical to hospital's activation process. If an agreement cannot be reached, the appropriate Administrative Council members should be consulted to assist in the decision making process. If the married employees have a preference as to which employee shall be assigned to the activation team, reasonable attempts to satisfy their needs shall be attempted but not at the cost of the needs of our patients during a hurricane.

- With each Activation called, employees must call the LSU HCSD Hotline at 1 866 431-4571 (toll free) within forty eight (48) hours after the storm has passed and provide contact information to include a telephone number where the employee can be reached, an address and the employee's availability to return to work. Failure to contact the LSU HCSD Hotline within forty eight hours after the storm has passed may result in termination.

WATCH:

The ***Watch*** phase will be called when a hurricane may threaten within 96 hours (4 days).

- Code Grey Watch will be announced at LSU INTERIM HOSPITAL and at the outer buildings at the start of the Watch phase and at 7 a.m., 11 a.m., 3 p.m., 7 p.m. and 11 p.m. **and** via initiation of departmental call trees. An email will also be sent to the *LSU INTERIM HOSPITALNO Department Director* group to announce the Code Grey Watch.

- Department directors or their designees shall communicate with their teams to assess readiness at the start of the Code Grey Watch and as necessary. The Incident Command Leaders and Chiefs shall meet for the first time in the Incident Command Center one hour after the Code Grey Watch is announced. A Department Director's meeting will be scheduled as necessary.

- Incident Command Unit Leaders will check for critical supplies, equipment deficiencies and staffing shortages. Any deficiencies found shall be reported to the Unit Leader's Chief. Staffing shortages will be reported to the Labor Pool Unit Leader, Medical Staff Unit Leader or Nursing Pool Unit Leader as applicable. Action plans to correct deficiencies must be developed and implemented within 24 hours of the start of the ***Watch*** phase.

- Activation Team rosters will be reviewed for shortages (vacations, illnesses, etc.). Activation Team shortages will be reported to the Labor Pool Unit Leader, Medical Staff Unit Leader or Nursing Pool Unit Leader as applicable. Action plans to cover shortages must be developed and implemented within 24 hours of the start of the ***Watch*** phase.

- All employees are strongly encouraged to initiate their own personal hurricane plans including plans for their property and family members.

- A decision may be made regarding the transfer of patients to other facilities.

- Informational flyers will be given to all patients/significant others during the hurricane season and at admission once a Code Grey Watch is called. Designated staff will distribute the information flyers to all inpatient units for the nursing staff to hand out to inpatients.

- Public Relations will supply media with information regarding the closure of the Emergency Department, Ambulatory Clinics and inpatient facilities.

WARNING:

The ***Warning*** phase will be called when a hurricane may threaten within 72 hours.

- A Code Grey Warning is announced on each campus and at the outer buildings at the start of the Warning phase and at 7 a.m., 11 a.m., 3 p.m., 7 p.m., and 11 p.m. **and** via initiation of departmental call trees. An email will also be sent to the *LSU INTERIM HOSPITALNO Department Director* group to announce the Code Grey Warning.

- Incident Command members are notified by the Incident Commander or designee.

- An Incident Command Center will open at LSU INTERIM HOSPITAL.

- The Chief Executive Officer, in conjunction with Incident Command Center Leaders will make decisions regarding facility closure, patient discharges, patient transfers to other facilities and canceling elective procedures and clinics. Morgue and blood supply status will be obtained by the Ancillary Services Director.

- Prior to activation, the Department of Environmental Services will coordinate the removal of all medical waste and sharps containers and arrange for all dumpsters to be emptied.

- The following must be completed for each patient and placed within their medical record. These items will be attachment to the patient with a safety pin in a plastic Ziplock bag if evacuated:
  - A Patient Triage Card shall be completed by the physician caring for the patient. The Patient Triage Card must include the patient's last name, first name, middle initial, social security number, LSU INTERIM HOSPITAL medical record number, gender, date of birth, age, diagnosis, triage category i.e., red, yellow or green, if the patient is ambulatory or must be moved via stretcher, if the patient has an IV, if the patient is on a ventilator, if the patient

is on a cardiac monitor, if the patient is oxygen dependent, or if the patient is dependent on electricity. See Reference #2011-B for an example.

- Patient Demographic Information must be completed on each patient. The patient's nurse or designee shall print the CLIQ Patient Demographics Page for each patient and verify the accuracy of the demographic, patient contact information and next of kin information included on the CLIQ Demographics Page. If the patient demographic information is incorrect, it should be corrected in writing on the printed Patient Demographics Page. See Reference #2011-C for an example.
- A Patient Evacuation Transfer Summary Report shall be completed by the physician caring for the patient. The Patient Evacuation Transfer Summary Report should be written as a transfer summary to include at minimum, the following elements: admit diagnosis, diagnosis (diagnoses) on transfer, operative procedures, history of present illness, significant clinical findings, hospital course, condition on transfer, transfer disposition, prognosis, diet, activity, medications, follow up care and transfer instructions. See Reference #2011-D for a template.
- A three (3) day supply of medication to go with the patient.

PLEASE NOTE:
Triage Status
RED = critical care, ventilator dependent and/or dialysis
YELLOW = non-critical, non-ambulatory
GREEN = "walking wounded"; able to ambulate on own feet

- Departmental Code Grey Plans are to be initiated.
- Incident Command leaders will meet to assess last minute issues.
- Parking restrictions will be initiated.
- Packages containing emergency parking tags, Activation Team registration forms and Activation Team armbands are distributed to each Administrative Council member at the beginning of the hurricane season.
- Hospital access restrictions are initiated by Hospital Police. Restricted access is defined as limiting entrance to one entrance at front of facility and one entrance at the back of the facility **and** restricting visitor entrance. Visitors will be notified during this time that once the Activation phase is called, any visitor who leaves the facility will not be allowed to return.
- When the decision to activate is made, Activation Team I will be released from duty to go home or is notified by their department to prepare and return to LSU INTERIM HOSPITAL within twelve (12) hours. Activation Team I returns. Staffing, while Activation Team I is away

from duty, will be covered by Activation Team II and Recovery Team. Recovery Team may be called in to duty while the Activation Teams are at home preparing to return.

ACTIVATION:

The ***Activation*** phase will be announced when a hurricane may threaten within 48 hours (See Tracking Chart) with execution at 24 hours prior to landfall.

- Code Grey Activation will be announced three times on each campus and at the outer buildings at the start of the Activation phase and at 7 a.m./11 a.m./3 p.m./7 p.m./11 p.m. An email will also be sent to the *LSU INTERIM HOSPITALNO Department Directo*r group to announce the Code Grey Activation.

- Activation Team II will be released from duty as Activation Team I returns. Activation Team II is due back to LSU INTERIM HOSPITAL within twelve (12) hours. The Recovery Team should be off initiating their personal hurricane preparedness plans.

- Registration Desk opens when Activation is announced.

- Disaster supplies, waterless hand cleaner, food and water are moved into LSU INTERIM HOSPITAL above the first floor area.

- All ancillary buildings are closed, except for Laundry and Warehouse.

- Notice of Non-Acceptance of Non-Emergency Transfer is given to all ambulance companies.

- Notice of Ambulance Diversion is given.

- Visitor restriction is initiated. All visitors, except the one visitor who will remain with the patient, will be asked to leave. The one visitor remaining per patient must register and receive an armband at the Registration Desk. No visitors will be allowed to enter or re-enter any LSU INTERIM HOSPITAL building once the Activation phase is enacted.

- When the Activation phase is enacted, it is the responsibility to the Department of Registration/Admitting to print 50 copies of the Patient Census. These census copies will be used by the charge nurses for the Triage Summary Report and other during evacuation.

- Substations for CMS, Pharmacy, Dietary, Warehouse and Laundry to be set up at LSU INTERIM HOSPITAL.

- All outside travel by Activation Team members will stop in accordance with city and state directives.

- Employees on Activation must pick up their portable personal toilet and supplies from the Department of Environmental Services. See Reference #2011-E, How to Convert a Bucket into a Portable, Personal Toilet for complete instructions.

EVACUATION:

- The Evacuation phase is outlined in the Emergency Management Evacuation, Reference #1026 within the Emergency Management Plan.

RECOVERY:

- If an evacuation occurs, Code Grey Recovery will be announced three times on each campus and at the outer buildings at the start of the Activation phase and at 7 a.m./11 a.m./3 p.m./7 p.m./11 p.m. An email will also be sent to the *LSU INTERIM HOSPITALNO Department Directors* group to announce the Code Grey Recovery.

