



Health Sciences Center

HOUSE STAFF MANUAL

**GENERAL INFORMATION
&
POLICIES AND PROCEDURES**

2011-2012

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

RESIDENT MANUAL 2011 – 2012

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FROM: The Office of Graduate Medical Education

Welcome to LSU Health Sciences Center. The Graduate Medical Education office provides support services to the residents and training programs at the Health Sciences Center. We look forward to serving your needs. Please feel free to stop by our office in the hospital (Room A1-19) or call us at 5-5069 if we can be of any assistance to you. Or, you can view the Graduate Medical Education Website at www.lsuhsershreveport.edu/ for information.

Sincerely,

Kim J. Hunter, Director
khunte@lsuhsc.edu

Kelli Strong, Coordinator
kstron@lsuhsc.edu

On behalf of the faculty and staff, I welcome you to the Louisiana State University Health Sciences Center at Shreveport. As a Physician, you are joining a team of committed health care professionals devoted to providing high quality health care in an academic setting.

The Louisiana State University Health Sciences Center is an outstanding health care facility that serves the citizens of Louisiana in an atmosphere of caring and concern.

Sincerely,

Robert Barish, M.D., M.B.A.
Chancellor

Welcome to the LSU Health Sciences Center-Shreveport and to the University Hospital. You are entering upon the second phase of your medical career, which promises to be both challenging and rewarding. Over the coming years you will have progressive responsibility for the care and treatment of large numbers of patients with a variety of disease, different economic status, and varying degrees of education and personalities. Yet, they are all bound by one common thread—they are human beings who are entrusting their lives and the lives of their families to your skills. Using the proven standards of a good history and physical examination supplemented with appropriate laboratory and radiological tests, as well as exciting new technology, you will (with supervision of your staff) be able to return a significant number of these patients to full health, and improve the quality of life of others.

University Hospital excels in its service to patients and its training for residents. We can, however, always improve; and your thoughts, recommendations and suggestions are always welcome. All of us look forward to the coming years and challenges. We urge you to feel free to communicate your ideas to your staff and to the members of the Graduate Resident Medical Education Committee. Working together we can make a truly great Hospital even better.

Thank you for choosing LSU Health Sciences Center for your postgraduate medical training. We are honored to have a part in the furtherance of your career.

Sincerely,

Kevin Sittig, M.D.
Senior Associate Dean for Clinical
Affairs/Chief Medical Officer

It is a pleasure to welcome you to Louisiana State University Health Sciences Center, University Hospital, in Shreveport. As a member of our Resident staff, you will have many opportunities to serve patients, to learn about the practice of medicine, to assist in the teaching of other learners, and to grow in your personal life. It is also my hope and expectation that our hospital staff may contribute measurably to you in these important experiences.

The mission of the School of Medicine in Shreveport is to improve the health and human condition of Louisiana residents. The School of Medicine in Shreveport accomplishes its mission through the training of competent, ethical physicians, by serving as a focus for teaching and research in the health sciences, and by delivering quality health care to Louisiana residents.

Fulfillment of the hospital's responsibilities involves many varied problems and requires the help of every person on the staff. Your contribution is most essential. Your suggestions are invited and will be carefully considered.

The standards of care and the patient relationships that you maintain both establish and contribute to the reputation of LSUHSC. Obviously, we must all strive for excellence in all we do. The entire hospital staff stands ready to assist you in any way possible. My thanks to you for the seen and unseen dedication you bring to your work. We all look forward to the good that is yet to be.

Sincerely,

Joe Miciotto
Hospital Administrator

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT
COMPLIANCE PROGRAM

CODE OF CONDUCT

All employees and affiliated professionals of LSUHSC shall conduct all activities in a manner that will promote integrity and compliance while practicing sound, ethical, and professional judgment.

All employees and affiliated professionals of the HSC shall abide by regulations set forth by the state and federal healthcare programs and their appointed agents in conjunction with the policies and procedures established by the HSC.

HSC employees and affiliated professionals shall prepare complete and accurate medical records, financial information, and bills.

HSC employees and affiliated professionals shall report suspected non-compliant behavior that violates any statute, regulation, or guideline applicable to a state or Federal healthcare program or HSC policies. All reports are confidential. All employees have the right to remain anonymous. The HSC will not retaliate upon any employee that reports suspect behaviors in any form or fashion.

All employees shall attend and/or complete the mandated annual training requirements.

All employees shall participate in any reviews, investigations, or audits whether conducted by an internal or external agency.

All employees shall refuse any type of illegal offers, remuneration, or payments to induce referrals or preferential treatment from a third party.

All employees shall disclose to the compliance officer any information received from the state or federal healthcare programs or their agents.

All employees shall adhere to the Code of Conduct as a condition of employment at LSUHSC. All employees and affiliated professionals can be suspended, terminated, or barred from further employment or affiliation with the HSC as a result of non-compliant behavior.

GENERAL
INFORMATION

Louisiana State University Health Sciences Center
University Hospital
1541 Kings Highway, Shreveport, LA 71130

A HISTORY

The first steps toward establishment of a state-maintained hospital in Shreveport were taken in 1876 when the Louisiana Legislature appropriated \$10,000 to maintain a hospital that would care for the indigent in North Louisiana. Shreveport Charity Hospital was established in a group of log and frame buildings located in what is now downtown Shreveport. A five-man board was appointed to oversee operations of this new hospital.

A Chief Surgeon, an Intern and a Physician staffed that early hospital. Six years later the Louisiana Legislature appropriated \$20,000 to purchase a site for the hospital, and four acres on Texas Avenue were acquired. (This is the present location of Shreveport's City Hall.)

The first Shreveport Charity Hospital built on the Texas Avenue site was erected in 1889 and was of frame construction. Dimensions of the two-story building were 215 feet by 38 feet. By 1904, there was need for a new hospital building and another was constructed at the same location for about \$80,000. At this same time, the Charity Hospital School of Nursing, which is now defunct, was established.

Between 1916 and 1919, an outpatient clinic was begun so that medical needs of the indigent could be treated without having to admit the patients into the hospital. By the mid 1920's the bed capacity at the Shreveport Charity Hospital was 250. The bed capacity was nearly doubled by 1930; however, extensive renovation was done to repair damage the hospital suffered when a fire destroyed an entire wing in the late 1920's. Two hundred and eighteen patients had to be moved to safety from the fire, though none were injured.

The renovation program lasted for two years and, when completed, the hospital's bed capacity was 400. However, even this number of beds was considered to be insufficient to meet the patient load.

In 1930 the first cancer clinic in the State of Louisiana was organized at Shreveport Charity Hospital. About the same time, the hospital established a public outreach program through daily radio broadcasts of health programs narrated by local physicians. Airtime was provided free to the hospital, which had its own radio studio, by a member of the hospital's board, who also owned a radio station.

The hospital continued to grow, keeping stride with the advances in the health field. By the late 1940's plans were being completed for construction of another hospital building

to be constructed on a site further south of downtown that would allow for future expansion.

In 1953 the new building was completed at the corner of Linwood Avenue and Kings Highway. Cost of construction of that building was 10 million dollars. Bed capacity was 800. This building, although modernized and renovated, still houses the hospital today. A three-story Outpatient Clinic building was opened in 1973 adjacent to the hospital as the hospital continued to expand its role as provider of outpatient medical care to the indigent in North Louisiana.

Since 1953, there have been two name changes from Shreveport Charity Hospital to Confederate Memorial Medical Center. Shortly after the hospital marked its 102nd anniversary in 1978, the name again was changed. The name of the hospital today is Louisiana State University Hospital in Shreveport, a part of the Louisiana State University Health Sciences Center.

The change in name reflected the change of status that occurred in the hospital in 1976 when the Louisiana Legislature transferred ownership and control of the hospital from the Louisiana Health and Human Resources Department to the LSU Health Sciences Center.

Since the 1940's, the hospital has been engaged in postgraduate physician training, and with the opening of the LSU Health Sciences Center, School of Medicine in Shreveport in 1969, the hospital has become even more closely involved in the medical education not only of physicians but of other health professions as well.

The hospital was the primary teaching hospital for the School of Medicine, and with the opening of the School of Medicine buildings adjacent to the hospital in 1976, the affiliation became even closer. The heightened educational emphasis was matched by a rapid growth in institutional commitment to basic and applied research. Programs also grew in various allied health professions.

Since the mid 1970's, the hospital has embarked upon a program of renovation and construction designed to assure that LSU Hospital in Shreveport continues to keep pace with the most current medical advances in patient care and to affirm its obligation to the citizens of Louisiana through excellence of medical care as well as medical education and public service. In addition, LSU Hospital in Shreveport is recognized as a Burn Center, Bone Marrow Transplant Center, Level I Trauma Center, full-service surgery center, and also offers Centers of Excellence for Cancer and Rheumatology.

Today the LSU Hospital in Shreveport is a 459-bed licensed hospital providing tertiary care through its many specialty programs while maintaining its special mission for Louisiana's indigent. The hospital's outstanding programs increasingly attract a full-spectrum of patients from the region and beyond.

**LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER-
SHREVEPORT- University Hospital**

MISSION STATEMENT

The Mission of Louisiana State University Health Sciences Center - Shreveport's University Hospital is to serve the Ark-La-Tex community by providing:

- quality patient care services,
- a teaching environment for training future medical and
- allied health care professionals,
- and support for medical and scientific research.

Quality Patient Care is the first priority of the organization. Empowered employees will maximize Quality Patient Care by balancing Patient Expectations, Patient Needs, and Available Resources.

DEFINITIONS

Patient Expectations are those aspects of care most appropriately identified by the patient. The patient and secondly their families take the leadership role in defining Patient Expectations. These include consideration for a patient's rights, comfort, culture, dignity, privacy, security, and individuality. Collectively, how these patient's interests are allowed to affect patient treatment shows our respect and care for the individual.

Patient Needs are those clinical aspects of care best identified by healthcare professionals. Attending physicians take a leadership role in defining needs. Other physicians, nurses, technicians, allied health professionals, and others involved in helping those who deliver care all have expertise to contribute towards identifying and meeting the needs of the patient. The patient has the right to expect that these needs will be coordinated in an atmosphere that supports quality, interdisciplinary respect, and professionalism.

Available Resources are the facilities, equipment, supplies and people that are brought to bear to improve the health of the patient. Resources are limited in quantity. The use of resources must respect the long term viability and priority goals of the organization. The end use of all resources should support our mission.

The challenge to the physicians and the employees of the hospital is to balance Patient Expectations, Patient Needs, and Available Resources to achieve Patient Satisfaction and Quality Care. This can best be accomplished within a culture of mutual trust, mutual respect, and appropriate empowerment of patients, physicians, and hospital employees.

Louisiana State University School of Medicine
P. O. Box 33932
Shreveport, LA 71130

Established in 1965-66 by Acts of the Louisiana Legislature, the School of Medicine in Shreveport graduated its first class of students in 1973. In 1975 the new School of Medicine complex was completed, and a class enrollment of 100 students per year was approved. The medical school is part of the Louisiana State University Health Sciences Center.

Type: Public

2011-2012 total enrollment: 451

Clinical facilities: (Shreveport):

Louisiana State University Hospital- Shreveport

Overton Brooks Veterans Administration Medical Center

Christus Schumpert Medical Center

Shriners Hospital for Crippled Children

CPC Brentwood

Willis-Knighton Medical Center

E.A. Conway Memorial Hospital (Monroe)

Rapides Regional Medical Center (Alexandria)

North Caddo Memorial Hospital (Vivian)

Medical School Complex

Building A Comprehensive Care and Family Practice

Building B Academic Departments, etc.

Building C Library, Testing Center, Medical Communications, etc.

Hospital Complex

The letters A-K designate the wings or areas of the hospital.

ROOM NUMBERING SYSTEM

The last two lines of information in a listing are a location. For example, the first entry in the organizational directory is as follows:

	Accounting
	55222
	Director
(1st Floor-Rm. 115A)	1-115A
	Administration Bldg.

Building B of the Medical School has two corridors, west and east. The west corridor connects to the hospital via A and G wings. The east corridor overlooks medical center parking lots.

A similar entry pertaining to the hospital would look as follows:

	Medical Education
	55069
Wing A-1st Fl.- Rm.19	A-1-19
Building	Hospital

SERVICE/BED ASSIGNMENTS

(Due to ongoing construction projects, service assignments are often relocated.)

Location	Service	Beds as of Summer 2011
1J	Burn Unit	17
2G	MED	22
2 SI	SICU	4
3D	NeuroICU	10
3J	SICU	18
3G	Day Surgery	23 (non-licensed)
4G	Obstetrics/Gyn	22
4J	Obstetrics/Gyn	16
4J	Nursery	25 (non-licensed)
5PN	PED	31
5KN	NICU	40 (non-licensed)
6G	Women's Health	27
6J	Women's Health	14
6KE	HEM/ONC	23
6KW	BMT	12
7G	MED	25
7J	MICU	16
7KE	MED/TEL	23
7KW	MED/TEL	23
8K	SUR	46
9KE	NEU/Faculty	23
9KW	ORTHO	23
10H	PSYCH	51
10K	Neurosurgery	17
		451 licensed
		88 non-licensed
	<u>TOTAL BEDS</u>	

OFFICE OF MEDICAL EDUCATION

The Office of Medical Education/Resident Administration is strategically located on the first floor of the hospital (A1-19) on the connecting wing to the medical school. The office serves as the central contact point for all residents in the training programs. That point of contact begins at the time of selection to a residency or fellowship training program and continues throughout the training period until completion of that educational requirement of your professional career. The resident's permanent record remains in the Medical Education Office. The office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday, the telephone number is 675-5069, and the fax number is 675-4977.

Support services include but are not limited to:

Resident Contracts

Initial Hospital Orientation

Letters of Verification and Reference

Licensure Application and Renewal Support

Loan Deferments

Leave Requests

Coordination of Resident Payroll

National Residency Matching Program

Internal Reviews for training programs

Educational Forums

On-Call Quarters

Meal Program

PAGING AND PERTINENT TELEPHONE INFORMATION

PAGING:

Paging is conducted by an audible voice system through the hospital switchboard. It is limited to the Hospital. When needed, you will be paged by name. When you hear your name, go to the nearest hospital telephone and dial "0".

"House phones" are located in the dining room and Atrium Deli and provide automatic connection with the hospital switchboard.

POCKET PAGERS:

The Medical Center considers it essential to have certain employees readily accessible by phone in order to affirm its mission. To facilitate this accessibility need, the Medical Center maintains and operates a pocket pager system.

The pocket pagers are the property of the Medical Center and, therefore, the person to whom the pager is assigned has the responsibility for its safekeeping.

If the pager is lost or shows abuse other than normal wear and tear the resident to whom it has been assigned will be responsible for bearing its replacement cost, \$135.00.

HOW TO PAGE (BEEPERS):

- Listen for dial tone on telephone.
- Dial 57007 to access paging system. Listen for instructions.
- Voice-it will state "please dial in your number". Press your number. Press # sign followed by * sign. This procedure will let the next person/call access system immediately.

PERTINENT TELEPHONE INFORMATION:

Inward calls to the Medical Center from off campus will be completed by dialing #675 then the four-digit number of the department desired. Extension telephones will dial a five-digit number to dial any telephone on campus.

