ILH
Interim LSU Hospital

LSU

Graduate Medical Education

PERSONAL DATA FORM

PLEASE PRINT LEGIBLY OR TYPE

(Circle One): Internship Residency Fellowship

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

Name: _____
Last First Middle

Mailing Address: _____
Street City State Zip

Social Security Number: _____ Citizenship: _____

Date of Birth: _____ Place of Birth: _____

National Provider Identification (NPI#): _____

Beeper Number: ( ) Cell Number: ( ) Email: _____

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

ILH
Interim LSU Hospital

LSU

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#: _____

EMAIL: _____

PROGRAM COORDINATOR: _____ DATE: _____

PROGRAM DIRECTOR: _____

THIS FORM IS TO BE COMPLETED FOR ANY HOUSE OFFICER WHO WILL BE ON CLINICAL ROTATION AT INTERIM LSU HOSPITAL.

ILH
Interim LSU Hospital

Graduate Medical Education

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
DEPARTMENT: EMERGENCY MANAGEMENT	PAGE: 1 OF: 12
	EFFECTIVE: November 1, 2002
REVISED/REVIEWED: July 2014	

PURPOSE:

The purpose of this plan is to prepare the Interim LSU Hospital (ILH) 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 Region 1 ESF-Coalition, will determine the possible adverse impact that weather situations may have on the operations of Interim LSU 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 ILH announcements. All phases of the ILH 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

NOTE: The Saffir Simpson Scale only indicates the sustained winds that the cyclone will achieve. Potential impact on the facility can vary greatly depending on the size (diameter) and speed of the storm and associated storm surge. Preparation for the event needs to take those factors into account. Example is a large slow moving storm of lesser intensity may have more impact on operations than a fast moving storm of greater intensity. NOAA is continually improving on storm forecasting to predict storm surge, and other potential storm impacts.

- There are five (5) phases to ILH 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 ILH management and staff. The following information for initiating the ILH 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 ILH 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
- maintain 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 ILH'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. (At Risk Registry)

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 ILH's operational status and any other pertinent information for employees will be posted on ILH's website and social media, www.umcmc.org, https://twitter.com/umcno, https://www.facebook.com/umcno

TEAMS:

- ILH will use the Hospital Incident Command System for 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, e-mail address) to their department director or designee and the name and telephone number of a contact person that lives outside the New Orleans, Louisiana region if at all possible. See Reference #2011-A for the Telephone Call Tree template.

- All employees are expected to participate in the ILH 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.

- 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 Activation Team members will be given a status of 1 or 2. Team 1 is employees who will be assigned to the 7A to 7P shift. Team 2 is employees are those who will be assigned to the 7P to 7A shift

- The Code Grey plan requires that we staff our facilities with sufficient staff to provide essential and support services through various stages of severe weather events 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 may result in termination.

- When both members of a married couple are employed by ILH, 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 ILH'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 ILH Hotline at 1 800 256-2311(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 ILH 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). (NOTE: Storms that for in the Gulf May threaten in less than 96 hours. When this happens ILH may immediately issue a ***Warning*** depending on projected land fall.)

- Code Grey Watch will be announced at ILH and at the outer buildings at the start of the Watch phase, using the Mass Notification System, paging system, and via initiation of departmental call trees. An email will also be sent to the *ILH 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 to develop the IAP for the pending event. 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 emergency plan including plans for the safety of their property and family members.

- A decision will be made by the Medical Director and Incident Commander 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 Information Officer will supply media with information regarding the closure of the, 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 at the start of the Warning phase will be announced at ILH and at the outer buildings at the start of the Watch phase, using the Mass Notification System, paging system, and via initiation of departmental call trees. An email will also be sent to the *ILH Department Director* group to announce the Code Grey Warning.

- Incident Command members are notified by the Incident Commander or designee and through ILH mass notification system. .

- The Incident Command Center will open at ILH.

- The Chief Executive Officer, in conjunction with Incident Command Center Chiefs 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 Administrative Director of Pathology or designee.