- The decision regarding Recovery Team report time is made by the Incident Commander. The specified time for the Recovery Team to report will be communicated internally through the departmental telephone trees and externally through WWL 870 radio and television stations. It is the Recovery Team employees' responsibility to monitor the media for these announcements if they have left the site of their telephone number of record.
- Activation Team members will be released as Recovery Team members report for duty. Staffing shall be determined by the department director or designee.

- Department specific recovery plans will be followed to implement and/or re-implement departmental services.

TELEPHONE TREE:

The Department of Telecommunications is responsible for notifying personnel on the Incident Command List at the start of Watch and Warning phases. Each department director is responsible for developing and implementing his/her own department telephone tree at the start of the Warning phase. See Reference #2011-A, the Telephone Call Tree, for the template.

COMMUNICATIONS:

- The main line of communication during Code Grey activities will be 800 mhz radios issued by the Incident Command Center to the Incident Command Leaders.

- Hand held Nextel two way radio communications will also be used as long as that capability exists. It is the responsibility of the Department of HIS to maintain a listing of all LSU INTERIM HOSPITAL issued Nextel telephone numbers for distribution during the Activation phase.

- FRS radios shall be issued to Administrative Council members, department directors or designee and the attending staff physician or designee from each hospital service of each medical school by the Department of Hospital Information Systems. These radios are to be used for internal and campus-wide communication for essential communications only. **Conversations shared on these radios can be heard by everyone on the radio net so please share cautiously.** These radios will also be used for announcements regarding situation status at 08:00 a.m., 12 noon and 4:00 p.m.

- The Incident Command Leaders will communicate with other hospitals, EMS, the City of New Orleans and HRSA by way of the official HRSA 800 mhz radio.

- One generator per hospital site will be dedicated for charging all 800 mhz radios. It shall be the responsibility of Hospital Police to maintain this generator and charge all 800 mhz radios as needed.

- One computer with internet capabilities will also be maintained on the generator dedicated to charging the 800 mhz radios to keep email and internet channels open.

- LSU INTERIM HOSPITAL will also possess a portable HAM radio to assist in communication. HAM radio operators will be hired and/or taken on as volunteers to operate the HAM radios.

VISITORS:

- Visiting hours will be suspended at the start of the Activation phase. All visitation will end 48 hours before landfall. One visitor will be allowed to remain with inpatients after visiting hours are stopped. All visitors will be required to register at the Registration Desk and may be used as Labor Pool.

- ***The Chief Executive Officer or designee has the authority to cancel visitation and direct all visitors to leave LSU INTERIM HOSPITAL if deemed necessary for the safety of the family members, patients or the staff***.

PERSONNEL ACCOMMODATIONS:

Sleeping quarters will be designated for the Activation Team. Staff will be notified of the designated sleeping quarters at the time of distribution of parking passes. Personnel are required to stay in their designated location.

ACCOMMODATIONS OF FAMILY MEMBERS AND DEPENDENTS:

There will be no guest and/or family accommodations at the LSU Interim Hospital. Activation team members may not bring guests and/or family members during Code Grey activities.

HOUSE STAFF/ATTENDING STAFF ACCOMMODATIONS:

Accommodations for the house staff physicians and attending staff physicians will be made through the Medical Staff office and the Medical Director's office. **There will be no guest and family accommodations at the LSU Interim Hospital. Activation team members may not bring guests and/or family members during Code Grey activities.**

ACCOMMODATION PROHIBITIONS:

- Under no circumstances will patient rooms or clinics be used for staff and/or physician accommodations unless approved by the Incident Commander.

- **PETS ARE NOT ALLOWED ON LSU INTERIM HOSPITAL PREMISES.** Anyone who brings pets on LSU INTERIM HOSPITAL premises will be directed to remove them.

- No electrical appliance or combustion fuel equipment or supplies, i.e., Coleman stoves, non battery operated lanterns, candles, may be brought to the LSU Interim Hospital.

BEDDING:

All Activation Team employees are responsible for bringing their own sleeping bags, linens, blankets, pillows, etc. No LSU INTERIM HOSPITAL mattresses or "egg crates" may be distributed to anyone other than patients.

SUPPLIES:

- An assessment of critical supplies is made prior to the beginning of the Hurricane Season, no later than June 1st. Water and other critical supplies will be requisitioned, received and stored for use during hurricane season. Any supplies not used during hurricane season will be released for general use on December 1st or before expiration date, whichever comes first.

- Employee should bring sufficient clothing, food, water, medications and toiletries for 10-14 days. See Activation Team Hurricane Supply List, Reference #2015 within the Emergency Management Manual for suggested items.

DIETARY:

Food service will be available for Activation Team employees. As long as able, the cafeteria will serve breakfast, lunch and dinner at no cost to the employee. If needed, meals ready to eat will be available to Activation Team employees.

PARKING:

Parking will be available for Activation Team employees only. Each Activation Team employee may bring one car only. LSU INTERIM HOSPITAL will make every effort to arrange for elevated parking but no guarantees will be given.

SICK CALL:

If needed, employees, physicians or patient visitors may obtain medical care during the Activation phase between 6 a.m. and 8 a.m. and 6 p.m. and 8 p.m. Emergencies will be handled at anytime at each site. Payment for services will be in accordance with LSU INTERIM HOSPITAL Policy 1102 – Free Care Determination.

PAY:

All employees working during the Activation and Recovery phases will be paid cash. Overtime will be paid in accordance with Civil Service rules. Activation Team members must clock in using the official LSU INTERIM HOSPITAL time and attendance system at the start of Activation and out when relived at Recovery. The pay policy for Activation and Recovery will be published by the Department of Human Resources at the start of the Warning phase.

REGISTRATION:

The Registration areas will be designated at the initiation of the Activation phase. Everyone in an LSU INTERIM HOSPITAL building during Activation and Recovery will be required to register including employees, physicians and patient visitors. All physicians are registered by the Medical Staff office. An armband system for registration will be used as follows:

- Employees – Purple
- Patient Guest – Orange
- Physicians – Yellow

The Registration areas will be open during Activation and Recovery phases.

The Labor Pool will be responsible for reporting:

- Coverage for shortages in Activation staff to the departments 24 hours before landfall
- Total number of people registered to Dietary twelve (12) hours before landfall and as necessary; and
- Total number of people registered to the Incident Command Center(s).

Employees of departments that are not involved in direct patient care will be assigned to the labor pool as hall monitors, couriers, clerical assistants, dietary assistants or patient escorts. Training will be provided for hall monitors and patient escorts.

A team will be formed for each operational floor at each LSU INTERIM HOSPITAL site to include one hall monitor, one courier, one clerical assistant and one patient escort.

As people leave the facility, they will check out through the Registration Desk. Employees reporting in for the Recovery Team will sign in at the Registration Desk.

NURSING POOL:

The Nursing Pool will be comprised of nursing personnel from Ambulatory Clinics, Revenue Enhancement, Case Management, Staff Development and any other areas where nurses are assigned that are not considered direct patient care.

LSUHealth
INTERIM LSU PUBLIC HOSPITAL

CODE GREY

SEVERE WEATHER PLAN

I hereby acknowledge receipt of the Interim LSU Public Hospital (ILPH) Physicians Disaster Plan for Code Grey Operations Plan. I understand that:

- I am responsible for complying with the ILPH Physician Disaster Plan for Code Grey and the Code Grey Operations Plan,
- I may be assigned to an on-call team by my Department Chairman, Section Chief or Chief Resident
- The ILPH Medical Director has the final authority and responsibility for all assignments for all of the Staff (Medical Staff Members/Interns/Residents/Fellows).

_____ _____

Printed Name Cell phone Number

_____

Local Address City State Zip Code

_____ _____

Signature Date

Circle the appropriate status: Intern Resident Fellow

School/Department: _____

MEDICAL CENTER OF LOUISIANA
LSU Interim Hospital
Department of Medical Staff Affairs
and Graduate Medical Education (GME)

Policy Number: MS 0006

Policy Title: Medical Staff Code of Conduct

Inquiries to: Gail G. Runnebaum, CPMSM (504) 903-0381

Effective Date: April 29, 2010

Approvals:

_____
Administrative Director, Medical Staff & GME

Review/Revision Dates: 4/29/10
Medical Executive Committee Approval: 4/29/2010
Board of Supervisors Approval:

I. INTRODUCTION

The Medical Staff, (to include Faculty, Licensed Independent Practitioners and Residents, for this policy) at the Interim LSU Public Hospital (ILH) are committed to supporting a culture that values integrity, honesty, and fair dealing with each, and to promote a caring environment for patients, their families, physicians, nurses, other health care workers and employees.

The Medical Staff endeavors to create and promote an environment that is professional, collegial and exemplifies outstanding teaching, research and patient care.

Towards these goals, the Medical Staff strives to maintain a workplace that is free from harassment. This includes behavior that could be perceived as inappropriate, harassing, or that does not endeavor to meet the highest standards of professionalism.