- Dial "9" for placing off -campus calls.
- Dial "0" for the University operator for long distance calls.
NO PERSONAL CALLS MAY BE CHARGED TO THE MEDICAL CENTER.

Personal calls will not be screened by the operators, but will be placed on call park and, if not answered, will be forwarded to Department. Operator will not take or leave word.

CALL-PARK INSTRUCTION:

Operator will page via Pocket pager the following:

Digital: Operator will dial - 5 -plus 2-digit number. Digital does not accept the pound sign on the telephone pad. Go to the nearest phone and press the # on Telephone pad, press 521 - your call will be automatically transferred to you.

STAT OR EMERGENCY ON DIGITAL PAGER:

Any number followed by 222

(Ex- "222" - Call STAT 7181 by pressing "*" 222 - Call 7181 STAT)

TERMS OF EMPLOYMENT

Employment in residency or fellowship training is by contract. The contractual relationship governs issues that are specific to the residency/fellowship program and supplements those rules and regulations of the State of Louisiana and the LSU System. These items are covered more fully in other portions of the **Resident Manual**. Residents/fellows are expected to read this manual, as they are held accountable for its content. Although the residency/fellowship training programs may vary in length, contracts are issued for a period of **one-year**. Renewal of the contract for each subsequent year is completely discretionary at the option of either the resident/fellow or the Department.

Written notice of intent not to renew a resident's contract will be provided no later than four (4) months prior to the end of the resident's current contract. However, if the primary reason(s) for the non-renewal occur(s) within the four (4) months prior to the end of the contract as much written notice of the intent not to renew will be provided prior to the end of the contract as the circumstances will reasonably allow.

Louisiana law DOES NOT require that the Health Sciences Center allow appeals for a contract non-renewal. However, since the non-renewal of a training contract may have an effect upon a resident's/fellow's career the Health Sciences Center does provide a process by which the resident/fellow may appeal the decision of the Department not to renew the contract. The appeal for a contract non-renewal will be handled procedurally in the same manner as an **adverse action matter**. Residents/fellows are advised to read the section under **ADVERSE ACTION/DISCIPLINARY POLICY** carefully as certain time constraints and other regulations apply. Failure to meet timely the requirements may **WAIVE** the right of appeal.

ADVERSE ACTIONS/DISCIPLINARY POLICY

Disciplinary action is defined as those actions taken to correct, to encourage the correction of, or punish substandard performance or lack of professional conduct. Disciplinary actions beyond written counseling are considered to be serious offenses.

An adverse action is defined as something that adversely affects a resident's/fellow's career and includes not only disciplinary action but also such matters as a non-renewal of a training contract. As stated above a non-renewal of a contract **is not appealable under Louisiana law**. However, in keeping with the requirements of the ACGME, appeals for contract non-renewals are allowed since they represent a potential (but not necessarily certain) adverse effect upon the resident's chosen pathway.

NOTE: AS A MATTER OF LOUISIANA LAW, ANY STATE EMPLOYEE WHO IS CONVICTED OF A FELONY MUST BE DISCHARGED FROM STATE SERVICE WITHIN 48 HOURS AFTER THE CONVICTION IS FINAL. THIS LAW APPLIES TO RESIDENTS/FELLOWS, AS WELL AS ANY OTHER STATE EMPLOYEE. ANY RESIDENT OR FELLOW WHO HAS BEEN EXCLUDED FROM PARTICIPATION IN FEDERAL PROGRAMS MUST BE REMOVED FROM EMPLOYMENT IMMEDIATELY UPON DISCOVERY OF THEIR EXCLUSION.

Many disciplinary/adverse actions and clinical privilege actions have mandatory reporting to various federal and state agencies.

Residents/fellows are professional individuals who are expected to maintain a high standard of ethical conduct and performance. It is assumed that all residents/fellows who enter the various training programs genuinely want to afford themselves the opportunity to enhance their training, skills, and careers. The training programs at the LSU Health Sciences Center-Shreveport have a responsibility to train individuals to an acceptable level of competence and to protect the general public from unskilled and unqualified practitioners.

THE GMEC

The overall role of the Institutional GMEC at LSU Health Sciences Center-Shreveport is one of ensuring that individual departmental programs meet the Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME) and the program requirements of the various Residency Review Committees (RRCs). Residents/fellows with complaints/suggestions about their program are encouraged to bring these matters to the attention of their Program Director and the Departmental Chair. If they feel they have been unable to effect change within their respective program/departments by this method, residents/fellows are encouraged to bring these matters to the attention of their GMEC representative, the Chairman of the GMEC Committee, or the Vice Chancellor for Clinical Affairs.

The role of the Institutional GMEC in the adverse action/disciplinary policy is one of ensuring that due process mechanisms are in place and functioning. The GMEC Committee **does not hear adverse action/disciplinary matters against individual residents/fellows** but rather ensures that prompt, appropriate, fair and free access is available through an appeals mechanism.

FACULTY AND DEPARTMENTAL ROLES

Faculty members in the Departments of the sponsored programs are best qualified to judge the performance and capabilities of residents/fellows in their program. The Departments under the administrative guidance of the Departmental Chair and specific supervision of the program director have the responsibility for the educational program for their residency or fellowship program. They are responsible for the evaluation of those individuals enrolled in such programs according to the established guidelines of the ACGME and respective Residency Review Committees. Each Department establishes its mechanisms for the ongoing evaluations of its residents/fellows. Written evaluations should be provided and discussed individually with the residents so that they may be made aware of their strengths, weaknesses, and recommendations for improvement. The Departments evaluate their residents/fellows on a regular basis, but in no case less than **twice yearly**. At this time, the departmental representative conducting the evaluation should attempt to elicit recommendations from the resident/fellow to improve the quality of the resident's/fellow's training experience. These evaluations are residency/fellowship program specific but should include (but are not necessarily limited to) an evaluation of:

1. Core Clinical Competencies
2. Knowledge – including general medical and specialty-specific
3. Work habits
4. Personal interaction with patients, patient's families, peers, subordinates, and superiors.

If a resident's/fellow's performance is substandard, **disciplinary action is determined and administered by the program director and/or chairperson of the individual department.**

Disciplinary action may take the form(s) of:

1. Oral counseling
2. Written counseling
3. Suspension
4. Extension of residency training
5. Dismissal

PROBATION

Probation is the formal notification to the resident/fellow that the residents/fellow's performance is not satisfactory. While probation is sometimes divided into "Academic Probation" and "Conduct Probation", the University makes no distinction between them. Failure to meet any standard after this formal warning may result in serious consequences up to and including dismissal from the program or nonrenewal of the trainee's annual contract at expiration. Because probation is a formal warning of substandard performance and is intended to alert the resident/fellow to that effect, it is not appealable beyond the level of the Department Chair. If probation is combined with an adverse action (eg. extension of training), then any appeal would be on the adverse action.

DUE PROCESS

The LSU Health Sciences Center-Shreveport is committed to the principal of due process. Due process is defined as allowing an individual to be confronted with the allegations and evidence against him/her, to present his/her side of the story to the decision-maker, and unless the offense is egregious, be given the opportunity for improvement. The DECISION-MAKER for the resident/fellow is the resident/fellow's Department Chair.

The regular periodic evaluations (supplemented by any additional evaluations, counseling, and interactions with faculty) should alert the resident/fellow to his/her status. Since residents/fellows are professionals, they have the responsibility to be aware of their status, and to inquire of the faculty concerning their progress in the residency program. Upon receiving **ANY** negative evaluation, the resident/fellow should contact his/her program director **immediately** for advice and counsel.

Residents/fellows who are dissatisfied with departmental actions must, **within five (5) working days**, request in writing a review by the Departmental Chair. The decision of the chair in matters of oral counseling, written counseling, and suspension of less than **thirty (30) days will be considered final**.

An appeals process for suspensions of **thirty (30) or more days**, extension of residency training, or dismissal are allowed under the administrative procedures of the LSU Health Sciences Center-Shreveport. Additionally, although not required by Louisiana law, appeals will also be allowed for contract non-renewal. The decision of the appeals process for all matters will be either **to uphold or not uphold** the departmental action. The full procedure for appeals (including appeals committee membership) is described in the section entitled **Appeals Process**.

APPEALS

Residents/fellows may appeal the Decision of the Department Chair for any disciplinary actions involving 30 or more days suspension, extension of residency training, or dismissal. Additionally, although not required by Louisiana law, LSUHSC-S allows appeals for contract non-renewal. The Decision of the Appeals process will be either to uphold or not uphold the departmental action.

APPEALS PROCESS

Residency/fellowship training is a serious responsibility both on the part of the resident/fellow and the faculty responsible for imparting such training. As medicine has progressed, and specialization has become more complex, the departments providing such training are best equipped to judge the clinical capabilities of the resident/fellows in their departments. It is expected that the faculty within the department/section sponsoring a residency/fellowship program will be involved in evaluating residents/fellows within their respective programs.

The role of the appeals process is to ensure that the resident/fellow has been fairly evaluated according to departmental standards, has been made aware of his/her

deficiencies, and unless the offense(s) are egregious, be given the opportunity to correct them. The appeals process is an administrative one, and therefore the strict rules of evidence do not apply.

The appeals process follows the following the decision of the Departmental Chair is as follows:

- Step 1. Appeals Review Advisory Committee
- Step 2. Review by Senior Associate Dean for Clinical Affairs/Chief Medical Officer
- Step 3. An appeal to the Chancellor of LSUHSC-Shreveport (representing the Board of Supervisors).

THE APPEALS PROCESS IN DETAIL

1. Upon receiving one or more of these disciplinary/adverse actions, the resident/fellow desiring to contest this action must **within five (5) working days** request in writing a review by the Departmental Chair.
2. The Departmental Chair is the final **appeal** for all disciplinary matters of oral counseling, written counseling, probation, and suspensions of less **than thirty (30) days**. The Departmental Chair has **ten (10) working days** after receipt of the request to render an opinion. In disciplinary/adverse actions involving **thirty (30) or more days** suspension or for a non-renewal of a training contract, appeals may be made to senior university authorities, as outlined in this section.
3. In disciplinary/adverse action(s) involving **thirty (30) or more days** suspension or for a non-renewal of a contract, the resident/fellow desiring to contest this action must **within five (5) working days** of the action make a written request for a review by the Departmental Chair. This request must clearly state the reason for the appeal and the relief desired.
4. The Departmental Chair will have **ten (10) working days** from the receipt of the written request to render a decision in writing.
5. **Within five (5) working days** after receiving the decision of the Departmental Chair, the resident/fellow may request a hearing before the Appeals Advisory Review Panel. This request must be in writing to the Review by Senior Associate Dean for Clinical Affairs/Chief Medical Officer, and must state the factual basis for the appeal in detail, including but not limited to, specific reasons why the Resident/Fellow disagrees with the departmental action, other related issues that the resident/fellow desires to be considered, and the relief sought. **FAILURE TO COMPLY TIMELY WITH THESE DEADLINES AND REQUIREMENTS WAIVES THE APPEAL RIGHT UNDER THIS SECTION.**
6. The Senior Associate Dean for Clinical Affairs/Chief Medical Officer will appoint a committee made up of two chief residents from departments other than that of the resident/fellow and two physician members on the Hospital Clinical Board or Senior Professorial rank physicians who are not members of the

resident's/fellow's department. The fifth member of the committee shall be the hospital administrator, associate hospital administrator, or a senior administrator of the medical school (excluding the Chancellor, Dean, or Senior Associate Dean for Clinical Affairs/Chief Medical Officer) who shall preside over the committee but shall not vote except in the case of a tie. The Coordinator of Legal Affairs or a suitable designee shall be appointed by the Senior Associate Dean for Clinical Affairs/Chief Medical Officer to serve as the legal adviser to the committee, but shall not participate in nor be present during the Committee's closed deliberations.

7. The names of the members appointed to the committee shall be given to the resident/fellow and to the Department Chair. The resident/fellow and the Department Chair will each have **five (5) working days** from the receipt of the names of the committee members to notify (in writing) the Vice Chancellor for Clinical Affairs of any challenges to any member of the committee (including the Chairman). If challenges are not received within the allotted five-day time period, the committee will be considered duly constituted. Challenges to members of the Committee by either the resident/fellow or the Department must be in writing, must be member specific, and must contain factual information sufficient in detail to allow a reasonable judgment on the objection to be made. If challenges are received (and the reasons are deemed valid) the Senior Associate Dean for Clinical Affairs/Chief Medical Officer will appoint a replacement(s).
8. All information, including but not limited to, the resident's/fellow's house officer files in the medical education office, files in the department/section, any material used by the Departmental Chair in rendering the initial determination, and any written determinations shall be made available to the committee, and to the resident/fellow.
9. The chairman of the committee shall notify the resident/fellow of the time and place of the hearing, which shall be **at least ten (10) working days, but not more than twenty (20) working days** after the resident/fellow has received the written information described above.
10. Not later than **five (5) working days** prior to the hearing, all parties (resident/fellow and department) shall notify the Chairman of the Appeals Review Committee, in writing, of the witnesses and exhibits that they intend to use at the hearing. It shall be the responsibility of the department chair to prepare and submit the department's witnesses and exhibits. Failure of either party to timely submit a list of witnesses and exhibits will preclude presentation of those witnesses and exhibits without the consent of the other party.
11. Not later than **ten (10) working days** prior to the hearing, the department shall submit to that committee, in writing, specific behaviors/conduct or other matters on the part of the resident/fellow.
12. Any person connected with the LSU Health Sciences Center who refuses to

testify before the committee shall be subject to disciplinary action. All witnesses shall testify under oath administered by an individual duly authorized to swear witnesses under Louisiana law.

13. The resident/fellow or the Department shall have the option of having the hearing opened or closed. Regardless of whether the hearing is open or closed, witnesses to be called shall be excluded from the hearing until after their testimony.
14. The resident/fellow shall be permitted to have an advisor present at the hearing, and such should be indicated in the notice mailed to him/her by the chairman of the committee. The advisor may be a lawyer, friend, or other staff member. Such advisor should have the opportunity to be an active participant in the questioning of any witnesses and presentation of evidence before the committee; however, the advisor may not be a witness.
15. The resident/fellow or their representatives shall be permitted to cross-examine all witnesses and will be allowed to present exhibits/witnesses on his/her behalf, in accordance with provision thirteen (13) of this section.
16. The resident/fellow may, but is not required to testify during the proceedings, or to testify in his/her own defense.
17. The committee Chairman shall arrange for a full and complete transcript of the hearing to be made by a certified court reporter. The resident/fellow may order a copy of the transcript from the court reporter at his/her expense.
18. The structure of the hearing shall be as follows:
 - A. The Chairman of the Committee should read the general charges (unless waived by the resident/fellow and the Department) and indicate on the record the parties present during the hearing including any members of the committee who are absent.
 - B. The department may elect to make any opening statement not to exceed ten minutes or elect to waive the making of such statement.
 - C. The resident/fellow may make an opening statement not to exceed ten minutes or may waive the right to make such a statement.
 - D. The department shall present evidence to support the action taken or may choose to proceed on the record of the prior proceedings.
 - E. The resident/fellow shall present evidence or else waive the right to do so.
 - F. If the resident/fellow presents evidence, the department may present evidence in rebuttal.
 - G. The Department may elect to present a closing statement not to exceed ten minutes in length.
 - H. The resident/fellow may elect to present a closing statement or else waive the right to do so. The closing statement of the resident/fellow shall not exceed 15 minutes in length.