- 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 Zip lock 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, ILH 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 Patient Demographics Page for each patient and verify the accuracy of the demographic, patient contact information and next of kin information included on the EHR 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 ILH 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 *ILH Department Director* group to announce the Code Grey Activation.

- Activation Team 2 will be released from duty as Activation Team 1 return. Activation Team 2 is due back to ILH 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 ILH above the first floor area.

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

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

- Notice of Ambulance Diversion except for Trauma may be given.

- Visitor restriction is initiated. All visitors will be asked to leave except the one visitor who may remain with the patient. 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 ILH 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 a copy of the Patient Census for each patient unit. The census copies will be used by the charge nurses for the Triage Summary Report and other patient tracking during evacuation.

- Substations for CMS, Pharmacy, Dietary, Warehouse and Laundry to be set up.

- 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 and at the outer buildings at the start of the Activation phase will be announced at ILH and at the outer buildings at the start of the Watch phase, using the Mass Notification System, paging system, and department call trees. An email will also be sent to the *ILH 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, the 800#, on ILH web site 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 may 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.

RETURN TO NORMAL OPERATIONS:

- The hospital will return to normal operations at the conclusion of the Code Gray and **All Clear** is announced three times. If a mandatory evacuation order was issued by the City, Return to Normal Operations will be after the Mayor rescinds the evacuation order and All Clear is announced. All employees shall return to duty once the hospital returns to normal operations.

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 #2011A, the Telephone Call Tree, for the template.

COMMUNICATIONS:

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

- Cell phones and text messaging will used as long as that capability exists. It is the responsibility of the Department of HIS to maintain a listing of all ILH issued mobile 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 Leader will communicate with other hospitals, EMS, the City of New Orleans and HRSA by way of the official HRSA 700 MHz radio.

- If there is a loss of the main generators one portable generator will be dedicated to charging 700 MHz radios and portable communication devices. It shall be the responsibility of Hospital Police to maintain this generator and charge all communication devices as needed.

- One computer with internet capabilities will also be maintained on the generator dedicated to charging the 700 MHz radios to keep email and internet channels open.

- ILH will also possess UHF and VHF HAM radios to assist in communication. HAM radio operators will be hired and/or taken on as volunteers to operate the HAM radios.

- ILH also has satellite Bgan radio with capable of voice and data transmission.

VISITORS:

- Visiting hours will be suspended at the start of the Activation phase. All visitations will end when Code Grey is announced. 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 ILH 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 Interim LSU Hospital. **Activation team members may not bring guests, pets 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, pets and family accommodations at Interim LSU 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 ILH PREMISES.** Anyone who brings pets on ILH 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 Interim LSU Hospital.

BEDDING:

All Activation Team employees are responsible for bringing their own sleeping bags, linens, blankets, pillows, etc. No ILH 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 (MRE) 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. ILH 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 ILH Policy 1102 – Free Care Determination.

PAY:

All employees working during the Activation and Recovery phases will be paid. Overtime will be paid in accordance with ILH pay policy. Activation Team members must clock in using the official ILH 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 ILH 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.

LABOR POOL:

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 ILH 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 registered nurses are assigned to areas that are not considered direct patient care.

See: Emergency Management Ref. #2011A Telephone Call Tree
Emergency Management Ref. #2012 Team Designations
Emergency Management Ref. #2014 Code Grey Department Responsibilities

ILH
Interim LSU Hospital

Graduate Medical Education

CODE GREY

SEVERE WEATHER PLAN

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

- I am responsible for complying with the ILH 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 ILH 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
Interim LSU 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:

ILH
Interim LSU Hospital

MEDICAL STAFF CODE OF CONDUCT POLICY

I. INTRODUCTION

The Medical Staff, (to include Faculty, Licensed Independent Practitioners and Residents, for this policy) at the Interim LSU 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.