II. PURPOSE

The purposes of this Code of Conduct are to:

- clarify the expectations of all health care providers during interactions with any individual at the ILH;
- encourage the prompt identification and resolution of alleged inappropriate conduct;
- encourage identification of concerns about the well-being of a health care provider whose conduct is in question.

Disruptive conduct and inappropriate workplace behavior may be grounds for suspension or termination of a contract, or cancellation, suspension, restriction or non-renewal of privileges.

The process set forth in the ILH (MCLNO) Medical Staff Bylaws and Rules and Regulations will be followed for matters which have an impact upon an individual's privileges, employment or a house officer's academic standing.

III. POLICY STATEMENT

Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. Thus, all Medical Staff members and Allied Health Professionals practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

This Policy outlines collegial and educational efforts that can be used by Medical Staff leaders to address conduct that does not meet this standard. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the process in the Medical Staff Bylaws, Rules and Regulations.

This Policy also addresses sexual harassment of employees, patients, other members of the Medical Staff, and others, which will not be tolerated.

In dealing with all incidents of inappropriate conduct, the protection of patients, employees, Practitioners, and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. Complying with the law and providing an environment free from sexual harassment are also critical.

All efforts undertaken pursuant to this Policy shall be part of the Hospital's performance improvement and professional and peer review activities.

IV. DEFINITIONS

"Appropriate behavior" includes any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized Medical Staff, or to engage in professional practice including practice that may be in competition with the hospital.

"Inappropriate behavior" means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as "disruptive behavior."

"Disruptive behavior" means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

"Harassment" means conduct toward others based on their race, religion, gender, gender identity, sexual orientation, nationality or ethnicity, which has the purpose or direct effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment.

"Sexual harassment" means unwelcome sexual advances, requests for sexual activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive intimidating or otherwise hostile work environment.

"Medical staff member" means physicians and others granted membership on the Medical staff and for purposes of this Code, includes individuals with temporary clinical privileges and residents.

V. TYPES OF CONDUCT

A. APPROPRIATE BEHAVIOR

Medical staff members cannot be subject to discipline for appropriate behavior. Examples of appropriate behavior include, but are not limited to, the following:

- Criticism communicated in a reasonable manner and offered in good faith with aim of improving patient care safety;
- Encouraging clear communication;
- Expressions of concern about a patient's care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
- Use of cooperative approach to problem resolution;
- Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
- Professional comments to any profession, managerial supervisory, or administrative staff, or members of the Board of Directors about patient care or safety provided by others;
- Active participation in medical staff and hospital meetings
- Membership on other medical staffs; and
- seeking legal advice or the initiation of legal action for cause.

B. INAPPROPRATE BEHAVIOR

Inappropriate behavior by medical staff members is discouraged. Persistent inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as "disruptive behavior". Examples of inappropriate behavior include, but are not limited to, the following:

- Belittling or berating statements;
- Name calling;
- Use of profanity or disrespectful language;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Personal sarcasm or cynicism;
- Deliberate refusal to return phone calls, pages, or other messages concerning patient
- care or safety;
- Inappropriate comments or behavior in meetings
- Intentionally condescending language; and
- Intentionally degrading or demeaning comments regarding patients and their families, nurses, physicians, hospital personnel and /or the hospital.

B. DISRUPTIVE BEHAVIOR

Disruptive behavior by medical staff members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

- Physically threatening language directed at anyone in the hospital including, physicians, nurses, other medical staff members, patients, their families, any hospital employee, administrator, or member of the Board of Directors;
- Physical contact with another individual that is threatening or intimidating;
- Throwing instruments, charts, or other things;
- Threats of violence or retribution;
- Sexual harassment;
- Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation; and
- Repetitive inappropriate comments or disruptions in meetings.

VI. GENERAL GUIDELINES/PRINCIPLES

1. Issues of employee conduct will be dealt with in accordance with the Hospital's Human Resources Policies. Issues of conduct by members of the Medical Staff or Allied Health Professionals (hereinafter referred to as "practitioners") will be addressed in accordance with this Policy. If the matter involves an employed practitioner, hospital management in consultation with appropriate medical staff leaders and legal counsel will determine which of any applicable policies will be applied.

2. This Policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken to address concerns about inappropriate conduct by practitioners. However, a single incident of inappropriate conduct or a pattern of inappropriate conduct may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the Executive Committee or the elimination of any particular step in the Policy.

3. In order to effectuate the objectives of this Policy, and except as otherwise may be determined by the *Medical Staff Executive Committee (or its designee)*; the practitioner's counsel shall not attend any of the meetings described in this Policy.

4. The Medical Staff leadership and Hospital Administration shall provide education to all Medical Staff members and Allied Health Professionals regarding appropriate professional behavior. The Medical Staff leadership and Hospital Administration shall also make employees, members of the Medical Staff, and other personnel in the Hospital aware of this Policy and shall institute procedures to facilitate prompt reporting of inappropriate conduct and prompt action as appropriate under the circumstances.

VII. PROCEDURES

Every individual should feel free to file a complaint in good faith about unprofessional behavior without fear of reprisal or retaliation. Medical Staff members have an obligation to address and/or report incidents of inappropriate and disruptive behavior. Complaints about a member of the Medical Staff regarding allegedly inappropriate or

disruptive behavior should reported within 5 business days and be in writing, signed and directed to Medical Staff Services. and Risk Management.

The complaint should include to the extent feasible:

1. name of practitioner , the dates(s), time(s), and location of the inappropriate or disruptive behavior;
2. a factual description of the inappropriate or disruptive behavior;
3. the circumstances which precipitated the incident;
4. the name and medical record number of any patient or patient's family member who was involved in or witnessed the incident;
5. the names of other witnesses to the incident;
6. the consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or hospital personnel or operations; and
7. any action taken to intervene in, or remedy, the incident, including the names of those intervening.

VIII. INITIAL PROCEDURE

1. The Medical Director of the Medical Staff Office or designee will screen all complaints to determine the authenticity and severity of the complaint. If the complaint is clearly not valid, it may be summarily dismissed. If it is determined that the complaint may have substantial validity, the Medical Director of the Medical Staff Office (or designee) will speak with the complainant and the subject of the complaint.

2. Medical Staff members who are the subject of a complaint shall be provided with a summary of the complaint and a copy of this Policy in a timely fashion, in no case more than 30 days from receipt of the complaint. The subject shall be offered an opportunity to provide a written response to the complaint; any such response will be kept along with the original complaint in all relevant files.

3. The Medical Staff member will be notified that any attempt to confront, intimidate or otherwise retaliate against the complainant is a violation of this Code of Conduct and may result in corrective action against the Medical Staff member.

4. The complainant will also be provided a written acknowledgement of the complaint and an explanation of how complaints are handled. If the complaint is determined to have no substance or validity, the complainant will be counseled regarding appropriate use of the incident reporting system.

5. After discussion with the Medical Staff member, the Medical Director of the Medical Staff Office (or designee) will document the disposition of each complaint and a record shall be kept in the appropriate files.

6. The Hospital Center Head and the appropriate Medical School Department Chair will be kept informed regarding complaints directed toward their department members.

IX. DISPOSITION OF UNFOUNDED COMPLAINTS

If the information obtained in the investigation fails to demonstrate that the incident complained of took place, or if the reported behavior did not, in fact, deviate from expectations of professionalism, The Medical Director of the Medical Staff Office *(or designee)* may find that there is no basis for the concern. In this event, the complaint will be retained in the Practitioner's file in accordance with this policy, with a clear indication that it was unfounded together with the information that substantiates this.

X. SUBSTANTIATED COMPLAINTS

If it is determined that inappropriate conduct took place, a staged approach to behavior management shall be considered in light of the prevalence, severity, persistence and consequences of the incident or behavior.

1. The Director of the Medical Staff Office (or Designee) will meet with the Practitioner. Either may request the presence of a third party for this meeting.
2. At the meeting the following information will be provided to the Practitioner:
   a. the details of the incident about which the report was received; and
   b. an explanation of how this behavior deviated from expectations.
3. The Practitioner will be provided with the opportunity to respond to the information, either orally, during the meeting, or within 14 days in writing.
4. In discussion with the Practitioner the Medical Director of the Medical Staff Office (or designee) will determine whether further investigation as to the cause of the behavior is warranted. Such an investigation will certainly be warranted where the Practitioner feels that the behavior is outside of his or her own control. The Practitioner could be referred for an independent evaluation.