- I. The department may present a closing rebuttal but only in the event the resident/fellow shall have presented a closing statement. The department shall be allowed no more than five minutes for rebuttal. There will be no sur-rebuttal.
 - J. Upon the conclusion of the presentation of evidence and arguments, the case will be submitted to the committee in closed session, with only the committee members present. They will make written findings of fact with respect to the charges alleged and render a recommendation to uphold or not to uphold the department's actions.
 - K. The decision shall be made by the majority vote of the committee members. Any member not concurring in the opinion may be allowed to file a dissenting opinion indicating the reasons for his/her position. The dissenting opinion will be attached to the committee's majority opinion.
19. The committee's signed recommendation shall be submitted to the Senior Associate Dean for Clinical Affairs/Chief Medical Officer. The Vice Chancellor may concur or not concur with the recommendation of the committee. The final decision of the Vice Chancellor will be transmitted to the resident/fellow and the Department Chair within **five (5) working days** after the receipt of the recommendations from the committee. A copy of the committee's report shall be transmitted to the resident/fellow and the Department Chair at that time.
20. Should the resident/fellow or the Department be dissatisfied with this decision, the resident/fellow or Department may appeal to the Chancellor of LSUHSC-Shreveport (representing the Board of Supervisors) within **five (5) working days** of the receipt of the Vice Chancellor's action on the Committee's recommendations. This Appeal must be in writing and shall contain the factual basis on which the resident/fellow or the Department believes the decision is wrong.
21. The Chancellor, or his designee, will review the matter and will notify all parties of the final decision within **thirty (30) working days** of its submission to the Chancellor. The Chancellor's review shall be made on the record of the previous hearings.
22. The disciplinary/adverse action shall be carried out after the decision of the Department Chair (who is the decision-maker). Should the resident or fellow prevail on the appeal to Senior University Official's, the resident/fellow will be entitled to all back pay and allowances from the date of the disciplinary/adverse action. Although the disciplinary/adverse action shall be carried out after the decision of the Department Chair, no notification of the appropriate boards and agencies will occur until the final step in the appeal. An exception to this notification may be made when required by law, rule, regulation, or contract.

GRIEVANCE PROCEDURES

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER SHREVEPORT

Graduate Medical Education Grievance Appeals Process

Purpose:

To define the Grievance Process for disciplinary actions within Graduate Medical Education.

Definitions:

A grievance is defined as any circumstance thought to be unjust or injurious and grounds for complaint or resentment, or a statement expressing this, against a real or imagined wrong; or a complaint arising from circumstances or conditions relating to one's employment. A Resident has several options in which to have a grievance resolved.

Policy:

Residents and Program Directors are encouraged to work within their departments to address and resolve any issues of concern to the Residents, including concerns related to the work environment, faculty, or the Resident's performance in the program. All such concerns should be presented by the Residents to their Program Directors for resolution.

A Resident may choose to submit a grievance unrelated to the Resident's performance. In writing to the Medical Education Office for investigation. The Director of Medical Education in conjunction with the Institution Official will investigate the grievance and provide a written follow up response within thirty (30) days of the complaint/grievance being filed. Identified problems, trends or patterns will be forwarded to the Graduate Medical Education Committee (GMEC) and appropriate actions taken to resolve the issue.

In addition, a grievance procedure for all non-union classified and unclassified employees was established at Louisiana State University Health Sciences Center so that employees who are dissatisfied or who have a personal complaint may discuss their situation freely with appropriate personnel. All employees may request to receive proper consideration toward resolving the problem. The employee should do so without fear of reprisal from anyone for using the procedure provided the effort to resolve the problem is sincere. The policy may be found in the Employee Handbook, "Grievance Procedure" (5.6). The steps of the Grievance Procedure are as follows:

Step 1: The employee shall present the grievance in writing to his/her immediate supervisor within five (5) working days beginning with the day after the occurrence of the incident which caused the employee to be aggrieved. The supervisor will promptly establish a meeting with the employee to discuss the grievance and/or will render a written answer to the grievance within three (3) working days beginning with the first working day after the grievance is presented to the supervisor.

- Step 2: If the employee is not satisfied with the decision of his/her immediate supervisor, he/she may, within three (3) working days, submit his/her grievance in writing to the Department of Human Resource Management. The designated representative of the Department of Human Resource Management will conduct an investigation within five (5) working days. If the Department of Human Resource Management representative feels that, based on the facts, the employee has a valid grievance; he/she will notify the department head of his/her findings. If the department head does not concur with the Department of Human Resource Management representative's findings, or if the Department of Human Resource Management representative feels that the grievance is not justified, the Department of Human Resource Management representative will render a written decision to the employee and the department head within three (3) working days after the initial response was rendered.
- Step 3: If the employee is not satisfied with the decision at Step 2, he/she shall, within two (2) working days beginning with the first working day after receiving the decision submit his/her grievance in writing to the appropriate Dean or Senior Associate Dean of Clinical Affairs/Chief Medical Officer. The Dean or Senior Associate Dean, or his designee, will discuss the grievance with the employee within five (5) days and render a written decision within three (3) working days beginning with the first working day after the grievance is discussed with the employee.
- Step 4: If the employee is not satisfied with the decision at Step 3, he/she shall, within two (2) working days beginning with the first working day after receiving the written decision, submit his/her grievance in writing to the Chancellor for decision. The Chancellor, or his designee, shall meet with the employee within four (4) working days of receipt of the written grievance and shall render a written decision within five (5) days thereafter.
Decisions rendered by the Office of the Chancellor are final within the university.

Any employee interested in informally discussing a potential complaint may do so by contacting the Department of Human Resource Management, Assistant Director of Employee Relations, Room 122-Allied Health Building, or call 675-5611.

As set forth in the Resident Manual, Due Process and Appeals Policies provide additional procedures for Residents to request review of certain academic or other disciplinary actions taken against Residents that could result in dismissal, non-renewal of a Resident's agreement or other actions that could significantly threaten a Resident's intended career development.

Administrator

Date

- Clinical Board Approved:
- Written:
- Removed:
- Reinstated:
- Revised:
- Reviewed:

GRADUATE MEDICAL EDUCATION COMMITTEE ROLES AND RESPONSIBILITIES

PURPOSE:

The Graduate Medical Education Committee is responsible for monitoring and supervising all aspects of residency education. The Graduate Medical Education Committee is appointed by the Dean of the Health Sciences Center or his/her designee. Voting members on the committee include The DIO, representatives of the Program Directors, Resident representatives selected by their peers, Resident Association President, Hospital Administrator, Hospital Medical Director/Vice Chancellor for Clinical Affairs, and the committee chairman. Additional members of the committee include the Associate Dean for Academic Affairs who will serve as an Ad Hoc Member and the Director of Medical Education.

The Chairman of the GMEC attends and reports to the Hospital Clinical Board. The membership of the Clinical Board consists of the Clinical Chairs, Administrative Representatives as well as Medical Staff Committee Chairs.

The GMEC meets monthly. Minutes are maintained in the Office of Medical Education and are available for reference and inspection by appropriate accreditation personnel.

In the absence of the DIO the Institution and DIO has designated the Executive Director of Medical Services the responsibilities of the DIO. Examples of responsibilities include, but are not limited to, signing of all program information forms, correspondence submitted to the ACGME or ACGME Residency Review Committees, etc.

The GMEC roles and responsibility:

1. establish and implement policies and procedures regarding the quality of education and the work environment for the residents in all ACGME-accredited and non-accredited programs.
2. annually review and make recommendations to the Sponsoring Institution on resident stipends, benefits, and funding for resident positions to assure that these are reasonable and fair.
3. establish and maintain appropriate oversight of and liaison with program directors and assure that program directors establish and maintain proper oversight of and liaison with appropriate personnel of other institutions participating in the ACGME-accredited programs of the Sponsoring Institution.
4. establish and implement formal written policies and procedures governing resident duty hours in compliance with the Institutional and Program Requirements. The GMEC must assure that the following requirements are met:
 - a) Each ACGME –accredited program must establish formal written policies governing resident duty hours that are consistent with the Institutional and Program

Requirements. These formal policies must apply to all participating institutions used by the residents and must address the following requirements:

- 1) The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty-hours and call schedules must be monitored by both the Sponsoring Institution and programs and adjustments made as necessary to address excessive service demands and/or resident fatigue. ACGME-accredited programs must ensure that residents are provided appropriate backup support when patient care responsibilities are especially difficult or prolonged; and
 - 2) Resident duty hours and on-call time periods must be in compliance with the Institutional and Program Requirements. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident.
 - 3) Duty periods of PGY-1 residents must not exceed 16 hours in duration
 - 4) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
 - 5) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
 - 6) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
 - 7) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit.
- b) The GMCC must develop and implement procedures to regularly monitor resident duty hours for compliance with the Sponsoring Institution's policies and the Institutional and Program Requirements.
 - c) The GMCC must develop and implement written procedures to review and endorse requests from programs prior to submission to an RRC for exceptions in the weekly limit on duty hours up to 10 percent or up to a maximum of 88 hours. All exceptions requested must be based on a sound educational rationale. The procedures must outline the process for endorsing an exception in compliance with the ACGME policies and procedures for duty-hour exceptions. The procedures and their

application, if the institution has utilized them, will be assessed during the institutional review.

1. assure that ACGME-accredited programs provide appropriate supervision for all residents that is consistent with proper patient care, the educational needs of residents, and the applicable Program Requirements. Supervision of residents must address the following
 - a) Residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability, and experience.
 - b) On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty.
 - c) The teaching staff must determine the level of responsibility accorded to each resident.
2. assure that each program provides a curriculum and an evaluation system to ensure that residents demonstrate achievement of the six general competencies listed in Section III.E and as defined in each set of Program Requirements.
3. establish and implement formal written institutional policies for the selection, evaluation, promotion, and dismissal of residents in compliance with the Institutional and Program Requirements.
4. regularly review all ACGME program accreditation letters and monitor action plans for the correction of concerns and areas of noncompliance.
5. regularly review the Sponsoring Institution's Letter of Report from the IRC and develop and monitor action plans for the correction of concerns and areas of noncompliance.
6. review and approve prior to submission to the ACGME
 - a) all applications for ACGME accreditation of new program and subspecialties;
 - b) changes in resident complement;
 - c) major changes in program structure or length of training
 - d) additions and deletions of participating institutions used in a program;
 - e) appointments of new program directors;
 - f) progress reports requested by any Review Committee;
 - g) responses to all proposed adverse actions;
 - h) requests for increases or any change in resident duty hours;
 - i) requests for "inactive status" or to reactivate a program;
 - j) voluntary withdrawals of ACGME-accredited programs;
 - k) requests for an appeal of an adverse action; and,
 - l) appeal presentations to a Board of Appeal or the ACGME.
7. conduct internal reviews of all ACGME-accredited programs including subspecialty programs to assess their compliance with

the Institutional Requirements and the Program Requirements of the ACGME Residency Review Committees in accordance with the guidelines in Section V.

ACGME SIX COMPETENCIES

The Graduate Medical Education Committee (GMEC) is responsible for ensuring that the residency training programs require its residents to obtain competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

Educational Program:

- a. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
- b. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
- c. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
- d. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals.
- e. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
- f. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

LSUHSC-S EMPLOYEE ASSISTANCE PROGRAM

It is estimated that in a typical employee population, six to ten percent of the work force suffers from alcoholism or an alcohol related problem; two to three percent have difficulty with drugs, and six to seven percent experience emotional problems. Statistics specifically related to hospital employees reflect estimates similar to the general employee population. Studies indicate that approximately 15% of physicians are alcohol or drug dependent. Data regarding nurses indicate problems with chemical dependency as well as with depression, stress, and burn-out. Also, because 75% to 80% of a typical hospital's employees are women, family problems such as divorce and domestic violence as well as concerns about alcoholism or drug dependence of a family member may be more prominent than in other employee populations. During periods of economic recession and unemployment when many women workers become the family's sole economic provider, financial and legal difficulties appear more frequently.

Because of the nature of their work, many health care professionals are subject to considerable job stress. The life and death responsibilities of hospital work and the need to be always caring and concerned can create substantial stress and strain on an employee's emotional life. Also, the disruption in an employee's routine caused by rotating shifts, weekend work, and on-call duties can magnify personal problems. Stressful work situations can often exacerbate existing problems.

The impact of personal problems on health care workers can have more serious and lasting consequences than in some other occupations. An impaired health care worker can cause direct harm to patients through carelessness, mismanagement of medication, or failure to communicate the patient's requirements.

Although personal problems occur among hospital employees with at least the same frequency as in other work forces, the belief that health care workers should be immune from personal problems impedes the identification of these problems. An EAP in a hospital can provide "help for the helper."

The Employee Assistance Program (EAP) is a sponsored service which is designed to encourage employees to take the initiative for their own health and wellness. With the

assistance of professional consultation, employees can solve a wide range of personal problems that could adversely affect their personal lives or professional careers.

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Drug-Free Workplace – To enforce the drug-free policy and to help employees maintain employment as they recover from alcohol/drug use, the EAP offers services to identify, screen and monitor impaired employees.

Can I be guaranteed that participation in the Employee Assistance Program will not hurt my job promotional opportunities?

It is in your best interest to seek early counseling through the EAP program. Even if management has talked to you about a possible problem, you may voluntarily seek treatment and counseling by stepping forward and accepting the help that is available. If management is sufficiently concerned about job performance, a formal referral to EAP may be made. If the employee elects not to follow referral for evaluation and possible treatment, the referral person will be notified. Should job performance continue to decline, disciplinary actions may be taken by LSUHSC-S management.

How confidential is the program?

The Employee Assistance Program goes to great lengths to respect your right to privacy. Like all medical files, EAP records and discussions regarding the nature of personal problems will be handled in strict confidence. EAP records will be maintained separately from personnel files by the Director of the EAP program. EAP insures that employees at all levels have the opportunity to obtain the best professional help in an atmosphere of understanding and privacy.

My problems are private. What right does LSUHSC have to interfere with my personal life?

You're right! Your problems are personal...until they begin to have a detrimental effect on your work performance. Then personal problems affect more than just you; they affect your co-workers and the productivity of your team.

Can I participate even if job performance has not been affected?

Absolutely! LSUHSC-S hopes that awareness of the EAP and understanding of its principles will encourage employees to seek help on their own before problems impact job performance.

Who will pay for the cost of the counseling, or for other recommended assistance?

The EAP guidance and referral services are free. Diagnosis and treatment cost outside Employment Health Services will, to the extent they are covered by regular group health insurance, be paid for by your insurance.

How long does it take to get help?

It's LSUHSC-S's goal to have all employees receive the help they need as soon as they contact the EAP Director. Once the medical/emotional problem is evaluated, you will be counseled and offered referrals to an appropriate treatment source.

Counseling Services for Residents

Purpose:

To provide Residents with a support/assistance program in a confidential manner.