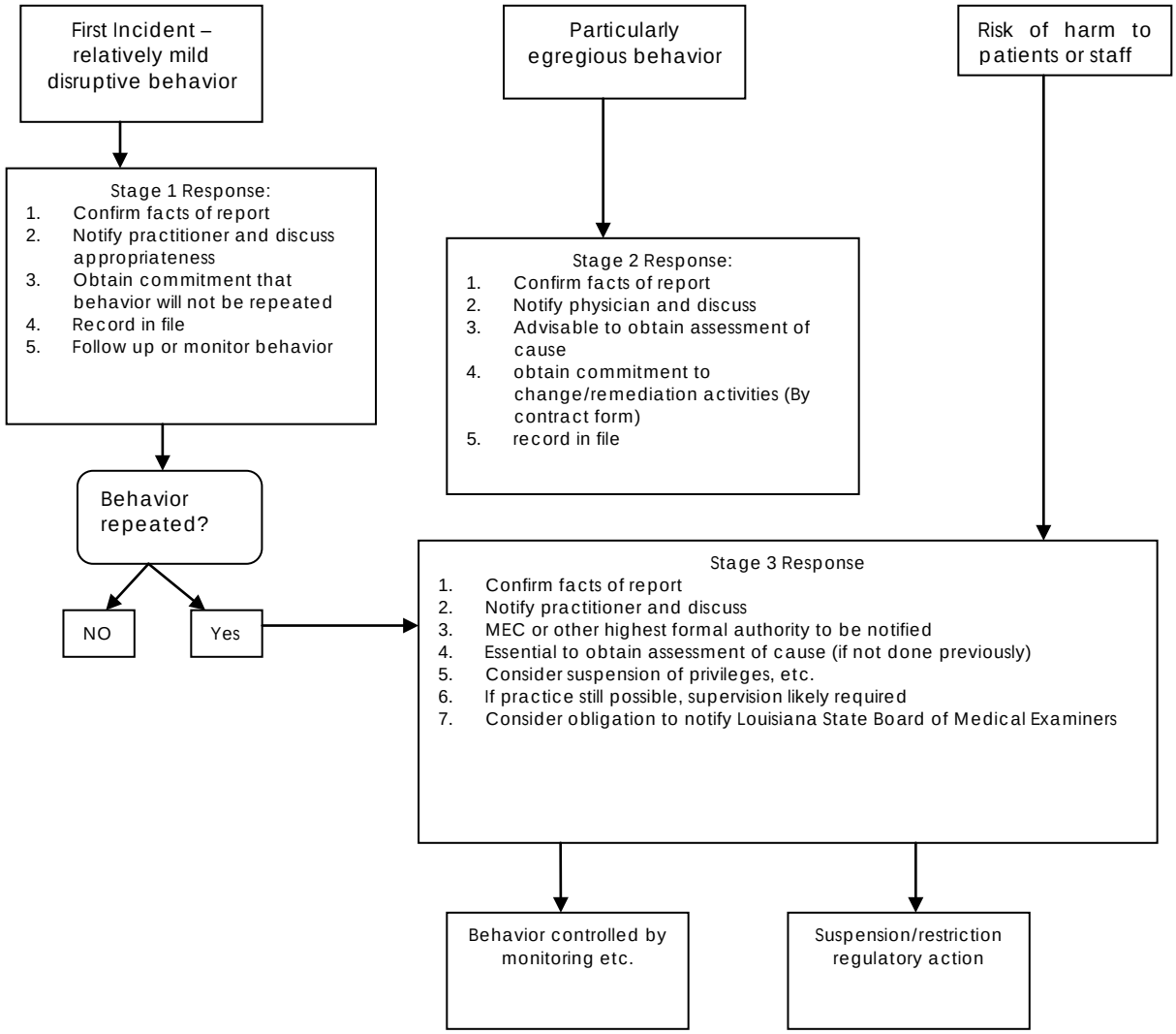
Recommended by the Executive Committee this **29th** day of **April, 2010**

_____
President of the Medical Staff

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

Please sign the Code of Conduct Signature Page and **keep this document** for reference

Behavior Management Flow Chart



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ILH
Interim LSU Hospital

Medical Staff Services & Graduate Medical Education

Code of Conduct

ACKNOWLEDGMENT

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

_____
(Print Name)

_____
Signature Date