XI. BEHAVIOR MANAGEMENT

Unless behavior complained of poses an immediate threat to patient care or the safety of others, or unless the outcome of a prior complaint has indicated otherwise, the Medical Director of the Medical Staff Office (or designee) will consider the findings of the review and make the following recommendations:

- expectations in relation to behavior in the future;
- remediative measures, if any. (An effort will be made to reach agreement with the practitioner about the steps required towards changing his or her behavior; in keeping with a staged approach to management, the course of action could include such components as stress management training, psychotherapy, monitoring, teamwork training, an apology, monitoring etc.) The agreement as to what measures will be undertaken may take the form of a written contract between the practitioner and the institution;
- disciplinary action, as may be appropriate;
- the consequences of any repeated inappropriate behavior; and
- further follow up, as required.

The Director of the Medical Staff Office *(or designee)*will provide the Practitioner with a written summary of the meeting and a copy of the written summary will be retained in the Practitioner's file.

The Medical Director of the Medical Staff Office will provide a report to the MEC.

XII. EGREGIOUS/REPEATED UNPROFESSIONAL BEHAVIOR

If the behavior complained of poses an immediate threat to patient care or the safety of others, or if the outcome of a prior complaint has indicated as much, the matter will not be dealt with by the Medical Director of the Medical Staff Office. Rather, (the appropriate higher level of authority: the President of the MEC, a committee appointed by the President of the MEC and/or the MEC) will consider the findings of the review and make the determination as to outcome, which could include suspension of privileges or dismissal from the Medical Staff.

If the Practitioner feels that the process or determination is flawed, then the Practitioner is entitled to request a formal appeal as outlined in the Medical Staff Bylaws, Rules and Regulations.

A Practitioner who fails to act in accordance with this policy may be subject to disciplinary action, up to and including suspension/termination of privileges.

XIII. CONFIDENTIALITY

The complaints investigation procedure is intended to be a confidential procedure. All parties to the process are expected to respect and maintain the confidentiality of the process and not to divulge the details of the investigation to anyone. Where there is any risk to other Practitioners, employees and patients, disclosure will be made to the extent necessary to offer adequate protection.

XIV. BEHAVIOR DIRECTED TOWARD A MEDICAL STAFF MEMBER

Inappropriate or disruptive behavior which is directed against the organized medical staff or directed against a medical staff member by a hospital employee, administrator, board member, contractor, or other member of the hospital community shall be reported by the medical staff member to the hospital pursuant to hospital policy or code of conduct, or directly to the hospital governing board, the state or federal government, or relevant Accrediting body, as appropriate.

XV. AWARENESS OF CODE OF CONDUCT

The Medical Staff shall, in cooperation with the hospital, promote continuing awareness of this Code of Conduct among the Medical Staff and the hospital community, by:

1. Sponsoring or supporting educational programs on disruptive behavior to be offered to Medical Staff members and hospital employees.
2. Disseminating this Code of Conduct to all current Medical Staff members upon its adoption and to all new applicants for membership to the Medical Staff.
3. Educating the members and the hospital staff regarding the procedures the Medical Staff and hospital have put into place for effective communication to hospital administration of any Medical Staff member's concerns, complaints, and suggestions regarding hospital personnel, equipment and systems.

XVI. SEXUAL HARASSMENT CONCERNS

Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the following actions:

1. A meeting shall be held with the member of the Medical Staff to discuss the incident. If the member of the Medical Staff agrees to stop the conduct thought specifically to constitute sexual harassment, the meeting shall be followed up with a formal letter of admonition and warning to be placed in the confidential portion of the practitioner's file. This letter shall also set forth those additional actions, if any, which result from the meeting.

2. If the member of the Medical Staff refuses to stop the conduct immediately, this refusal shall result in the matter being referred to the Medical Executive Committee for review pursuant to the Medical Staff Bylaws, Rules and Regulations.

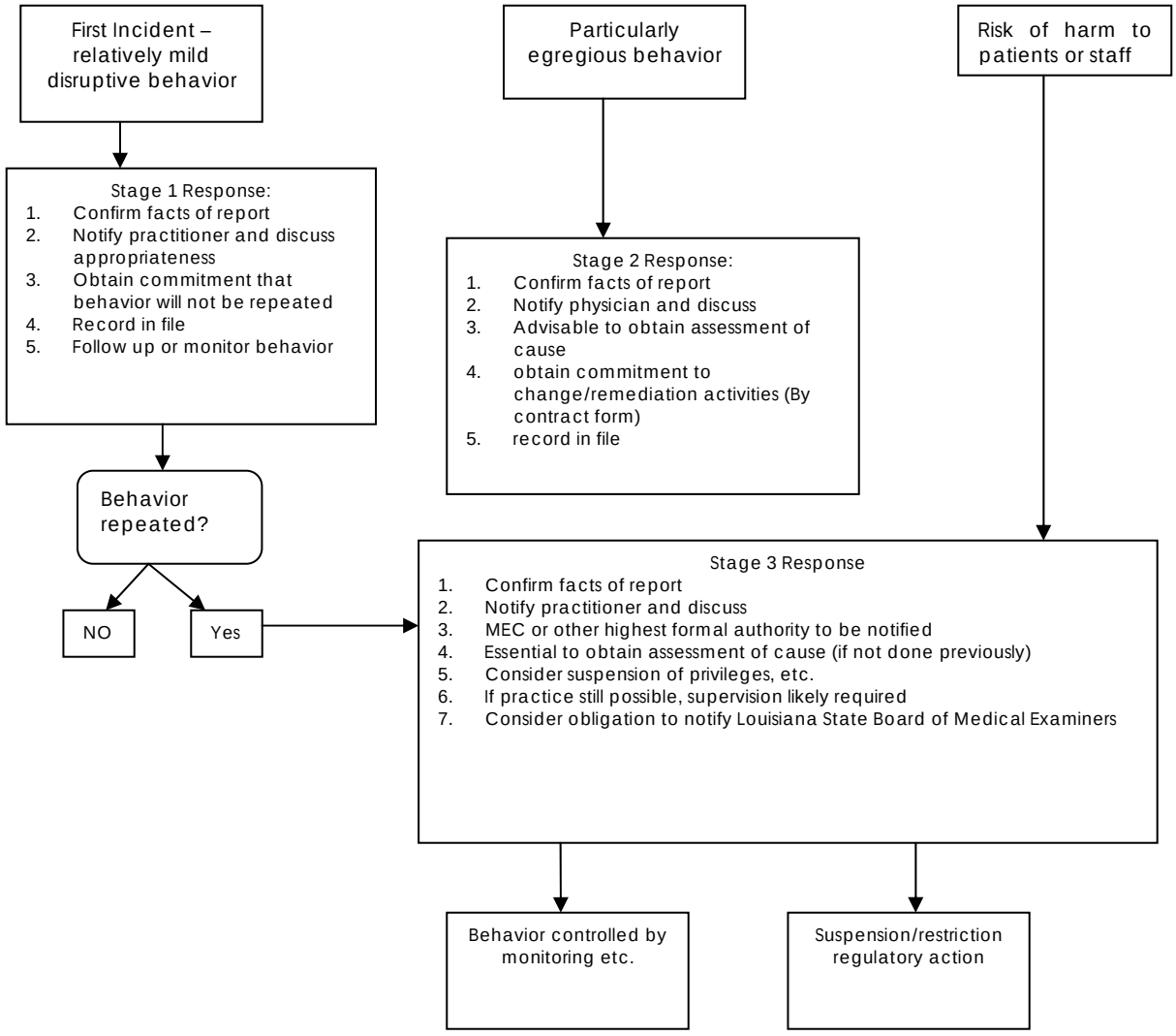
3. Any reports of retaliation or any further reports of sexual harassment, after the member of the Medical Staff has agreed to stop the improper conduct, shall result in an immediate investigation. If the investigation results in a finding that further improper conduct took place, the President of the MEC will appoint a committee with a formal investigation or other steps in accordance with the Medical Staff Bylaws, Rules and Regulations. Such referral shall not preclude other action under applicable hospital human resources policies. Should the Medical Executive Committee make a recommendation that entitles the individual to request a hearing under the Medical Staff Bylaws, the individual shall be provided with copies of all relevant reports so that he or she can prepare for the hearing subject to agreement of the practitioner and counsel, if any, not to retaliate in any way.

Recommended by the Executive Committee this **29th** day of **April, 2010**

_____
President of the Medical Staff

Approved by the Board this _____ day of _____, 20___.

Behavior Management Flow Chart



LSUHealth
INTERIM LSU PUBLIC HOSPITAL

Code of Conduct

ACKNOWLEDGMENT

This is to acknowledge that I have read and understand the Interim LSU Public Hospital Medical Staff Code of Conduct.

_____
(Print Name)

_____
Signature Date

LSU Health
INTERIM LSU PUBLIC HOSPITAL

ILH Key Elements

Welcome to ILH!