Group Support, Employee Assistance Program and the Physician's Health Committee are available to provide counseling support and direction for the resident seeking assistance. **Physicians take care of others continuously. However, physicians also need assistance at times, and we want you to know that it is ok to ask for help. It is the primary role of the Physicians' Health Foundation of Louisiana (PHFL) Physicians Health Program (PHP) to offer assistance to physicians who may be suffering from difficulties such as substance use issues, depression, anxiety, etc., in addition to a host of physical ailments and disruptive behavioral patterns. The PHFL PHP supports physicians who are in our program and advocates for them with hospitals, health plan networks, malpractice insurance carriers, medical boards, etc.**

Physician's Health Committee (PHC) functions under the direction of the Shreveport Medical Society as approved by the Louisiana State Board of Medical Examiners.

The Resident may contact the PHC directly (1-888-743-5747) to seek assistance or a referral/request may be made by a concerned individual regarding the physician. The PHC proceeds very carefully in their review of the individual's case. All inquiries are

handled with extreme confidentiality. In the event the physician in question is in immediate danger or may endanger his patients, a suspension could occur until adequate data has been collected.

If the physician is found to have impairment and agrees to work with the PHC to address the problem, the Louisiana State Licensing Board will not penalize him or her. Confidentiality is always stressed.

Dr. Mary Fitz-Gerald, Department of Psychiatry, is the LSUHSC representative of the PHC. As the needs occur, Dr. Fitz-Gerald will work closely with the PHC and make referrals as appropriate. Dr. Fitz-Gerald will also be available to conduct programs dealing with stress and other related topics for the clinical departments as requested.

Any resident who is in need of psychiatric care may contact Dr. Fitz-Gerald or a psychiatry faculty member. Dr. Fitz-Gerald is available for confidential evaluation and referral if necessary. The resident may also request short-term counseling from the Employee Assistance Program.

In the event that a residency-training director believes that a psychiatric evaluation is necessary for training to continue, the Residency Training Director will request an evaluation by Dr. Fitz-Gerald or another psychiatry faculty member in writing. This request will also list specific information as to why the evaluation is warranted. Dr. Fitz-Gerald will request the resident sign a release of information in order to notify the Residency director of diagnosis, treatment recommendations, and if the recommendations are followed. If the resident doesn't agree with the above, he has access to the due process as outlined in this manual.

LSUHSC-Shreveport
Dr. Mary Jo Fitz-Gerald
(318) 675-6040 Department
1-888-743-5747 PHC

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER SUBSTANCE AND ALCOHOL ABUSE POLICY

A. PROVISION

All Residents must understand that continued employment is contingent upon their willingness to comply with the Drug Free Workplace Act of 1988 and The Drug Free Schools and Communities Act of 1980. All employees are required to notify the Director of Human Resources Management within five (5) days following a conviction of any drug related criminal charge that is work related.

Because of the potential for errors of omission or commission, and because unlawful manufacture, distribution, dispensing, possession or use of a controlled substance violates state and/ or federal laws, it is the policy of

Louisiana State University Health Sciences Center in Shreveport to maintain an environment free of drugs and alcohol. The illegal use, possession or distribution of illicit drugs and alcohol abuse by students and employees on the university premises or as any part of its activities is prohibited.

B. SCOPE

Laboratory drug tests of appropriate body fluid specimens may be required of a Resident should there be reasonable suspicion to believe a chemical abuse problem exists. Such reasonable suspicion to believe such a problem exists may include, but is not limited to, the appearance of impairment or intoxication on the job or abhorrent behavior. Testing may also be required after an accident, near accident or incident.

C. DISCIPLINARY SANCTIONS

The Health Sciences Center will impose disciplinary sanctions on employees who violate the policy. Among the disciplinary sanctions, which may be imposed on employees, are the following: oral warning, written reprimand, suspension, termination and referral for prosecution. The Health Sciences Center may require completion of an appropriate rehabilitation program for continued participation in Health Sciences Center programs or employment.

D. PHYSICIANS HEALTH COMMITTEE

As a physician, you may already be aware of the need to provide assistance to someone who may be dealing with a substance abuse problem. Today, there is a mechanism in place to provide counseling to that individual.

At Louisiana State University Health Sciences Center in Shreveport, the Physicians Health Committee is in place and working. The program has been set up through the Shreveport Medical Society. The process is confidential and each case is handled on an individual basis.

If you have questions or comments, please contact Dr. Mary Fitz-Gerald, Phone Number 675-6040 in the medical school Room 3-423.

GENERAL INFORMATION FOR ALL RESIDENTS

Human Resource Management packets must be completed and **ALL** forms returned to the Human Resource Management Office (room AHB-116A). Failure to complete the packet will result in the resident **NOT** being paid.

ADOPTION POLICY - Residents

The Resident is required to notify the Medical Education Office and Program Director as soon as placement has been made. The Resident will be allowed to take the allocated sick leave and annual leave available through their residency program. Any leave required beyond that time frame will be considered Leave Without Pay and result in the extension of the training program.

HEALTH CARE INSURANCE

It is required that proof of Health Care Insurance be presented at the beginning of each contract year. **The institution does not offer free health care to residents.** The institution offers a variety of Healthcare insurance coverage benefit options for its employees. Residents may purchase healthcare insurance as part of the benefits package. Questions should be directed to the Benefits Section of Human Resources (phone: 55632).

RESIDENT CLEARANCE

Your certificate of graduate training will be contingent upon the recommendation and signature of the Residency Program Director, completing all records, all required training i.e. TB Skin Testing, CED online training, and HIPPA training settling professional and financial obligations, and returning all Health Sciences Center property such as books, equipment, beepers, keys, etc. You must complete the check out clearance form in order to receive your certificate or verification of training.

RESIDENT CALL IN POLICY

All scheduled leave must be recorded in the Medical Education Office as outlined in the Leave Policy. Any unscheduled leave, emergency, sick, etc. must be reported immediately to the Assigned Service representative. The Resident must notify his service contact (Staff or responsible Resident whether Chief Resident or Team Resident). The service resident will be responsible for notifying the Medical Education Office who will notify the Program Director and record the absence. Upon notification of the need to take leave, the Resident will be advised to call in daily if sick leave is being requested. A physician's excuse may be necessary to return to work. Other emergencies will require identifying a specific number of days prior to leave being taken to establish a date of return to service. Any leave taken without following the proper procedure may result in leave without pay and/or delay in program completion as determined by Program Director/Chief of Service.

RESIDENT ROTATION SCHEDULES

Rotation schedules for off-service residents must be finalized by the 20th of each month prior to start of that new month.

ID BADGES/SECURITY ACCESS CARDS

ID badges are required and can be obtained in the Public Safety Office (Room G-213) in the Medical School. ID badges are combined with the access cards. These combination ID Badges will allow you access to certain authorized areas of the hospital, including the On-call quarters. Badges/Security Access cards will be issued as part of the Orientation Program. To ensure security efforts are not hindered the Office of Public Safety should be notified of any lost/misplaced card immediately. Replacement cost is \$20.00 each payable by the resident.

LEAVE

Annual Leave - Vacation

First-year residents are allowed three weeks (15 weekdays) vacation with pay, and second through sixth year residents are allowed four weeks (20 weekdays) vacation with pay, except where prohibited by departmental policy or specialty board regulations. You are encouraged to take your vacation in increments of at least one week (5 days). If a resident applies for one week of vacation (Monday through Friday) it is expected that the resident will also be free of duty for one of the adjoining weekends (and, the adjoining weekend will not be charged to the resident's leave).

Vacation leave is non-cumulative—it must be used during the academic year earned and cannot be carried forward.

Vacation Requests

Your request for leave is to be submitted to your department on appropriate application for leave form. It will be circulated for appropriate departmental approval from your department; then submitted to the Medical Education department to document.

Vacation requests are to be made within the time frame established by the various Departments, but not less than 60 days prior to the leave you are requesting. All leave requests should be submitted in writing. **Off service leave requests should be submitted to that service for consideration no later than August 31.**

Vacation Limitations

VACATIONS ARE NOT ALLOWED DURING THE FIRST TWO WEEKS OR THE LAST TWO WEEKS OF YOUR RESIDENCY YEAR OF TRAINING.*

*Exceptions to the above must be approved by the Clinical Department Head to which you are assigned.

Sick Leave

Each Resident is eligible for 10 weekdays of paid sick leave during the academic year and cannot be carried forward.

The Resident must be ill in order to request sick leave; sick leave cannot be requested for the illness of a family member. (Please refer to the Family and Medical Leave section).

If sick leave is more than three (3) consecutive workdays, the resident is required to bring a physician's certificate. If an illness exceeds 10 weekdays, vacation leave may be used to cover an extended period of absence due to illness. If sick/annual leave is exhausted, the Office of Medical Education must be notified by the Clinical Department Head and/or Residency Program Director so that arrangements can be made to keep the resident's insurance current. In the event there is excessive sick leave, extension of the training contract may be requested by the Program Director if deemed necessary to meet the Program Training Requirements.

Sick leave may not be used for vacation time.

Educational Leave

Educational leave may be granted by the Program Director and/or Clinical Chief. Educational Leave should be recorded with the Office of Medical Education. Residents participating in specialty boards, licensing exams, etc. should record the leave as "educational". Education leave for taking USMLE step 3 must be submitted at least 30 days before the beginning of the rotation month. The program director has the final approval of all leave.

Off service educational leave requests must be submitted to the service assignment by August 31 for consideration, the program director of that service has final approval.

Special and Holiday Leave

In addition to one's vacation, certain holidays and special leave will be considered; i.e., military, civil for court appearances, etc.

Maternity Leave/Paternity Leave

The Resident is required to notify the Human Resources (675-5634), the Medical Education Office and their Program Director as soon as pregnancy has been confirmed. Sick leave and Annual leave, if necessary, will be used for the maternity absence. Any leave beyond that will necessitate Leave Without Pay Status and result in the extension of the training period.

Paternity leave is authorized only if the Resident has adequate annual leave available.

Funeral Leave

Funeral leave may be given to Residents without loss of pay or required use of annual leave or sick leave to attend the funeral or burial rites of an immediate family member when such rites occur on a scheduled work day, in accordance to University Policy on Funeral leave.

Immediate family is defined as: father, mother, step-father, step-mother, sister, step-sister, brother, step-brother, husband, wife, child, step-child, mother-in-law, father-in-law, grandchild and grandparents.

Family and Medical Leave

All employees who have been employed for twelve (12) months and who have worked for at least 1,250 hours during the 12 months preceding the start of a leave, are eligible for up to 12 weeks of unpaid leave for certain qualifying events. Qualifying events include:

- A. the birth of a son or daughter and to care for the child,
- B. the placement of a son or daughter by adoption or foster care,
- C. to care for a spouse, son, daughter or parent if the family member has a serious health condition.

The University shall require thirty (30) days advance notice of the request whenever reasonable. Certification as to the authenticity of the precipitating event will be required.

Employees must substitute any applicable accrued paid leave for the 12 weeks of unpaid leave.

The University's portion of employee health coverage will be maintained while the employee is on leave without pay and as long as the employee's portion is paid. LSU will not contribute to other benefit plans during periods of unpaid leave.

Requests for leave along with pertinent certification documents should be forwarded by the employee's supervisor and Department Director to the Employee Relations Section of the Human Resource Management Department. The Human Resource Management Department will determine the employee's eligibility under the Family and Medical Leave Act.

Employees returning to work from Family and Medical Leave will be restored to the same jobs held before going on leave, or to equivalent positions with the same pay, benefits, and other terms and conditions of employment.

Family and Medical Leave (FMLA) Act Expanded for Military Families

President Bush has signed into law the Support for Injured Service Members Act, which grants additional leave under the FMLA to "eligible" employees who have family members in the military. The legislation creates two (2) new categories of FMLA leave:

- 1) **Active Duty Family Leave** – Employees with a spouse, parent, or child who is on or has been called to active duty in the Armed Forces may take up to 12 weeks of FMLA leave when they experience a "qualifying exigency".
- 2) **Injured Service member Leave** – Employees who are the spouse, parent, child, or next of kin of a service member who incurred a serious health or illness on active duty in the Armed Forces may take up to 26 weeks of leave in a 12-month period (including regular FMLA leave).

Employees may take "injured service member leave" intermittently but must use it up within 12 months.

More information on the new leave requirements will be forthcoming once guidelines have been issued by the Department of Labor.

You may contact Jean Brown, Human Resource Management, 675-5634, with your questions or concerns.

The Family and Medical Leave (FMLA) packet/forms are now available for our employees on the LSU Health Sciences Center – Shreveport website at the following link:

<http://myhsc.lsuhsershreveport.edu/hr/FMLA.php>

LEAVE OF ABSENCE

The Graduate Medical Education Committee (GMEC) supports the policy for Leave of Absence as referenced by the Presidential Memorandum PM 20, “Leave Policies for Academic and Unclassified Employees and Classified Personnel”.

Residents who find themselves in a position to require the need to “request a leave of absence” must do so in writing. The request shall be submitted to the Program Director and/or Clinical Chief. The “Leave of Absence” is approved by the Program Director and submitted to the Medical Education Office for record keeping.

The leave of absence shall not exceed the resident’s current contract. When leave is taken, the Resident and Program Director are encouraged to address an anticipated date of return as well as identify the length of time the period of training will need to be extended.

Residents granted a “leave of absence” shall be in a non-paid or “leave without pay” status. During this period, the Resident will be responsible for both portions of the health insurance premium payment if the “leave without pay status” exceeds a two-week period. The Resident shall be directed to review the payment options with the Department of Human Resources, Benefits Division.

PRESCRIPTION PADS

All Residents are required to use preprinted prescription pads. Residents are required to only use their own preprinted prescription pads. Initial issue of preprinted prescription pads is four pads of 100. Requests for additional prescription pads should be made in the Medical Education office @ 675-5053.

Residents are responsible for safeguarding their prescription pads at all times, to prevent unauthorized use of them. Each resident must pick up his or her prescription pads in person only in the Medical Education Office.

WHITE COATS/SCRUB SUITS/DRESS CODE

Initial issue of white coats is three. Requests for new coats should be made in the Medical Education office, Room A1-19.

Cobalt Blue Scrub Suits – are to be worn ONLY in the Operating Room Suite

Green Suits – are restricted to Obstetrics, Labor, and Delivery

Blue Suits – initial issue is two. These suits may be worn in the Health Sciences Center other than the restricted areas as outlined.

University Police has been directed to instruct personnel leaving the institution with “Hospital Owned” scrub suits of the current scrub suit policy (hospital owned scrub suits are not to leave the designated area). Continued abuse of the scrub suit policy may result in disciplinary action.

Residents are encouraged to dress appropriately as a medical professional. Individuals are reminded personal hygiene is also an aspect of a physician’s professionalism. Individual departments may establish more specific guidelines for dress.

DISABILITY INSURANCE

Residents receive, without charge, a basic group disability insurance benefit. Additional coverage may be purchased by the Resident.

Any questions concerning the Disability Program and its benefits should be directed to the Medical Education Office. The Medical Education Office then will refer the Resident to the current representative of the benefit.