This presentation will give you some basic information, as well as introduce you to the Key Elements of our hospital orientation.

Please print out an answer sheet and complete it as you go through the presentation.

ILH Core Values

- **C**ustomer Focused
- **H**ealing Environment
- **A**ccountability
- **R**espect & Integrity
- **I**nnovation
- **T**eamwork
- **Y**es We Can

You are expected to demonstrate these every day!

Appearance Standards

- All physicians, students, contract workers, volunteers, and vendors shall present a neat and clean appearance, and dress in a manner appropriate for a healthcare environment
- No denim, shorts, or revealing clothing
- Everyone must wear an official ID badge while on the premises
- You may have a specific dress code
- Specifics are available in MCL Policy 8134

Customer Service

We have two kinds of customers:

- Internal (employees/coworkers, vendors, students, faculty, etc)
- External (patients and their families)
- Treat both with the same level of courtesy and respect

Providing excellent customer service is a choice;

Choose excellence every time!

Universal Service Expectations

1. Introduce yourself and your purpose.
2. Be courteous and respectful.
3. Make sure the customer knows how to reach you.
4. Answer calls for help immediately and provide solutions/help quickly.
5. Communicate with patients/families in a way they can understand. Do not use medical terminology.

Patients' Rights

- Follow all the National Patient Safety Goals
- Rights include being treated with respect, pain management, healthcare advocacy, population-specific care, having information explained in understandable ways.
- Responsibilities include providing an accurate medical history and following hospital rules
- A Patient Advocate is available if needed

Personal Etiquette

- Things to do:
  - pay attention and listen
  - monitor your volume and tone of voice
  - let people finish sentences
  - be aware of your body language & facial expressions
  - make eye contact with the customer.

Personal Etiquette

- Things to avoid
  - Taking the last of something without replacing it
  - Gossip and complaining
  - Body language that says you don't care
  - Humor that could offend or demean anyone

Sexual Harassment

- Everyone has the right to a work environment free from sexual harassment.
- It can come from anyone: employee, volunteer, supervisor, vendor, student, faculty, etc.
- Sexual harassment is never acceptable.

If someone harasses you:

1. Say "no" and tell them to stop
2. Notify your instructor or department manager immediately

Communication Skills

- Communication can mean different things to different people.
- Nonverbal communication may be a stronger message than the words you use.
- Be aware of culture differences, for instance differences in personal space preferences.
- Always use language the person understands.
- Listen as much as you speak and be patient.
- Check with the person regularly to see that they understand you.

Health Literacy

- The ability to understand and act upon health information
- Poor health literacy results in patient dissatisfaction, poor health outcomes, and higher costs due to noncompliance with instructions, resulting in repeat visits and more severe symptoms.
- Affects people of every age, culture, socioeconomic and educational levels

Standards of Health Literacy

- Listen and show unconditional respect
- Explaining information in ways the patient understands.
- Welcome and encourage any and all questions
- Ask patients to repeat back or explain the instructions you have given them.
- Explain all treatments and medicines before giving them
- Give patients the information they will need to take care of themselves at home

Helping Patients Who Don't Speak English

Always use the Cyracom "blue phone", when communicating with patients and their families

Dealing with Difficult Customers

- Anticipate peoples' needs and try to prevent problems before they occur
- Apologize for any difficulties. Remain calm and listen; don't interrupt
- Notify the unit manager/supervisor
- Try to solve the situation before it escalates to an unsafe one
- Know when and how to obtain assistance for the customer, when you are unable to help or answer their question. Consult the Patient Advocate, if needed.

Quiz True or False?

1. I can treat coworkers differently than my patients

2. I'm not an ILH employee; I don't have to provide excellent customer service

3. It's ok to tell a patient "sorry, I don't know that"

4. I can ask a coworker or family member, to interpret for a patient who doesn't speak English

Answers

1. No. Coworkers also (internal) customers. Provide them the same respect and helpfulness as you would your patients
2. No. Even though you are not employed by ILH, patients and families expect the same service from you. You are representing ILH to our patients.
3. You can't know everything; but you are expected to find the accurate information and then convey it to the person who needs it.
4. No; always use the Cyracom "blue phone"

Telephone Etiquette

- Answer promptly; state name of department and your name
- Listen, show interest, take notes
- Transfer only when necessary; give the caller the number before you transfer them
- Convey messages quickly and accurately, repeat the message before hanging up with the customer

Email etiquette

- Would a personal conversation be better?
- Re-read before sending
- Copy only the people you think need this information. Be careful about selecting "reply all".
- Avoid multiple topics or lengthy messages, copying others as a form of coercion, using all caps or multiple exclamation marks!!!

Internet Use

- The ILH internet may not be used for any personal business, including during breaks or lunch.
- Internet usage is monitored and reported to leadership.
- The use of "social media", when discussing patients or coworkers, is a breach of confidentiality.

Ethics

- You are expected to do the right thing, at the right time, in the right place, for the right reason.
- The Ethics Committee provides an official forum for discussion of ethical concerns.
- You can reach an Ethics Committee member 24 hours a day/7 days a week by calling the hospital operator at 903-3000.

Gift Policy

- No Public Servant (a public employee) shall solicit or accept, directly or indirectly, any thing of economic value as a gift or gratuity from any person who has or is seeking a business relationship with that person's agency.
- For more specific information, please read MCL Policy 0019

Americans with Disabilities Act

- ILH provides reasonable accommodations to people with disabilities, when possible, and focuses on abilities rather on disabilities.

Tobacco Free Environment

- ILH is a tobacco free facility, including all buildings and grounds owned by the hospital, with the exception of designated smoking areas on Gravier St. and across the street on Perdido St.
- Smoking Cessation Classes are offered to patients and employees – contact:

  Lucretia Young, MA, Cessation Specialist

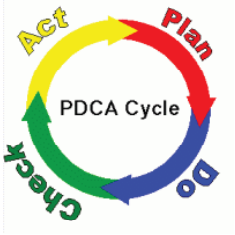
  LSUHSC-School of Public Health, Tobacco Control Initiative(504)903-5059 or lyoun2@lsuhsc.edu

ILH Drug Use Policy

- ILH is a drug- and alcohol-free workplace.
- Follow all drug-testing policies.

ILH Performance Improvement Model

- *Plan*
- *Do*
- *Check*
- *Act*



- Everyone participates in performance improvement

Incident Reporting

An incident is any occurrence that is not consistent with routine ILH operations, or has the potential to result in harm or loss, to an individual or property.

All employees, volunteers, physicians, vendors, contractors, students, and faculty are responsible to report incidents. The manager of your area can assist you with this.

Safe Haven Law - Policy 0073

- ILH provides a **"safe haven"** for a parent who relinquishes the care of an infant to the state, providing the infant is
  - less than 30 days old
  - free from signs of abuse or neglect
  - left in the care of any employee at a designated emergency care facility.
- **The parent can remain anonymous and without threat of prosecution.**
- Take all relinquished infants to the ED.

Abused or Neglected Patients

- Indicators for abuse and neglect are listed in MCL Policy 5065.
- It is mandatory to report suspected abuse or neglected in three populations:
  1. people of any age who have a disability
  2. people over age 60
  3. people under age 18
- Report your findings to Case Management-you may also have to report to agencies outside the hospital; Case Management can help you with this.

Abused or Neglected Patients

You may also identify abuse or neglect in patients who are not in one of the three mandated populations

- Assess and document your findings
- Show compassion and respect
- Ask the patient if they would like you to report
- Offer them services (Case Management, outside agencies, police)
- Document your offer and the patient's response

Quiz: True or False

5. I'm not a manager; I don't have to worry about performance improvement

6. I'm not an ILH employee; I don't have to worry about incident reports

7. If my patient is 70 and I suspect abuse, I have to make a report

Answers

5. No; everyone participates in performance improvement
6. No; everyone who witnesses or is involved in an incident has a role to play . If you are not an employee, you will participate by providing information to the employee who is completing the report.
7. Yes, this is an example of a mandated report

Safety

Code Blue

1. **Call for help**
   - Inside the hospital building, call 2-5000
   - Outside the hospital building, call 911

2. **Begin the steps of BLS**

Rapid Response Team

- If you think anything is wrong with the patient, notify the doctor or nurse immediately.
- Inside the hospital, you can also call the Rapid Response Team - call 2-5000.
- If the patient continues to worsen, call for Code Blue, and begin the steps of BLS.