LICENSURE

Full Medical Licensure or PGY I Registration

US Medical School graduates who are first-year residents may serve the PGY I (internship) year with a PGY I Permit issued by the Louisiana State Board of Medical Examiners (LSBME). If you took the USMLE you **will** be granted PGY I Registration on that basis, and a copy of the test results must be furnished to the Medical Education Office. The PGY I Registration Application can be downloaded from the LSBME website at www.lsbme.louisiana.gov. Please check with the LSBME to verify the fee schedule.

International graduates who are not eligible for full license will be processed for Licensure of the Graduate Education Temporary Permit as outlined by the LSBME. International medical graduates must complete three (3) years of training in the same specialty to be eligible for full license. The Graduate Education Temporary Permit (GETP) application can be downloaded from the LSBME website at www.lsbme.louisiana.gov. Please check with the LSBME to verify the fee schedule.

U.S. Medical School graduates who have completed one (1) year of post-graduate training and successfully passed USMLE Step 3 must obtain a full-unrestricted Louisiana medical license. International Medical School graduates who have completed three (3) years of post-graduate training in the same specialty and successfully passed USMLE Step 3 must obtain a full-unrestricted Louisiana medical license. The license application can be downloaded from the LSBME website at www.lsbme.louisiana.gov. Please check with LSBME regarding the fee for full license.

All applicants applying to LSBME for licensure must initiate a criminal background check. The background check materials can be requested from LSBME.

It is the responsibility of all House Officers to maintain appropriate licensure during their training program. Failure to do so will result in Leave Without Pay until licensure is obtained.

USMLE

Residents are responsible for making application in accordance with time frames established by the LSBME FOR THE USMLE* or the Federation of State

Licenses. Any questions regarding the USMLE should be referred to the LSBME or to the Federation website (www.fsmb.org).

(*Applicable to those who are not fully licensed in Louisiana)

MAIL BOXES

Internal Medicine, Internal Medicine Primary Care, Internal Medicine/Pediatrics, Pediatrics and OB/GYN residents has an assigned mailbox for receiving correspondence. Mailboxes are the combination type and are located on the ground floor of the hospital. **The resident's mailbox should be checked at least twice a week.**

All other house officers receive their mail in assigned boxes as designated by their respective departments.

Fellows receive their mail in their assigned boxes as designated by their Training Program Director.

MALPRACTICE INSURANCE

The State of Louisiana provides professional liability coverage pursuant to LSA-R.S. 40:129939 et.seq. to Residents when acting within the course and scope of their training or staff which they are assigned as part of their prescribed training, regardless of where the services are performed. However, Residents assigned to a health care facility outside the state of Louisiana may be required to provide additional professional liability coverage with indemnity limits set by the Residency Program Director.

Malpractice Insurance is provided through the State of Louisiana self-insurance plan at no cost to the resident, and covers in-house duties only. Moonlighting is not covered. Any questions regarding any malpractice claims or legal inquiry should be reported to the Office of Legal Affairs (675-5406).

MEALS

The cafeteria is located on the ground floor of the hospital. Cafeteria hours of operation for hot meals and grill items are:

Breakfast	6:15 a.m. - 10:30 a.m.
Closed	10:30 a.m. - 11:00 a.m.
Lunch	11:00 a.m. - 2:00 p.m.
Limited Menu	2:00 p.m. - 4:00 p.m.
Dinner	4:00 p.m. - 9:00 p.m.*
Late Night	11:30 a.m. – 4:00 a.m.*

*Closed Monday-Friday at 9:00 p.m.

*Closed Saturday, Sunday and Holidays at 7:30 p.m.

Atrium Deli and Coffee Bar hours of operation for breakfast and lunch are as follows:

Breakfast	7:00 a.m. – 10:00 a.m.	Monday – Friday
Limited Menu	10:00 p.m. - 11:00 p.m.	Monday – Friday
Lunch	11:00 a.m. – 4:00 p.m.	Monday – Friday
Closed on Holidays and Weekends.		

Vending machines are located throughout the Health Sciences Center for easy access to snack food. Vending refunds are available in the Deli.

Residents are not authorized to feed family, friends, students, hospital personnel or others. To do so may result in the loss of your meal privileges. Meals taken by the resident are charged to the resident account. It is necessary that you stop at the cash register and PRESENT YOUR ID to the cashier in order to ring up the charges for your meal.

There will be a payroll deduction of \$10.00 per pay period for participation in the meal plan. The meal plan will operate on an inclining balance of \$250.00 per month, with the balance returning to \$0.00 on the first day of each month. Beyond this \$250.00 limit, residents and fellows are expected to pay cash for all meals at the time of purchase.

ON-CALL QUARTERS

Services requiring overnight coverage have designated call rooms in a secured area accessible by card access only on the ninth (9th) floor of the hospital. Clean linens are provided on a daily basis. Each room has a telephone for call-back. Do not use any room not assigned to your service. All call rooms are accessible by key and/or combination only. Residents must request a key or door code through his/her respective departments. The call room should only be utilized by on-call Residents.

The Resident lounge is also located on the 9th floor. The lounge has several sofas, a microwave, TV, telephone and refrigerator.

If your room requires additional cleaning during the week, please make proper use of the "Second Cleaning Required" signage available in each room. If your room requires additional cleaning on the weekends, please notify the Environmental Services Office at extension 5-6337.

Medical Records, Radiology Films and other patient documents should not be left in the on-call rooms. Periodic room inspections are conducted and items may be removed and returned to their appropriate location.

Hospital owned scrub suits should be returned to the appropriate designated area.

Residents have a responsibility for removing their personal items as deemed appropriate to allow proper cleaning of the on-call room.

Any problems with the on-call rooms should be reported to the Office of Medical Education for follow-up. On weekends, if a problem occurs, the House Manager should be contacted.

CONTROLLED SUBSTANCES

Obtaining an individual DEA NUMBER for prescribing controlled substances is a three-step procedure stated below. (No outpatient prescriptions are filled in the hospital pharmacy).

1. FULL Louisiana Medical License.
2. LOUISIANA STATE NARCOTIC NUMBER. This application is obtainable once you have a current Louisiana Medical License.
3. FEDERAL DEA NUMBER - can be obtained once you have fulfilled requirements 1 and 2 above. Applications for your Louisiana State Narcotic number and federal DEA number are available in the Medical Education Office.

Prescription orders for controlled substances may be issued by physicians, dentists, and veterinarians who are authorized to prescribe controlled substances by the jurisdiction in which they are licensed to practice their profession and either are registered with the DEA under the Controlled Substances Act for the appropriate schedules or are exempt from registration.

Residents are issued a temporary DEA number which can be used only until the resident is eligible for his/her own Federal DEA number. You will be responsible for securing the appropriate narcotic licenses and maintaining those permits. Residents and internationally trained physicians may dispense, administer, and prescribe controlled substances under the registration of LSUHSC in Shreveport in lieu of being registered themselves provided that the following conditions exist:

The dispensing, administering, or prescribing is in the usual course of professional practice;

The individuals are authorized or permitted to dispense, administer, and prescribe by the Louisiana State Licensing Board; LSUHSC has verified that the individual has never had a DEA registration application denied or revoked;

The practitioners are acting only within the scope of their employment at LSUHSC;

LSUHSC authorizes individual practitioners to dispense or prescribe under the hospital's registration and designates a special code number for each individual. **The temporary number is issued initially to all first year residents for their use at LSUHSC only until they receive their own DEA numbers.** Issuance and monitoring of the number shall be through the Medical Education Office in conjunction with the Chief Pharmacist.

A current list of internal codes assigned to practitioners is kept and is made available to other registrants and law enforcement agencies upon request to verify the authority of the prescribing individual practitioner. The Medical Education office keeps the current list of numbers and signatures, with Pharmacy receiving a copy.

Residents will be required to pursue DEA Registration upon receipt of their medical license unless their training specialty does not routinely require prescription orders.

PARKING TAGS & CARDS

Residents are currently assigned to "P" lot at no charge, but must register to park with the Office of Auxiliary Enterprises.

Applications for parking are obtained from the Office of Auxiliary Enterprises, ADM G22. The registration record of your vehicle must be presented at the time of completing the parking application.

Emergency (call-back) parking should not be in designated fire lanes. If you require an escort after hours, please notify University Police.

Adherence to the University Parking Rules and Regulations is expected. Violations may result in fines and/or towing of your vehicle.

PAYDAYS

Paydays are every other Friday. Please note that there are 26 paydays in our fiscal year. Supplemental pay will be the last working day of the month.

Residents assigned to E.A. Conway, and Alexandria, still continue to be paid by LSUHSC-S. Medical Education will mail checks to the appropriate facility on the Thursday preceding the payday for you to receive your check on Friday. Residents assigned to VAMC, WK, Shriners, etc. will continue to be paid by LSUHSC. Your checks will be delivered to your departments.

If you have any questions regarding your check, please contact the Office of Medical Education or the Payroll Office.

PERFORMANCE RATING REPORTS

Your performance is evaluated at the end of each service rotation, or in the case of categorical residents and residents 2 through 6, at six-month intervals. These reports become part of your permanent record.

SALARIES

Salaries are reviewed on an annual basis. Salaries are listed by Post Graduate Year below.

PGY - I	\$44,168.00	PGY - V	\$50,720.05
PGY - II	\$45,500.00	PGY - VI	\$52,937.44
PGY - III	\$47,179.00	PGY - VII	\$54,890.83
PGY - IV	\$49,030.43	PGY - VIII	\$56,916.30

PRE-EMPLOYMENT REQUIREMENTS

The Louisiana State University Health Sciences Center-Shreveport consists of the School of Medicine and its teaching Hospital, Louisiana State University Hospital, and campuses of two other professional schools, the School of Graduate Studies and the School of Allied Health Professions. All are part of the statewide Louisiana State University Health Sciences Center. The Graduate Medical Education Committee (GMEC) supports the LSU Health Sciences Center pre-employment requirements, which include a drug screen and full background review, including a review of any questions, which may be raised concerning the application. The signature of the applicant on the application gives the Institution approval to verify any information pertaining to the application involving inquiries.

The Department of Human Resources coordinates the pre-employment process and reports any significant "findings" to the appropriate individual for action and/or follow-up.

Individuals who fail to comply with the pre-employment requirements may not be eligible for employment at LSU Health Sciences Center-Shreveport. The Department of Human Resources shall notify the appropriate individual (s) as soon as feasible.

In the event that a Resident's status changes and he/she does not meet the requirements established by the Institution, the Resident will be advised of his/her non-compliance and appropriate action will be taken. The action taken may include "leave without pay status" until compliance with the institutional

requirements are met, or the action may extend to Resident resignation, and/or termination.

GUIDELINES FOR RESIDENTS CHANGING GRADUATE TRAINING PROGRAMS WITHIN LSUHSC-S

If a Resident in a graduate training program in the University Hospital intends to leave that program prior to its completion to accept an appointment in another graduate training program within the institution, the Resident's intentions should be made known to the Clinical Department Head in which he is presently serving at least 90 days before the end of his contract period.

Chairmen who are discussing appointments to their Department should require the Resident to obtain a release from the Chairman of his present Department before making an offer to accept that Resident in his program.

RESIDENT QUALITY IMPROVEMENT

All residents receive instruction in quality assurance/performance improvement at the Annual Resident Orientation. The Residents are required to participate in the University's Quality Improvement Program as approved by the Clinical Board. Each clinical department is charged with including resident(s) in the discussion of the QI events in their department. As part of the educational program, it is important that autopsies are performed whenever possible and appropriate. The Autopsy Review is automatically included in the QI monitors for the clinical departments. The institution encourages the Resident to request an autopsy when appropriate in order to provide not only an adequate educational experience but to enhance the quality of patient care. The Medical Records System is available at all times and documents the course of each patient's illness and care.

LINES OF RESPONSIBILITY

All Residents in training programs function under the supervision of a member of the Medical Staff.

Each Clinical Service may have the following levels of supervision.

- Clinical Chair
- Section Chief
- Program Director
- Attending Physician
- Clinical Fellow
- Chief Resident
- Resident
- Medical Students

Other Allied Health Students and Medical Center Staff

Direct Supervision – the supervising physician is physically present with the resident and patient.

Indirect Supervision:

With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but it immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Each faculty member with direct teaching assignments must provide a written summary of the assessment of the Resident's performance during the period that the Resident was under his direct supervision.

MEDICAID NUMBER ASSIGNMENT

Medicaid ID numbers are issued to each Resident by the Department of Health and Hospitals through the Medical Education office. The number must be recorded on each Medicaid patient prescription, and will be pre-printed on your prescription pad. Your Medicaid number will remain active until you complete your training.

MOONLIGHTING

The direct provision of patient service for pay (moonlighting) is considered an augmentation and a privilege that should not detract from the goals and objectives of the educational program. Internal moonlighting hours must be counted toward the 80-hour weekly limit on duty hours, and monitored by the training program. Internal moonlighting is defined by the ACGME as moonlighting at the sponsoring institution or the non-hospital sponsor's primary clinical site.

The Graduate Medical Education Committee (GMEC) adheres to the standards set forth by the ACGME regarding moonlighting.

- A. Residents are not required to engage in moonlighting.
- B. If moonlighting does occur, each resident must have a written statement of permission from the program director that is made part of the resident's file.
- C. Resident performance will be monitored for the effect of moonlighting activities upon performance and that adverse effects may lead to withdrawal of permission.
- D. **PGY-1 Residents are not allowed to moonlight**

- E. Due to Federal Guidelines, individuals with the J-1 VISA are not allowed to moonlight.
- F. Time spent by residents in Internal and External Moonlighting must be counted towards the 80-hour Maximum Weekly Hour Limit.

External moonlighting is not included in the 80-hour weekly limit but must adhere to the standards set forth above.

As recommended by the Clinical Board, the Residents are encouraged to limit the number of moonlighting hours per month as outlined by their Program Directors.

Residents must notify their Program Directors of the average number of external moonlighting hours per month.

Residents are reminded that the Louisiana State Malpractice Plan does not cover malpractice for moonlighting hours outside the LSU System.

Under no circumstances should the Resident moonlight during their regular scheduled program hours of service.

Residency training programs may establish moonlighting guidelines more limiting than these, and must have written policies and procedures regarding duty hours and moonlighting.

The Medical Education Office processes moonlighting hours worked within the Health Sciences Center on a monthly basis.

NATIONAL RESIDENT MATCHING PROGRAM

Residency Program Directors are encouraged to utilize the National Resident Matching Program (NRMP) in the selection process of their incoming residents. The institutional administrator registers LSUHSC-S each year for participation in the NRMP. Each participating program director must register for participation in the NRMP via the NRMP website by agreeing to abide by the match agreement. Changes in quotas and other program data must be submitted to the Office of Medical Education for submission to NRMP. The Medical Education Office provides support to the Residency Programs in the data entry of the ranking listings. The Program Directors confirm the official NRMP results and the individual is then processed as a new resident.