Preventing Fires

- Follow all ILH safety rules and regulations
- Use electrical equipment safely
- Enforce the no-smoking policy
- Know the locations of fire alarm pull stations, fire extinguishers, and emergency exits in your work areas

Code Red - Inside the Hospital

In the immediate area of the fire: RACE

Rescue persons in immediate danger
Activate the alarm; call 2-5000
Close doors
Extinguish or **Evacuate**

Code Red—Inside the Hospital

If you are in an area that is above, below, or adjacent to the fire, "defend in place":

Move patients into rooms
Close all doors and windows
Wait for further instructions

Fire Extinguishers

ABC fire extinguishers may be used on any type of fire

To operate: PASS

Pull the pin
Aim the nozzle at the base of the fire
Squeeze the handle
Sweep from side to side

Code Red—Outside the Hospital

If you are in any building outside of the hospital (clinics, offices):

Call 911
Evacuate immediately

Electrical Safety

- Inspect all electrical equipment before use; do not use if damaged or wet.
- Plugs must have 3rd prong.
- Remove by pulling the plug, not the cord.
- In the event of power failure, use the red outlets for essential equipment, such as a ventilator.
- Only ILH electricians may open electrical panels and reset breakers.
- Only ILH-approved electrical equipment may be used.

Electrocution

If you encounter someone being electrocuted:

1. Disconnect the power source
2. Call for help (Code Blue or 911)
3. Begin the steps of BLS

Quiz: True or False?

8. Only ILH employees can call for the Rapid Response Team

9. If I see fire or smoke, I should run for help

10. An ABC fire extinguisher can be used on any type of fire

Answers

8. Anyone can call for Rapid Response, including students, families, and visitors

9. No; the first step is to rescue anyone in immediate danger (R.A.C.E.)

10. Yes.

Hospital Security

- Everyone is responsible for a safe environment.
- Everyone must wear an ID badge above the waist, and in plan view.
- Report any unusual or unsafe situation to Hospital Police (903-6337)
- Watch for and report any potential violence.

Violence in the Workplace

- Violence can be verbal or physical.
- It is often preceded by warning signs
- Domestic situations can result in violence at work - notify Hospital Police
- Call **Code White** for any potential or actual violent situations, 2-5000.

Prisoner Care

- Treat prisoner patients with dignity and respect.
- Prisoners must wear a restraint device and law enforcement officers must be physically present at all times.
- Prisoners cannot have phone calls, messages, or visitors.
- Prisoner patients are given discharge instructions pertaining to their care, but are not given discharge date or follow up appointment information.

Prisoner Care

If you have any problems with prisoners or law enforcement officers, call Hospital Police at 2-6337.

For any prisoner-related violence:

Call Code Gold 2-5000

Hazardous Materials

- A **Material Safety Data Sheet** (MSDS) is a document that gives safety information about chemicals and substances (risks, storage, handling, disposal, etc.)
- Every chemical in your work area has an MSDS; these are available online or in the MSDS yellow binder.
- Follow all instructions given in the MSDS
- Use appropriate personal protective equipment

If there is a chemical or radioactive spill, evacuate the area and call Code Orange: 2-5000.

Code Pink

If an infant or child is missing **call Code Pink, 2-5000.**

- go to the nearest hospital exit.
- watch for anyone leaving the hospital with an infant or child.
- do not attempt to detain the person.
- Observe their appearance, vehicle, and direction of travel, and report any details to the hospital police

Internal Disaster

Disruption of services that could damage the facility, or threaten the health and safety of patients, visitors or employees

1. **Call Code Brown 2-5000**
2. **Follow the instructions of hospital leadership**

Bomb Threat/Code Black

- If you receive a call, pay attention to any details
- Tell the caller that the hospital is occupied and this could result in injuries and death
- **Call 2-5000 and tell the operator "bomb threat report"**
- Give the operator the details of the call
- Remain calm; notify your coworkers
- Do NOT notify patients or families
- Follow the instructions of hospital leadership

Code Silver

- Someone with a weapon (gun or knife) in the facility
- Evacuate the area immediately
- Call the operator (2-5000) and ask for code silver - give location and description of the person
- Police will take control of the situation

You can call 2-5000 for any emergency.

Quiz: True or False?

11. Prisoner patients have no right to any healthcare information
12. I can find information on how to handle chemicals safely 24/7
13. I can call 2-5000 for any emergency

Answers

11. False. They have the right to know about their own health and treatment plan. However, they cannot be given any information about discharge date/time, or followup care appointments
12. Yes. You can look up any chemical information in the Material Safety Data Sheets
13. Yes. However, if you are located outside the ILH building, you will call 911 for Code Red or Code Blue

Preventing Falls

- Everyone is responsible for preventing injuries in the workplace. Act responsibly.
- Keep walkways clear, dry, and well-lit.
- Pay attention to your work, wear proper clothes and shoes, and follow safe work practices.
- Keep yourself free from injury.
- When you see a hazardous situation, request repairs or environmental services immediately; your manager can help you do this.

Preventing Patient Falls

ILH's fall prevention initiative is called RAGTIME

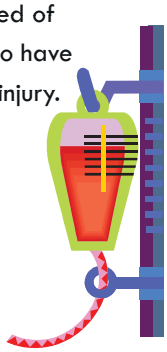
- Identify patients at high risk for falling
- Take immediate precautions
- Notify the department nursing supervisor
- Implement a plan to prevent falls
- Everyone who cares for patient is notified and will work to keep patient from falling ("green dot")

Safe Medical Device Act

Federal law that says the FDA must be informed of any medical product causing, or suspected to have caused, a serious illness, injury, or potential injury.

MDR- Medical Device Report 3500 is used to report:

- difficulty operating
- incorrect use
- adverse patient reactions/injury
- defective equipment



Defective Equipment

When a device is defective or appears to be malfunctioning:

- Immediately remove it from the patient care area
- Clearly label it defective
- Complete the sticker (from CMS) and include the specifics of what you think is wrong
- Take the equipment down to CMS/Biomed for repair

Infection Prevention and Control

Infection Prevention and Control

- No eating or drinking in any patient care area
- Do not come to ILH if you are sick
- Perform hand hygiene
- ILH encourages flu vaccination
- Ask your healthcare provider about other immunizations; some may be mandatory.
- Use Standard Precautions with every single patient.
- Use personal protective equipment (PPE).

Hand Hygiene

- Before and after patient contact
- After removing gloves and PPE
- Before preparing and giving food, medication, or handling any patient care supplies
- Soap and water: wash for 15 seconds
- Alcohol-based hand sanitizer may be used if no visible soiling; but not when C. Difficile is present; allow it to dry completely

Respiratory Hygiene: Cough Etiquette

- Cover mouth and nose when coughing or sneezing
- Contain secretions in a tissue. Then dispose of in a touch less receptacle.
- Perform hand hygiene afterward.
- Mask all coughing patients.

Blood borne Pathogens

- Treat all body fluids as if contaminated.
- Identify risks of exposure (your job duties); always use safe work practices.
- Use all safety devices as directed.
- Use PPE if exposure is possible.
- Never recap needles; dispose of in appropriate containers.
- When sharps bins are ¾ full, call for replacement.

Blood or Body Fluid Exposure

1. Act fast!
2. Wash exposed area with soap and water
3. Report exposure to the department manager
4. Immediately report to the Urgent Care Clinic (or Emergency Department during off-hours)
5. Complete incident report. Department manager can help you with this.

Tuberculosis (TB) Control Plan

- Complete TB screening (required).
- If you have any symptoms of TB, do not come to ILH; notify your healthcare provider immediately.
- **If you suspect TB symptoms in your patient:**

1. Explain this to the patient
2. Apply an N95 mask
3. Notify your department manager
4. Place patient in isolation room

Symptoms of TB

- Cough that lasts over 2-3 weeks
- Chest pain with cough
- Fever, chills, night sweats
- Weight loss, poor appetite
- Fatigue, weakness
- Short of breath

Quiz: True or False?

13. I only have to perform hand hygiene when the patient has infectious disease

14. PPE is worn only when the patient is in isolation

15. I'm not an ILH employee; if I get a blood/body fluid exposure, I only have to tell my instructor

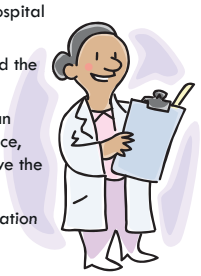
Answers

13. False; perform hand hygiene before and after any patient contact, handling patient care equipment, eating, drinking, or using the bathroom, etc.
14. No; PPE is worn anytime you suspect that you will be exposed to blood or body fluids
15. No; you will report to the department manager as well as to your instructor; you will follow ILH policy—the department manager will guide you through this process

Corporate Compliance

Responding to Visits by Regulatory, Licensing or Accrediting Agencies

- Welcome our guests appropriately and contact the hospital operator at 2-3000.
- Give the operator the name of the visiting agency and the location.
- Do not leave the visiting agency representative until an appropriate ILH representative (Regulatory Compliance, Quality Management, Administration) arrives to receive the visiting agency representative.
- The appropriate ILH personnel will verify the identification and nature of the visit with the visiting agency representative.