OUT OF STATE – AWAY ROTATION

Requests for Residents to rotate to an away elective must be reviewed and approved by the Office of the Associate Dean for Academic Affairs prior to processing by the Legal Affairs Office. The review will allow Administration to determine if services are not offered at this facility and to review the benefits of the rotation provided by another facility or affiliation. It is the responsibility of the

Resident and Program Director to provide the required documentation for rotations that are not within the current affiliation rotations of the program. The Office of Legal Affairs requires at least two to three months to process the request. Appropriate supervision, license, evaluation, malpractice coverage, salary and other benefits will be addressed in the affiliation agreement by the Legal Affairs Office.

RESIDENCY CLOSURE/REDUCTION

The Graduate Medical Education Committee (GMEC) has delegated the responsibility of communicating results of all Residency Review Committee (RRC) surveys as follows. If the Residency Program should receive notification of a change in the Residency Program, the Department Chairman and/or Resident Program Director will notify the Residents of such changes, which include a reduction in the size of the residency program, or closure of a Residency Program. Interviewing and potential Resident applicants shall also be notified by the Department Chairman and/or Resident Program Director of a reduction or change in the status of a Residency Program. The notification shall be in writing to each resident enrolled in the current program and LSUHSC-Shreveport shall allow the Residents already in the ACGME accredited program to complete their education. or assist the Residents in enrolling in another ACGME accredited program to complete their education.

Further, it is the institution's policy to both inform Residents of the results of a Resident Review Committee survey and continue their financial support as outlined in the ACGME guidelines for Residency closure.

VISA RESTRICTIONS

VISA Eligibility and Requirements:

The Office of Legal Affairs serves as the liaison for all immigration issues involving Residents. The institution accepts applicants on a J-1 visa status to participate in training programs. The Educational Commission for Foreign Medical Graduates (ECFMG) should be contacted for application materials (www.ecfm.org). It is the responsibility of the applicant to initiate the visa process.

The U.S. code of Federal Regulations governing the alien physician category of the J-1 Exchange Visitor Program strictly forbids the performance of activities outside the primary objective of clinical training covered by the resident contract and is considered unauthorized employment. An exchange visitor who is found by ECFMG to engage in unauthorized employment is considered to be in violation of program status and may be terminated. In addition, the consequences of allowing unauthorized employment could result in a loss of federal grants and contracts for LSUHSC. The Resident is responsible for the continuity of his/her sponsorship or employment authorization to continue as a Resident at this institution.

Due to Federal Guidelines, individuals with the J-1 VISA are not allowed to moonlight.

**IMMIGRATION ACT OF 1990
FORM I-9 EMPLOYMENT ELIGIBILITY VERIFICATION FORM**

The Immigration Reform and Control Act of 1986 and the subsequent amendment by the Immigration Act of 1990 requires employers to verify that employees hired after November 6, 1986 are either United States citizens and nationals or aliens authorized to work in the United States. This law seeks to preserve jobs for those who are legally entitled to them. In order to comply with this law, LSU Health Sciences Center must complete and certify the Employment Eligibility Verification Form (I-9) for each new person hired.

The form requires each new employee to produce for employer examination and verification the appropriate original document or documents as listed on the reverse side of the form. If employees are unable to present the required document(s) within three (3) business days of the date employment begins, they may be subject to dismissal from the University. When an employee’s work authorization expires, the employment eligibility must be verified again. The employee must present a document that shows either an extension of the employee’s initial employment authorization or new work authorization. If the employee cannot provide this proof of current work authorization, LSU Health Sciences Center cannot continue to employ that person.

LSUHSC-S RESIDENT ASSOCIATION

The purpose of the Resident Association is to support residents experiencing difficulties, help improve the overall training environment, provide an avenue of communication between residents and the institution, and participate in decisions made by various hospital committees. Residents should feel free to voice any issues to our board members without fear of disciplinary action. Residents are encouraged to attend meetings, and express their opinions and ideas. All current residents are considered members. Board members are elected yearly. Feel free to contact any board member with questions and/or concerns.

Current Board Members are:

President –	Shubhrajana “Raj” Wadyal – Psychiatry
Vice-President –	Nafisa Ahmed – Pediatrics
Secretary –	Felix Geller - Psychiatry
Treasurer –	Prashant Chittiboina – Neurosurgery
Members-at-Large –	Krystal Baker – OB/GYN, Michael Henry – Pediatrics, Brenda Salvador – Pediatrics

RESIDENT PHYSICIANS AUXILIARY (RPA)

The RPA is an organization whose membership is open to Residents, Fellows, and their spouses or significant others of LSUHSC-Shreveport. Supporters of the RPA include the Medical Education Office of LSUHSC-Shreveport, the Shreveport Medical Society Auxiliary, and the Louisiana State Medical Auxiliary. The RPA provides a peer support group, offers social activities, helps newcomers get established. As a member of the RPA, you are invited to the Shreveport and Louisiana State Medical Auxiliary functions throughout the year. Membership dues are \$15 per year, which entitles you to receive monthly newsletters which keeps you informed of the group's activities.

Annual Projects/Events

- Newcomers Packet
- Welcoming Dinner
- Membership Tea
- Christmas Party

RESIDENT RESPONSIBILITIES

The Graduate Medical Education Committee welcomes you as a new employee. LSUHSC-Shreveport employees more than 5,000 employees who have chosen to work in this large teaching hospital and who contribute by their services to the important task of patient care, teaching, research either directly or indirectly. The future development of this campus depends on each employee, their pride, and a continued development of productive effort. The Graduate Medical Education Committee (GMEC) recognizes that communication plays a vital role toward your development. Toward that goal, the following responsibilities have been outlined to communicate your responsibility in maintaining LSUHSC-Shreveport a center of excellence in providing patient care, teaching and learning. The following guidelines will be reviewed with you during orientation and may be re-emphasized by your assigned training program.

As a Resident of LSU Health Sciences Center-Shreveport you will have the responsibility to:

- Participate in safe, effective, and compassionate patient care under the appropriate level of supervision and at the level of advancement and responsibility assigned by your home training program. The level of required supervision is provided in your assigned training program's goals and objectives. Further, the GMEC recommends that if a Resident does not understand what level of supervision is required in providing patient care that is his/her responsibility to seek appropriate clarification from the Program Director or Department Chairman.

- Comply and follow Hospital policies, EEO guidelines, Mandated compliance programs, the Medical Staff rules, regulations and bylaws for the Medical Staff; also to comply with the Joint Commission on Accreditation for Healthcare Organizations standards emphasizing the appropriate documentation of patient care including compliance with timely chart completion, clinical pertinence, etc.

Attend and participate on appointed institutional committees and councils whose actions affect future education and/or patient care.

Report to assigned patient care areas in a timely and efficient manner, notifying the direct supervising physician.

Provide an annual “confidential” evaluation of the educational experience of your assigned training program and of the faculty to the Program Director.

Attend and participate fully in Department or Institution specific educational and scholarly activities, which shall include the responsibility of teaching and supervising other students and residents in training. The requirements will vary from one resident to another but each resident is expected to meet compliance with the program’s requirements. Examples may include but are not limited to special case presentations, research, attendance at conferences and grand rounds, participation in lectures, teaching of other residents, students, written publications, etc.

Follow and adhere to other policies and procedures of the institution, such as Safety, Infection Control, Medical Records, Confidentiality, Information Management, and the use of support services in a cost effective and useful manner.

Complying with Federal laws and regulations, such as billing compliance, conditions of Medicare Participation, EMTALA/COBRA, etc. Maintain compliance with the ethics of the institution in providing safe and efficient patient care in a protected environment to assure the well being of all patients.

Adhere to patient confidentiality and other institutional requirements for the security of patient information.

POLICIES OF THE UNIVERSITY HOSPITAL

Policy number: 5.10
Effective Date: 8/01/05

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

ADMISSION TO LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER

PURPOSE:

To provide a mechanism to facilitate the inpatient admission of patients to LSUHSC.

POLICY:

1. LSUHSC welcomes all Louisiana resident patients of physicians on its medical staff. No patient is to be denied admission due to race, color, religion, ancestry, financial class or national origin. Non-resident (out of state) patients must make the necessary financial arrangements prior to admission.
2. Patients may be admitted to LSUHSC by faculty members of the medical staff with admitting privileges and by residents and fellows admitting patients to the designated attending physician for their assigned service. The patient's physician shall establish the patient's condition and provisional diagnosis on admission.
3. Acceptance of non-emergent admissions and transfers to LSUHSC shall be made contingent upon verification of available resources through Bed Control and patient eligibility for access to care at LSUHSC.
4. All admissions, excluding L&D and newborn admissions, require completion of the Admission Approval Form by the admitting physician.

Types of Admissions:

1. **Planned Admission** - A planned admission is an inpatient admission of a patient pre-planned in advance of the patient's presentation for inpatient care. All required admission paperwork (including the Admission Approval Form) is submitted prior to the date upon which the patient is to be admitted. The patient is instructed to report to the Admitting Department. There the Admission Face Sheet is printed and the patient is escorted to the appropriate inpatient area.
2. **Admission From Outpatient Clinics** - Patients may be directly admitted from one of the LSUHSC Outpatient Clinics. The

Admission Approval Form is completed in the Clinic and submitted to the Admitting Department. The Admitting Department completes necessary admission processes and the patient is transported to the assigned bed.

3. **Admissions From Outpatient Surgery** - Patients requiring inpatient admission following outpatient surgery are admitted by submitting the Admission Approval Form to the Admitting Department from the outpatient surgery area or from the PACU. The Admitting Department completes the inpatient admission process and the patient is then transported to the assigned bed.
4. **Admissions From the Emergency Room** - Emergency Room patients requiring inpatient admission must have the Admission Approval Form and other required information forwarded to the Admitting Department. The Admitting Department completes the admission process and the patient is transported from the Emergency Room to the assigned bed.
5. **Admission of Outpatient Observation Patients** - When an observation patient is determined to require inpatient care, a copy of the attending physician's orders is sent to the Admitting Department. A new face sheet, patient ID card and armband will be prepared and sent to the unit. The patient is then transferred to the assigned bed on an inpatient unit.
6. **Admission from Psychiatry Unit** - Psychiatry patients requiring inpatient admission must be discharged from the Psychiatry Unit prior to being admitted to an inpatient bed. The Admission Approval Form and other required information are forwarded to the Admitting Department. The Admitting Department completes the admission process and the patient is transported from the Psychiatry Unit to the assigned bed.
7. **Admission to Psychiatry Unit from an inpatient unit** - Patients must be discharged from an inpatient unit prior to being admitted to the Psychiatry Unit. The Admission Approval Form and other required information are forwarded to the Admitting Department. The Admitting Department completes the admission process and the patient is transported from the inpatient unit to the Psychiatry Unit.
8. **Admission to Pediatric Unit** – Special consideration must be taken concerning the exclusion of patients admitted to the unit. Such patients would be: gang members, prisoner patients, pregnant patients, patients with gun shot wound/stab wound resulting from criminal activity, patients with pending felony/misdemeanor charges, patients with previous sexual misconduct on the unit, and, in addition any patient deemed as an

inappropriate admission to the pediatric unit by the Chief of Pediatrics. Specific names and medical record numbers of such patients will be Forwarded to Admitting.

Transfer of Patients Definitions:

1. **Appropriate transfer**
 - a. The receiving facility has available resources and agrees to accept the transfer and provide necessary treatment, and
 - b. The transferring facility provides the receiving hospital with a complete copy of the patient's records and other information (such as copies of X-rays, etc.), and
 - c. The transfer is affected through qualified personnel and transportation equipment, including use of necessary and medically appropriate life support measures during the transfer.
2. **Transfer of Emergency Patients from Other Hospitals** - When a request for a transfer is received from a physician attending an emergency patient at another hospital, the call is transferred from the Physician Referral Office or from the Nursing House Manager to the Emergency Room. The Emergency Room then coordinates the data collection for the transfer of the emergency patient.
3. **Transfer of Trauma Patients** - When a request for a transfer is received from a physician attending a trauma patient at another hospital, the call is transferred to the Trauma Team on Call. The Trauma Service then coordinates the data collection for the transfer of the trauma patient.
4. **Transfer of Non-emergency Patients from Other Hospitals** - When a request for transfer of a non-emergency patient is made, verification of bed availability, space, facilities and personnel is made (see policy 2.11 "Access To Care"). Transfers of non-emergent patients to LSUHSC may be made by contacting a member of the LSUHSC medical staff with admitting privileges, or by contacting the Physician Referral Office during weekday business hours.

Administrator

___7/20/05_____

Date

Approved by Clinical Board: 1/12/01, 3/16/04, 7/19/05
Written: 11/86
Reviewed: 6/95, 2/96, 8/97, 5/00, 1/01, 2/04, 6/05
Revised: 6/95, 2/96, 8/97, 5/00, 1/01, 2/04, 6/05

LOUISIANA STATE UNIVERSITY MEDICAL CENTER - SHREVEPORT
UNIVERSITY HOSPITAL

AUTOPSY GUIDELINES

Purpose:

To establish guidelines for the performance of an autopsy and to monitor the efficacy of medicine, surgery or other treatment the patient received.

Policy:

- I. The Department of Pathology shall perform an autopsy when requested by a physician and properly authorized by the legal custodian of the body.

II. GENERAL AUTOPSY GUIDELINES

A. Medical staff shall attempt to obtain an autopsy in all deaths meeting at least the following indications:

1. Cause of death is not documented in the chart (Cause of death is not known with certainty on clinical grounds).
2. Patient expired within 48 hours of surgical procedure (or other invasive procedure).
3. Patient expired on a general care floor and was not a "no code" or did not have a terminal condition.
4. All obstetric and perinatal deaths (up to 6 weeks after delivery).
5. All neonatal and pediatric deaths (up to 18 years of age).
6. Cases meeting the definition of a coroner's case but for which the coroner has elected not to perform an autopsy.

B. Permission: In general, the right to grant permission for the autopsy rests with the following persons IN THE ORDER NAMED:

1. Judicially appointed curator, if one has been appointed.
2. Spouse (legal divorce voids any rights over deceased; common law spouses are not recognized in Louisiana).
3. Any child of legal age (18 years old).

4. Any parent regardless of age.
 5. Any brother or sister of legal age (18 years old).
 6. Any relative by blood or marriage who assumes the right to control the disposition of the remains.
 7. Any friend who assumes control of the remains.
 8. In the event a deceased person has no surviving legal next of kin as defined in (1) through (7) above, the person who is legally empowered to make burial arrangements for the deceased may authorize an autopsy.
- C. Permission for an autopsy shall be obtained by the attending staff physician or resident. When the next of kin is present, a written approval shall be obtained. The physician shall ensure that the form "Authorization for Autopsy" (SN 1061) is COMPLETELY and CORRECTLY filled out. In addition, the person granting permission MUST also sign a funeral home release.
- D. The Nurse Manager or Charge Nurse shall be responsible for reviewing the form for completeness and accuracy, especially for next of kin. Once completed, the form and patient's chart are sent to the Admitting Department by the Nursing Manager or Charge Nurse. If any part of the form is incomplete, it shall be that nurse's responsibility to contact the physician to complete the form, and to inform him/her that the autopsy cannot be initiated until the form is completed. If there are difficulties in getting the form completed, the Nurse Manager, Nursing Director or Administrative House Manager shall be contacted for assistance.
- E. In the event an incomplete or incorrect autopsy request form is received in Pathology, the following procedure will be utilized:
1. The Pathology resident or faculty member handling the case will contact the requesting physician or the contact person for that area listed on the Patient Care Services directory; this individual will be informed that the autopsy cannot be completed until the paperwork is corrected. An **Incomplete Return Form** will be attached to the request, indicating the problem(s).
 2. The paperwork shall be forwarded to the Morgue Desk in Admitting, where it will be picked up by the responsible party, completed/corrected and returned.

3. The Morgue Desk will notify Pathology when the autopsy paperwork has been returned.
 4. Pathology will pick up the Autopsy request and verify accuracy and completeness.
- F. When the person authorized to grant permission for autopsy is not present, witnessed telephone consent may be obtained. Such consent is secured by the attending physician or resident who telephones the legal next of kin, with a second staff person participating on an extension line, requesting the next of kin's permission to perform the autopsy. The conversation shall require the person called to:
1. Identify himself/herself orally.
 2. Affirm his or her relationship to the deceased.
 3. Give his/her approval of the procedure.
 4. Indicate any restrictions that are to be made.
- G. Restrictions shall be written and signed by the physician as well as the staff person who witnessed and/or participated in the conversation. The staff physician or resident should also obtain the funeral home release Orally at the time the autopsy approval is sought. (Refer to Hospital Policy 5.16.1 Informed Consent)

Reference: LA Medical Consent Law, Revised Statute 40:1299.50 et seq.

- III. The legal custodian of the body may request an autopsy be performed if the physician does not order one. The custodian must submit the request in writing along with payment (certified check or money order) before the autopsy will be performed. Each case shall be reviewed by a Pathologist, who may decline to perform the autopsy. Information regarding the cost of the autopsy, and expected time of completion can be obtained by contacting the Pathology Department during normal business hours. Autopsy requests are not considered emergent and typically are performed Monday through Friday.

Administrator

Date

Approved by Clinical Board: 5/15/01, 8/17/04
Written: 2/83
Revised: 5/97, 2/98, 4/99, 3/01, 7/04

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT
UNIVERSITY HOSPITAL

CORONER'S CASE

Purpose:

To establish the procedure for notification of all deaths that are mandated to be reported to the Coroner's Office pursuant to Louisiana Law R.S.33:1561.

Policy:

1. All deaths are screened using the following criteria and shall be reported to the Coroner's Office if the criteria are met:
 - a) Suspicious, unexpected or unusual deaths
 - b) Sudden or violent deaths
 - c) Deaths due to unknown or obscure causes or in any unusual manner
 - d) Bodies found dead
 - e) Deaths without an attending physician within 36 hours prior to the hour of death.
 - f) Deaths due to suspected suicide or homicide
 - g) Deaths in which poison is suspected
 - h) Any death from which natural causes occurring in a hospital under 24 hours of admission unless seen by a physician in the last 36 hours
 - i) Deaths following an injury or accident, either old or recent
 - j) Deaths due to drowning, hanging, burns, electrocution, gunshot wounds, stabs, or cutting, lightning, starvation, radiation, exposure, alcoholism, addiction, tetanus, strangulation, suffocation, or smothering.
 - k) Deaths due to trauma from whatever cause
 - l) Deaths due to criminal means or by casualty
 - m) Deaths in prison or while serving a sentence
 - n) Deaths due to a virulent contagious disease that might be caused by or cause a public health hazard, (Examples - Acquired Immunodeficiency Syndrome, hepatitis).
 - o) Deaths of all infants under the age of one year.
EXCEPTION: Stillbirth deaths are not reportable, UNLESS the death is associated with a crime/trauma.

IF THERE ARE ANY QUESTIONS CONCERNING WHETHER A DEATH SHOULD OR SHOULD NOT BE REPORTED TO THE CORONER'S OFFICE, CONTACT THE CORONER'S OFFICE FOR ASSISTANCE.

OFFICE OF THE CORONER OF CADDO PARISH

500 Texas Avenue
Caddo Parish Courthouse
Shreveport, Louisiana 71101
(318) 226-6881

2. With the approval of the Coroner's Office and the legal custodian of the body, Coroner's Cases may have an autopsy performed by the Department of Pathology at the discretion of the pathologist. The pathologist may elect not to perform an autopsy in a case where court litigation is likely. The Department of Pathology does not usually do autopsies on the following cases:
 - a. Death occurring by violence or by suspicious or unnatural means (homicide, suicide, accident).
 - b. Patients who are dead on arrival, who probably expired of natural causes, and who have no previous medical history at LSUHSC.
3. Patient Processing shall be responsible for notifying the Coroner's Office of a possible coroner's case immediately upon the patient's death.
4. If a Coroner's Case, the Coroner's Office shall be responsible for granting permission to release the body to either the Parish morgue or funeral home.

Administrator

Date

Approved by Clinical Board: 3/19/02, 6/21/05
Written: 2/83
Revised: 10/95, 12/99, 2/02, 5/05
Reviewed: 4/98, 5/05

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER -
SHREVEPORT

CODE BLUE RESUSCITATION TEAM

Purpose:

To administer Advanced Cardiac Life Support (ACLS)/Pediatric Advanced Life Support (PALS) to individuals who have experienced a cardiopulmonary arrest.

Policy:

1. The **Code Blue Resuscitation Team** shall include a qualified representative from Internal Medicine, Surgery, Anesthesiology, Respiratory Therapy, Blood Gas, Critical Care Nursing, EKG Technician and two interns from the medicine service. Pharmacy shall assist when staffing permits. Other individuals whose services are needed may be called upon to assist by any member of the Code Team.

The **Pediatric Code Team** shall consist of a representative from Anesthesia and Respiratory, the resident and staff M.D. for PICU, the night resident for the ward, and a PICU registered nurse. The person who calls the operator to report the code shall request the **Pediatric Code Team** be notified.

2. The **Code Teams** shall be “**on call**” for twenty-four (24) hours a day, every day. Each team member shall carry, for a designated period of time, during his/her period of duty, a designated code beeper. Length of duty shall be determined by individual departments and/or services. The switchboard operator beep the Code Team shall twice daily as a test to ensure proper functioning of the Code Team beeper.

3. Staff shall call 55007 to access the Code Team. Staff shall inform the switchboard operator which Code Team is required (adult or pediatric) and the location of the code (floor, room & bed number).

4. The switchboard operator, following notification of a Code, beeps the **Code Team** and other necessary personnel. In the event of a second code, while the other is still in progress, the operator shall beep the code team and the code director shall determine the appropriate disposition and assignment of personnel to assist.

5. Registered Nurses assigned to the Code Team shall have a current Advanced Cardiac Life Support/Pediatric Advanced Life Support card.

6. The **Code Team** shall be responsible for:

- a. Responding immediately to all Code Blues.
 - b. Conducting the code according to current Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) protocols.
 - c. Recording any pertinent data on the patient's record.
7. The Code Team Lead Physician shall document a Code note for placement in the patient's medical record.
8. The nursing unit, clinic, and/or department on which the Code occurs, shall be responsible for initiating Basic Life Support (BLS) until the **Code Team** can respond.
9. The Charge RN/Designee in the patient care area on which the Code occurs shall be responsible for:
- a. Overseeing traffic control on the unit.
 - b. Ensuring that emergency equipment is brought to the bedside.
 - c. Delegating duties to appropriate personnel to ensure the unit's continued function.
 - d. Serving as the recorder for the resuscitation efforts or delegating an appropriate person to do so.
 - e. Documenting and completing the Cardiopulmonary Resuscitation form.
 - f. Contacting the admitting office (5082) if the patient needs to be transferred to a critical care bed.
 - g. Evaluating the situation to see if additional personnel are needed to ensure that the Patient Care Area continues to function.
10. The patient's primary physician shall be responsible for:
- a. Making arrangements for an ICU bed if needed.
 - b. Informing the patient's family of the situation.
 - c. Completing the medical record if the patient expires, documenting the events leading up to the patient's death, cause of death, date and time of death, coroner's case, autopsy requested, and physician signature.

11. The nurse member of the Code Team is responsible for managing the crash cart during the code and administering the drugs when the M.D. is unable to do so, reviewing the code sheet documentation post code and following up to ensure complete documentation.

Administrator

Date

Approved by Clinical Board: 8/15/00, 7/15/03, 6/21/05

Written: 11/85

Reviewed: 2/95, 1/98, 5/03

Revised: 1/98, 7/00, 5/03, 5/05

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

INFORMED CONSENT

Purpose:

To assure that informed consent is obtained from patients in compliance with Louisiana State Law RS 40:1299.40-65.

Policy:

1. Informed consent shall be obtained and placed in the patient's medical record for surgical procedures, use of investigational drugs, emergency service treatment, administration of blood and/or blood components, ambulatory care treatment, and other services, including treatment of minors and the mentally disabled, sterilization procedures, anesthesia and/or deep sedation.
 - A. A **General Consent**, (SN 1175) shall be obtained during the following registration processes:
 - Full registration
 - Upgrade of a full pre-registration
 - ER registration
 - Inpatient admission
 - B. **Specific Informed Consent** (Form S/N 1035) shall be obtained for those procedures designated by the Hospital Clinical Board (see appendix A for definition and list) this includes operative and other invasive procedures.
 - C. **Blood Consent** (Form S/N 1012) shall be obtained for the administration of blood and blood products
 - D. **Chemotherapy Consent** (Form S/N 1141) shall be obtained for the administration of chemotherapy products
2. Completed general and specific Informed Consent forms on inpatients shall be valid for the duration of the current hospital admission for the indicated procedure(s). General Informed Consents for outpatients shall remain valid for a period of time not to exceed twelve months. Specific informed consents for outpatients shall remain valid for 30 days. Treatment protocols that require multiple encounters, such as chemotherapy and radiation therapy, require consent prior to initiation, but need not be obtained with each subsequent visit for that treatment.

3. In an emergency situation, consent for treatment is implied; allowing treatment to proceed without obtaining written patient consent.

Emergency situation is defined as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- a. placing the health of the individual in serious jeopardy,
 - b. serious impairment of bodily functions, or
 - c. serious dysfunction of a bodily organ.
4. Guidelines for Obtaining Informed Consent
 - a. It is the legal responsibility of the attending physician/dentist, his/her physician colleague, or physician consultant, to inform the patient of the nature and purpose of the procedure whether diagnostic or therapeutic and calculated risks involved in the proposed procedure.
 - b. The physician/dentist shall also be responsible for completion of the informed consent form with the following information:
 1. The patient's name and medical record number shall be stamped with the addressograph or hand written at the top right corner. Patient's name shall be written on line 1 as indicated.
 2. Complete the "Name of Treatment", "Site of Treatment:", "What it is" and "What it is for".
 3. Complete "Patient's Problem".
 4. Identify risks of the treatment.
 5. Identify risks of any surgery/procedure and anesthesia.
 6. Identify other choices.
 7. Provide specific physician's name(s) for the doctor or doctors for this treatment.
 8. Signatures of the MD, Witness and patient/person authorized to give consent, will be obtained by the physician, dated and timed.
 9. The physician shall print and sign his/her name. MD signature shall be legible. Physician signature acknowledges that he/she has afforded the patient (or other person authorized to give consent) an

opportunity to ask any questions about the medical or surgical procedures, risks, or alternative and that he/she has answered such questions to the satisfaction of the patient or other person authorized to give consent.

- c. No abbreviations shall be written on a consent form.
- d. The informed consent process and/or discussion shall be documented in the Physician's Progress Note as a written preoperative note.
- e. A physician/dentist (other than the one performing the procedure), medical student, nurse, secretary, nursing assistant, or any adult, may witness the signature. The witness signature only verifies patient identification and does not indicate or imply responsibility for informed consent regarding the nature, purpose and calculate risks of the planned procedures whether they are diagnostic or therapeutic.
- f. The patient shall be free of distractions and not under the effects of sedation when signing the consent form. Preferably, 4-6 hours time should have elapsed since the last sedation was administered prior to obtaining informed consent. However, if, in an emergency situation, pain medications are given prior to obtaining consent, it is the responsibility of the physician who will be performing the procedure/treatment to determine if the patient is capable of making an informed decision regarding their care, and document that fact in the medical record.
- g. Any evidence that the patient has not been informed, has reservations, or is hesitant about the procedure shall be reported promptly to the physician(s)/dentist planning to perform the procedure.

The patient may, at any time, repudiate and revoke the signed informed consent form prior to the procedure being performed.
- h. No elective surgery or procedure requiring an informed consent shall be performed without a properly executed, written consent. Non-valid or incompletely executed consent forms shall be grounds for cancellation of the procedure or surgery.
- i. Corrections to the information shall only be made in very rare occasions. It is more appropriate for a new form to be completed and the erroneous form discarded rather than being placed in the chart. In the event corrections are made on the form, the following steps must be followed:
 - 1. Draw a single line through the entry to be corrected.
 - 2. Write "error" immediately above or next to the error entry.

3. Record your initials and the date and time the correction was made.
 4. Write the correct information adjacent to the prior entry.
 5. Have the patient initial the corrected entry.
- j. Louisiana Medical Consent Law, revised Statute 40:1299.40et seq., specifically delineates the persons authorized to give consent, either orally or otherwise, for any surgical or medical treatment or procedures including autopsy not prohibited by law, which may be suggested, recommended, prescribed or directed by a duly licensed physician such as:
1. Any adult for himself (age 18 years or older)
 2. The judicially appointed curator, if one has been appointed.
 3. Any parent, whether an adult or minor, for his minor child.
 4. Any married person, whether an adult or minor, for himself and for his spouse.
 5. Any person temporarily standing in “loco parentis” whether formally serving or not, for the minor under his care and any guardian for his ward.
 6. Any female, regardless of age and marital status, for herself when given in connection with pregnancy or childbirth.
 7. In the absence of a parent: any adult for his minor brother or sister.
 8. In the absence of a parent: any grandparent for his minor grandchild.
- k. Consent for treatment of an incompetent adult, or an adult temporarily not Capable of giving consent, may be given by one of the following persons (in the order named):
1. Judicially appointed curator of the patients if one has been appointed.
 2. The patient’s spouse not judicially separated.
 3. An adult child of the parent.
 4. The parents of the patient.
 5. The patient’s siblings

6. The patient's other ascendants and descendants.

If there is more than one person within the above named class in "3" through "6" then the decision shall be made by all of that class available for consultation upon good faith efforts to secure participation of all that class.