Compliance Program

Ensures that all governmental, LSU-HCSD, and hospital policies are followed

Your role:

- adhere to all rules, regulations, compliance policies, and the HCSD Code of Conduct
- Conduct all affairs with highest ethical standards
- Report any suspected violations

Definitions

- **Fraud:** when a provider/supplier *knowingly and willfully* deceives the Medicare program
- **Abuse** is practices of providers, physicians, or suppliers, which are inconsistent with accepted sound practices
- **Federal False Claims Act:** anyone who *knowingly* presents the government with a false claim is liable for penalties

EMTALA

Federal law that protects patients from financial discrimination

- Every patient must receive a medical screening, to determine if an emergency exists
- Cannot assess financial status before providing treatment
- Hospitals must report any possible violations
- Violations can result in fines or exclusion from Medicare reimbursement

Protected Health Information (PHI)

HIPAA is a federal law designed to keep patients' health information confidential

- PHI is any information that can lead to the identity of a patient
- Includes names, addresses, dates, numbers (social security or medical record), and any health-related information
- Can be written, verbal, non-verbal, electronic, disks, etc.

Protecting Health Information

- Treat all PHI as if it were your own
- Do not discuss patients in public places (hallways, cafeteria, elevators, etc), anywhere outside the workplace, or in "social media".
- Do not leave information or records in areas where others can see them.
- Access information only when authorized, when you have a legitimate "need to know".
- Keep your computer and passwords secure.

"When in doubt, report"

If you suspect any violations:

1. Ask your manager or supervisor
2. Ask the nursing services supervisor
3. Ask the compliance officer:

   Tori Stewart 903-0571

- Your call will be confidential
- There will be no retaliation against anyone for raising concerns.

Quiz: True or False?

16. I'm not an ILH employee; I won't have to talk with regulatory visitors

17. I don't have a password; it's ok for an employee to let me use theirs for computer data entry

18. I can discuss my patient in "social media", as long as I'm away from the hospital

Answers

16. False. You can tell the visitor that you are not an employee, but they may still ask you questions about the hospital. You will then offer to find an employee to help them.
17. False. You can only use your own password for the hospital's information systems. It is never acceptable to use someone else's login or password.
18. False; PHI is to be kept confidential. Use of "social media" to discuss patients is considered a breach of privacy.

Please give your completed quiz sheet to your instructor

Remember:

When you see anything wrong or unusual, notify the department supervisor or manager, and your instructor, immediately.

Thank You

Interim LSU Public Hospital

Department of Professional Development, Practice Excellence, and Clinical Affiliations

July, 2012

Environment of Care:
Key Elements

ILH Department of Professional Development
And Clinical Affiliations

Answer Sheet/Certificate of Completion

Participant: _____

Date: _____

Organization/Department/School: _____

Last Four Digits of Social Security Number: _____

Circle Correct Answer:

1. T F	6. T F	11. T F	16. T F
2. T F	7. T F	12. T F	17. T F
3. T F	8. T F	13. T F	18. T F
4. T F	9. T F	14. T F	19. T F
5. T F	1. T F	15. T F	20. T F

This sheet will serve as the record of your training. Please fill it out completely and give to your area supervisor. Name must legible on sign in sheet to receive credit, so please print. Any questions, please call Education/Staff Development, at 903-0702.

Rev. 7/09

It is against the law to knowingly submit a false claim for payment. Submitting a false claim includes using the wrong billing codes, falsifying medical records, or billing for services that are not provided or are not medically necessary. Violations of these laws can be punished by fines, prison terms or both. Providers can also be excluded from the Medicare or Medicaid program for submitting false claims. The policy of the HCSD is to bill accurately and only for medically necessary services that have been provided and documented. Any contractors that perform billing services for the HCSD provider must insure compliance with billing requirements as well. Additionally, all teaching physicians who utilize residents shall insure that all bills for services rendered comply with the teaching physician guidelines.

It is generally against the law for a physician to refer patients to providers of services in which the physician has a financial interest or relationship under both state and federal laws. Violation of the federal law can result in fines and exclusion from Medicare or Medicaid. The law in this matter is complex and questions should be directed to the appropriate administrative authority or the Compliance Officer at your facility.

9. The HCSD Shall Have Proper Regard for Health and Safety.

The HCSD shall work with all other relevant parties to ensure a workplace that conforms with all laws and regulations regarding occupational health and safety. The HCSD is committed to proper maintenance of the environment, and all medical waste, hazardous waste, and other products shall be used and disposed of in accordance with all applicable environmental laws and regulations.

10. The Code of Conduct is the Fundamental Basis for the Operation and Activities of the HCSD.

The Code of Conduct exists for the benefit of the HCSD, its Personnel, and all who have contact with the HCSD. The Code must be an integral part of the daily activities of the HCSD and its Personnel.

- The Code of Conduct is in addition to, and does not limit, specific policies and procedures of the HCSD and all Personnel must perform their duties in accordance with such policies and procedures. To facilitate daily operations and activity of the HCSD, managers and supervisors shall address disruptive behavior of individuals working at all levels of the organization. Disruptive Behavior is behavior which violates accepted rules of civil behavior and professional etiquette, violates legal standards of conduct or professional ethics, and disrupts the efficient and orderly operations of patient care.
- The Code of Conduct is a living document, and all Personnel are encouraged to suggest changes or additions to the Code.
- It is the duty of all Personnel of the HCSD to uphold the standards set forth in the Code of Conduct and to report any known or suspected violations of this Code or the compliance program by following the reporting procedures outlined by the HCSD.
- Any HCSD Personnel that finds himself/herself under criminal investigation, charged, or convicted for the violation of healthcare compliance laws or the perpetration of a fraud, must report such information to appropriate administrative officials. All Personnel shall also report any exclusions, debarments, suspension or removal from any government program to the compliance Officer.
- The administrative and medical leadership of the HCSD have a special duty to adhere to the principles set forth in this Code of Conduct, to support other Personnel in their adherence to the Code, to recognize and detect violations of the Code, and to enforce the standards set forth herein.
- Any action taken in reprisal against anyone who reports suspected violations of the Code of Conduct or other HCSD policies and procedures, in good faith, shall be prohibited and dealt with severely. However, deliberate false reporting is also prohibited and will result in disciplinary action.
- Alleged violations of the Code of Conduct or other policies and procedures of the HCSD will be investigated in accordance with established HCSD policies and procedures. Proper and prompt remedial action shall be taken in response to any improper activities revealed by an investigation, including reporting as required by law.
- Disciplinary action for violations of the Code of Conduct and other HCSD policies and procedures shall be enforced through the disciplinary policies and procedures of the HCSD. Disciplinary actions will be determined on a case-by-case basis and may include dismissal from employment. If the HCSD suspects that a violation has included criminal violations of law or regulation, the HCSD will cooperate with law enforcement or regulatory authorities in connection with the investigation and prosecution of the offender.

How to Report a Suspected Violation of the Code.

To report a suspected violation of the Code of Conduct, you should report all pertinent information to your immediate supervisor. If you prefer not to report such matters to your supervisor for any reason, you should call or notify your department manager, Hospital Administrator, Human Resources Director or Compliance Liaison Officer for your facility,

Toll -free Compliance Access Line 800-735-1185

All reports to the Compliance Access Line may be made anonymously and on a confidential basis as allowed by law. HCSD policy and whistleblower provisions of the False Claims Act protect employees from retaliation for reporting suspected fraud, waste, or abuse or non compliance with the Code of Conduct.

Please note that the Code of Conduct does not create any contract of employment, express or implied, between the HCSD and any individual. The HCSD reserves the right to amend the Code of Conduct at any time or from time to time in its sole discretion.

MCLNO Compliance Liaison Officer 504-903-0571

Revised May 2010

LSU
HEALTH CARE SERVICES DIVISION
LOUISIANA'S HOSPITAL SYSTEM

CODE OF CONDUCT

The Code of Conduct of the LSU Health Sciences Center - Health Care Services Division (HCSD) provides the guiding standards for our decisions and actions as members of the HCSD. Although the Code can neither cover every situation in the daily conduct of our many varied activities nor substitute for common sense, individual judgment or personal integrity, it is the duty of each officer, director, employee, leased employee, student and agent (Personnel) of the HCSD to adhere, without exception, to the principles set forth herein. All Personnel of the HCSD are subject to and shall comply with the terms of this Code of Conduct.

1. HCSD Shall Comply With All Applicable Laws.

It is the duty of all Personnel of the HCSD to take all reasonable steps to comply with all applicable laws and regulations. This includes, but is not limited to, compliance with the Health Insurance Portability and Accountability Act (HIPAA) pertaining to Privacy and Information Security, as well as, the revisions to the Social Security Act implemented by the Deficit Reduction Act of 2005 pertaining to the detection and prevention of fraud waste and abuse and the rights of employees to be protected as whistleblowers. All Personnel must be aware of the legal requirements and restrictions applicable to their respective positions and duties. The HCSD shall implement programs necessary to further such awareness and to monitor and promote compliance with such laws and regulations. Any questions about the legality or propriety of any proposed actions to be undertaken by or on behalf of the HCSD should be referred immediately to one's supervisor, department manager, Hospital Administrator, Human Resources Director, or facility Compliance Officer.

2. The HCSD Shall Conduct Its Affairs in Accordance With the Highest Ethical Standards.

The HCSD and all Personnel of the HCSD shall conduct all activities in accordance with the highest ethical standards of the State of Louisiana, the community, and their respective professions, at all times in a manner which upholds the HCSD's reputation and standing.

The HCSD does not pay for patient referrals, nor does it accept payment for any referrals it makes. No inducements shall be made to patients to choose the HCSD to provide healthcare services except for those of nominal value that conform to applicable laws and regulations.

Payment or inducements offered for participation in research studies shall be in conformity with applicable laws, regulations, grant requirements and HCSD policy.

All contracts involving the HCSD or its Personnel will be in accordance with the requirements of state and federal laws, including any anti-kickback and self-referral laws. All contracts will reflect due regard for any safe-harbors or exceptions to those laws. In addition, all contracts will reflect knowledge of the Privacy and Information Security provisions of HIPAA and provisions of the Deficit Reduction Act of 2005 noted previously.

3. All Personnel Shall Avoid Conflicts of Interest.

The HCSD is a state owned organization dedicated to the provision of healthcare to the general public and supporting the LSU Health Sciences Center, in its mission of providing health care services, education of health professionals and health-related research. All Personnel of the HCSD must faithfully conduct their duties, in their assigned roles and tasks, for the purpose, benefit and interest of the HCSD and those that it serves. All Personnel have a duty to avoid conflicts of interest with those of the HCSD and may not use their position and affiliation with the HCSD for personal benefit. Personnel must consider and avoid not only actual conflicts but also the appearance of conflicts of interest. Any questions relating to these matters should be directed to your supervisor, department manager, Hospital Administrator, Human Resources Director, or the facility Compliance Officer.

No Personnel shall accept gifts or anything of value from any person or company that does business with or uses the services of the HCSD. Any arrangement through which Personnel directly or indirectly benefit by receiving anything of value shall be reviewed prior to its implementation.

4. The HCSD Shall Strive to Attain the Highest Standard of Patient Care.

As leaders in health care, all Personnel of the HCSD must support the HCSD's mission to provide health services of the highest quality that meet the needs of our patients, their families and the community as a whole. The HCSD will take all reasonable steps to provide treatment in accordance with all pertinent federal and state laws. The care provided must be reasonable and necessary to the care of each patient, as appropriate to the situation, and such care must be provided by properly qualified individuals.

All patient care, and all patient records, must be properly documented as required by law and regulation, payor requirements, applicable contractual obligations, and professional standards. Billing records and the supporting documentation will be accurate, complete and as detailed as required. Records must be accurate as to the service provided, charges, identity of provider, date and place of service, and the identity of the patient.

The HCSD and all of its Personnel must protect the confidentiality of patient information. All patient information (including medical records) must be kept strictly confidential and not released to anyone not associated with the HCSD, or removed from HCSD facilities without written patient consent, lawful court order, pursuant to exceptions in the law, or in accordance with HCSD policies now in existence or as developed. All Personnel must avoid discussing confidential information with non HCSD Personnel or where others, including family, can overhear them. Internal access to medical records is not appropriate unless there is a legitimate work-related need to see the information.

The HCSD and its Personnel will make every reasonable effort to comply with all applicable laws, regulations and HCSD policies concerning the security and privacy of patient information and particularly electronically stored or transmitted patient information, in accordance with the applicable provisions of HIPAA.

5. The HCSD Shall Provide Equal Opportunity and Respect the Dignity of all Patients and Personnel of the HCSD.

The HCSD is committed to providing equal educational and employment opportunities for all persons, without regard to race, color, national or ethnic origin, religion, gender, sexual orientation, disability or veteran's status. The HCSD is committed to providing a patient care and workplace environment that emphasizes the dignity and respect of each individual. And, as a result, any type of prohibited discrimination, in any form or context, will not be tolerated.

6. The HCSD Shall Maintain the Highest Standards of Academic Integrity.

The HCSD, and the Personnel of the division, must uphold the highest moral and ethical standards in education of health professionals and health related research. All Personnel must undertake their academic activities with honesty and integrity and avoid any activities that would be detrimental to the individual, community, or reputation of the HCSD.

Personnel of the HCSD must also uphold the highest ethical standards in research. Activities that interfere with the rights of the HCSD's patients, including their right to confidentiality, and activities such as plagiarism or falsification or fabrication of data or results, are intolerable to the HCSD's goals and are strictly forbidden. Research must be conducted only with the applicable approvals required by the policies and procedures of the HCSD and LSU and in accordance with the requirements of granting agencies.

7. The HCSD Shall Maintain Proper and Accurate Records and a Relationship of Integrity With All Payor Sources.

The HCSD and its Personnel shall create and keep billing and supporting records and documentation that conform to legal, professional and ethical standards. The HCSD and its Personnel shall ensure that payment or reimbursement from government payors such as Medicare and Medicaid and private payor sources is for such care as is reasonable, medically necessary and appropriate, is provided by properly qualified persons, and is billed in the correct amount and supported by proper documentation.

Bills shall reflect the most appropriate CPT, ICD-9, E&M, APC, and DRG codes as reflected in the documentation of the services rendered, regardless of the impact on reimbursement. Billing will be for only medically necessary services, properly provided, in accordance with the medical necessity rules of the applicable payor. Billing shall reflect compliance with applicable bundling rules.

Any discounts offered to a patient or payor shall be reported as required by law. The HCSD will make a reasonable, good faith effort to collect co-pays and deductibles from its patients. Every reasonable effort will be made to be consistent in dealing with similarly situated individuals. No waivers of co-pays or deductibles shall be allowed unless there is an exception in accordance with federal regulations and HCSD policies. All reasonable steps will be taken to return credit balances in a timely fashion.

The HCSD and its Personnel will accurately respond to all governmental, payor, or patient inquiries as required by law. Personnel will report all unusual inquiries or requests for documentation to their supervisors in accordance with HCSD policies. Personnel will record any specific advice, guidance, or instructions received from the government or other payors.

8. All Business Practices of the HCSD and its Personnel Shall Be Conducted with Honesty and Integrity.

All business practices of the HCSD must be conducted with honesty and integrity and in a manner that upholds the HCSD's reputation with patients, payors, vendors, competitors and the academic community. All Personnel of the HCSD must maintain and protect the property and assets of the HCSD, including intellectual property and proprietary information, controlled substances and pharmaceuticals, equipment and supplies, and funds of the HCSD.

It is illegal to pay or receive payments for patient referrals or for a recommendation that someone needs healthcare services or items. It is the policy of the HCSD not to pay for referrals or recommendations or to accept payment for referrals made by its Personnel regardless of the payor source. "Payment" does not have to be cash; it can be anything of value, a discount or a free service or piece of equipment.

Louisiana State University Health Sciences Center
Health Care Services Division
Interim LSU Public Hospital

Corporate Compliance Attestation Statements

CODE OF CONDUCT

- This is to acknowledge that I have received ILH Code of Conduct and understand that it is my responsibility to read the entire document to make myself familiar with the content.

HIPAA CONFIDENTIALITY AGREEMENT

- I Agree to comply with ILH's HIPAA policies which include procedures for proper handling of Personal Health Information (PHI), computer passwords and access and confidentiality.
- I acknowledge that my violation of these policies by me may lead to immediate disciplinary action, up to and including the termination of my employment.
- I also acknowledge that my obligation of confidentiality continues to exist when I leave the employ of the LSU system facility.

Corporate Compliance Attestation Statement

- I have attended the mandatory Corporate Compliance training for all new House Staff Officers and understand that I am responsible for being familiar with the Corporate Compliance Program as it relates to my position and to the facility as a whole.
- I understand that I am responsible for following the Corporate Compliance policies and procedures as well as other policies and procedures of the facility.
- I understand that I am responsible for reporting any suspected fraud and abuse practices within this facility.

If I have any questions regarding compliance or HIPAA, I will contact my Coordinator or the ILH Compliance Liaison Officer as soon as possible.

House Officer's name printed_____

House Officer's Signature_____

Date_____