- I. Minors in the State of Louisiana may also grant consent for the performance of medical or surgical care or services upon themselves. Consent shall be obtained from the parents, if the parents are available. Prior to acceptance of the minor's consent, the physician/dentist shall ensure that the minor understands the content of the consent. A minor, while having the right to consent to medical treatment, has no right to refuse medical treatment when that treatment is consented to by his parents and proposed by a licensed physician. (Op. Atty. Gen. No. 88-232, Nov. 16, 1988) (R.S. 40.1095)
- m. When the person, other than the patient, authorized to grant permission is not present; a witnessed telephone consent may be obtained. Such consent is obtained by the attending staff physician or resident, telephoning the legal next-of-kin with a second staff person (physician, RN) participating on an extension line, regarding the next of kin's permission to perform the procedure. The conversation shall require that person called to:
 - 1. Identify him/herself orally
 - 2. Affirm his/her relationship to the patient
 - 3. Grant his/her approval of the procedure
 - 4. State any restrictions, which are to be made

3. HIV Testing

Testing for HIV requires special protocols as well as a defined consent format in accordance with Louisiana ACT 1054. Informed Consent and Agreement to HIV Testing Form S/N 1163, may be ordered from the General Service Store. The following protocol should be followed in obtaining consent for HIV testing:

- a. HIV related test includes, but is not limited to:
 - 1. HIV antibody ELISA
 - 2. Western Blot and Immunofluorescent assay (IFA)
 - 3. HIV viral cultures

4. Polymerase Chain Reaction (PCR) test for detection of HIV
- b. No person will order an HIV-related test without receiving written informed consent by the patient or consent by the person authorized by law to consent to healthcare for the patient except as noted in “e” below.
- c. Prior to execution of informed consent the healthcare provider requesting the test shall provide to the individual or person legally responsible for consent to healthcare for the subject except as noted in “e” below.
 1. The nature of AIDS and HIV related illness.
 2. Behavior known to pose risks for transmission and contraction of HIV infection.

Note: Information contained on the consent form meets the minimum State requirements.

- D. Policy for testing HIV includes:
 3. Outpatient: Health care provider obtains consent through completion of the Informed Consent and Agreement to HIV Testing, Form # 1163. Lab order is entered into the laboratory requisitioning system with specific notation that consent has been obtained.
 4. Inpatient: Health care provider obtains consent through the completion of the Informed Consent and Agreement to HIV Testing, Form # 1163 which is written and processed by the standard procedure.
 5. Anonymous Testing: Persons requesting an HIV related test but wish to remain anonymous will be referred at no charge to a local site which provides anonymous HIV testing. (Parish Health Unit, Louisiana AIDS hotline at 1-800-99AIDS).
- e. Informed consent for HIV testing is not required in the following circumstances:
 1. By a healthcare provider/facility in procuring human body parts or blood for transplantation or transfusion.
 2. For accredited research such that the identity of the subject remains anonymous and cannot be retrieved by the researcher.

3. On a deceased person to determine the cause of death or for epidemiological purposes.
4. If, in the opinion of the healthcare provider requesting the test, the request for consent would be medically contraindicated. The contraindication must be documented in the patient's medical record.
5. On a child taken into custody of the Department of Social Services where department officials have cause to believe the child is infected with HIV.
6. On a child when the child's attending physician or health care provider reasonably believes such test to be necessary in order to properly diagnose or treat the child's medical condition and documents such reason in the child's medical record.
7. On any person arrested, indicated, or convicted for crime of aggravated rape, forcible rape, simple rape, or incest when required by court to undergo an HIV related test.
8. When a health care worker becomes contaminated by a patient's body fluid.

Reference: Journal of La. State Medical Society, Vol. 146, pgs 402-420.

Administrator

Date

Approved by Clinical Board 3/17/98, 5/16/00, 10/17/00, 2/20/01, 3/19/02, 4/19/05
Written: 2/83
Revised: 5/95, 4/98, 6/99, 7/00, 3/05

APPENDIX A

Informed Consent must be obtained prior to the performance of procedures involving the puncture or incision of the skin or insertion of an instrument or foreign material into the body, including but not limited to, percutaneous aspirations and biopsies, cardiac and vascular catheterization, endoscopies requiring conscious sedation, angioplasties, and implantation, excluding venipuncture and intravenous therapy. The following list of procedures has been designated by the Hospital Clinical Board as procedures requiring an informed consent but should not be considered all-inclusive and does not negate the need for obtaining consent for procedures meeting the above referenced criteria.

Abortions

Administration of blood and/or blood products

Amniocentesis

Anesthesia and/or deep sedation

Autopsy Consent – refer to specific form (N106-I)

Biopsies (including those done outside of the surgical suite, e.g. uterine, liver, muscle, Bone marrow core, pleural, lung-transbronchial and percutaneous, lymph node, Skin, nerve, eyelids, external eye, transrectal or perineal prostate biopsy)

Bronchoscopy

Cardiac (all invasive procedures)

Cardioversion (elective)

Chemotherapy for cancer treatment

Cisternogram

Close reduction of fractures and dislocations

Cryosurgery

Cutdown

Cystoscopy (Retrograde Pyelography)

Dilatation of Urethral Stricture

Endoscopies requiring conscious sedation

Experimental Drugs – refer to Pharmacy policy

Fetal Blood Sampling

Fetal Blood Transfusion

Fetal Skin Biopsy

Fluorescein Angiography

Gamma Knife

Gastrointestinal Procedures:

Colonoscopy

Endoscopies Retrograde Cholangiopancreatography (ERCP)

Esophageal Dilatation

Esophageal Motility

Gastric Tamponade

Hollander Test

Pneumatic Dilation

Polypectomy

Small Bowel Biopsy

Laparoscopy

Hemodialysis (Shunt)

HIV Testing – Refer to “Informed Consent and Agreement to HIV Testing”

Form #1163

Induction of Labor (elective)

Intra Uterine Device (IUD) insertion or removal

Laser Procedures

Line Insertions:

Elective Central Vein Catheterization

Intra-Aortic Balloon

Arterial Pressure Line

Swan-Ganz

Umbilical Artery & Vein Catheterization

Lumbar Puncture/Spinal Tap

Peritoneal Dialysis (Shunt)

Radiographic Procedures

Angiography (all)

Orbit Venogram

Lymphangiogram

Intravenous Pyelogram

Bronchography

Cholangiography

Discography

Inferior Vena Cavography

Lumbar Venography

Myelography

Renal Vein Catheterization (venography & renal vein sampling)

Radioactive Isotope Therapy/Therapeutic Doses

Subdural Tap

Sterilization

Surgical Procedures:

General Anesthesia

Local Anesthesia

Major Surgery

Minor Surgery

Paracentesis

Thoracentesis

Pericardiocentesis

Vitreous Fluorophotometry (VFP)

“LIVING WILL”

By revised Statute 40:1299.58.IA, Louisiana's legislature addressed the fundamental right of persons to control decisions related to withholding life sustaining procedures in instances where such persons are diagnosed as having a terminal and irreversible condition. Nothing in that act of the Legislature requires application of medically *inappropriate treatment of life sustaining procedures or, in any way, interferes with medical judgment with respect to the application of medical treatment of life sustaining procedures.

DEFINITIONS

1. *"Attending Physician"* means the physician who has primary responsibility for treatment and care of the patient.
2. *"Declaration"* means a witnessed document, statement, or expression voluntarily made by a patient or a person acting for a patient, authorizing the withholding or withdrawal of life sustaining procedures. A declaration may be writing, orally, or by other means of nonverbal communication.
3. *"Life Sustaining Procedure"* means any medical procedure **or** intervention, including but not limited to invasive administration of nutrition and hydration, which, within reasonable medical judgment, would serve only to prolong the dying process for a person diagnosed as having a terminal and irreversible condition. The "life sustaining procedure" shall not include any measures deemed necessary to provide comfort care.
4. *"Qualified Patient"* means a patient diagnosed and certified in writing as having a terminal and irreversible condition by two physicians who have examined the patient: one of whom shall be the attending physician.
5. *"Terminal and Irreversible Condition"* means a condition profound comatose state with no reasonable chance of recovery or condition caused by injury, disease or illness which, within reasonable medical judgment, would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death.
6. *"Witness"* means a competent adult who is not related to the declarant or qualified patient (whichever is applicable) by blood or marriage and who would not be entitled to any portion of the estate of the person from whom life-sustaining procedures are to be withheld or withdrawn upon his/her decease.

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING TREATMENT

Purpose:

To establish policy and procedure concerning the withholding or withdrawal of life-sustaining treatment at LSU Health Sciences Center.

Policy:

1. The competent patient has the right to determine which treatment options he/she will accept or decline, including withholding or withdrawal of life-sustaining treatments.
2. Life-sustaining treatments may be withheld or withdrawn:
 - a. upon verbal oral or written request of a competent patient. Verbal directives require witnesses and written requests require a notary;
 - b. as specified by a valid advance directive when a patient lacks decision-making capability;
 - c. at the request of the Surrogate Decision Maker on behalf of an incompetent patient who has a previous advance directive.

Definitions:

1. Life-sustaining Treatment – Medical care, procedures, or interventions, which when applied to a patient with a terminal illness, would have little or no effect on the underlying disease, injury or condition and which would serve only to delay the timing of death. This may include, but is not limited to, resuscitation, artificial nutrition and hydration, mechanical ventilation, and dialysis.
2. Terminal Illness – A debilitating condition considered to be medically incurable or untreatable in terms of currently available technology, and which can be expected to cause death.
3. Advance Directive – An oral or written statement made by a competent patient, which states his/her preferences regarding medical treatments, including but not limited to, life-sustaining treatments or which designates a surrogate decision maker who will make decision regarding medical care in the event the patient is unable to do so.
4. Surrogate Decision Maker – Refers to a person who is authorized by this policy, consents to withholding or withdrawal of life-sustaining procedures on behalf of a patient who lacks decision-making capacity.

The decision maker is any of the following individuals, in the following order of priority:

- a. The judicially appointed tutor or curator of the patient if one has been appointed; this paragraph shall not be construed to require such appointment in order that a treatment decision can be made under this policy.
 - b. A health care agent designated in writing by the patient through execution of a durable power of attorney for health care or similar document while competent, to make the treatment decision for him/her should he/she be diagnosed as suffering from a terminal condition and lack decision-making capacity.
 - c. The patient's spouse (not legally separated);
 - d. An adult child of the patient or, if the patient has more than one adult child, the adult children who are reasonably available for consultation;
 - e. The parents of the patient;
 - f. The patient's adult sibling(s)
5. Substituted Judgment – Means a decision made by a surrogate decision maker on behalf of a patient who lacks decision-making capacity and who has not executed an advance directive. Substituted judgment decisions shall be made on the basis of indicators of the patient's own desires or, when such indicators are absent or insufficient, on the basis of an assessment of the patient's best interest.

General Information:

1. Advance directives will be honored in most circumstances;
 - a. The document must be produced and must conform to the requirements of state law. If a patient or Surrogate Decision Maker wishes to execute a Living Will, the following forms are available:
 - SN 1288 – Living Will Declaration (by Adult Patient)
 - SN 1289 – Living Will Declaration (for Adult Patient)
 - SN 1290 – Living Will Declaration (for Minor Child)
 - b. To activate the document, the patient must be diagnosed as suffering from a terminal and irreversible condition as determined by two physicians, one of whom must be the treating physician, who have personally examined the patient.
 - c. The patient must also be mentally incapacitated and have little or no likelihood of regaining competency within a reasonable period of time as medically determined.

2. Patients may designate a Surrogate Decision Maker to direct the course of their medical treatment in the event they have lost decision-making capacity.
3. Patients are not required to execute an advance directive as a condition to receiving care.

Responsibilities:

1. Nursing Services will:

- a. ensure a copy of the advance directive is placed in the medical record;
- b. notify the attending physician if patient has executed an advance directive;
- c. consult Social Services if the patient wishes to execute an advance directive or change an existing directive or wishes to obtain additional information;
- d. enter appropriate activities or discussion of advance directives in the medical record.

2. Social Services will:

- a. upon notification from nursing, meet with the patient to provide information regarding advanced directives and/or answer questions.
- b. if the patient wishes to execute or change an advanced directive, the Social Worker shall assist the patient in completing the directive, and
- c. notify the patient's nurse that the patient has executed a directive.

3. Attending physician:

- a. assists patients in making decisions about advance directives by providing information necessary to make an informed decision;
- b. review advance directive with patient upon admission or at significant change in patient's condition, or at patient's request.
- c. documents reviews of advance directives in the medical record.

Other:

1. Any physician who does not want to participate in withholding or withdrawal of life-sustaining treatment for any reason will not be required to do so. The physician will so indicate this to his/her supervising physician who will assign

another physician who can comply with the declaration and assure the responsibility for the terminal care of the patient.

2. See also Hospital Policy 3.2 Staff Rights.

Administrator
5/21/07_____

Date

Approved by Clinical Board: 2/20/01, 5/18/04, 5/15/07

Written: 6/95

Revised: 12/97, 4/04, 4/07

Reviewed: 1/01, 2/04, 4/07

Hospital Policies and Procedures:

The LSUHSC – Shreveport Hospital Policy and Procedure Manual is available online at http://www.sh.lsuhs.edu/policies/policy_manuals_via_ms_word/home.htm. Please check the website for updates to the hospital policies listed in this manual as well as to find a comprehensive listing of all hospital policies. It is your responsibility to comply with all hospital policies during your employment.

AMERICANS WITH DISABILITIES ACT OF 1990 POLICY STATEMENT

Louisiana State University (LSU) Health Sciences Center is an equal opportunity employer and makes employment decisions on the basis of merit. We want to have the best available persons in every job. LSU Health Sciences Center policy prohibits unlawful discrimination based on race, color, creed, sex, age, national origin, physical handicap, disability, medical condition, sexual orientation, or any other consideration made unlawful by federal, state or local laws. All such discrimination is unlawful.

LSU Health Sciences Center is committed to complying with all applicable laws providing equal employment opportunities to all individuals. That commitment applies to all persons employed by LSU Health Sciences Center and prohibits unlawful discrimination by all employees, including supervisors and co-workers.

To comply with applicable laws insuring equal employment opportunities to qualified individuals with a disability, LSU Health Sciences Center will make reasonable accommodations for the known physical or mental limitations of an otherwise qualified individual with disability who is an applicant or an employee unless undue hardship would result.

Any applicant or employee who requires an accommodation in order to perform the essential functions of the job should contact the Department of Human Resource Management and request such an accommodation. The individual with the disability should specify what accommodation he or she needs to perform the job. LSU Health Sciences Center will identify the barriers that make it difficult for the applicant or employee to have an equal opportunity to perform his or her job. LSU Health Sciences Center will identify possible accommodations, if any, that will help eliminate the limitation. If the accommodation is reasonable and will not impose an undue hardship, LSU Health Sciences Center will make the accommodation.

If you believe you have been subjected to any form of unlawful discrimination, provide a written complaint to the Director, Department of Human Resource Management, within 180 days of the alleged discriminatory act. If the complaint relates to personnel of the Department of Human Resource Management, provide your complaint to the Vice Chancellor of Administration and Finance or to the Chancellor. Your complaint should be specific and should include the names of the individuals involved and the names of any witnesses. LSU Health Sciences Center will immediately undertake an effective, thorough and objective

investigation and attempt to resolve the situation. If the complaint relates to personnel of the Department of Human Resource Management, provide your complaint to the Vice Chancellor of Business and Reimbursements.

If LSU Health Sciences Center determines that unlawful discrimination has occurred, effective remedial action will be taken commensurate with the severity of the offense. Appropriate action will also be taken to deter any future discrimination. Whatever action is taken will be made known to you and LSU Health Sciences Center will take appropriate action to remedy any loss to you as a result of the discrimination. LSU Health Sciences Center will not retaliate against you for filing a complaint and will not willingly permit retaliation by management, employees, or your co-worker.

AFFIRMATIVE ACTION/EQUAL OPPORTUNITY STATEMENT

Louisiana State University Health Sciences Center in Shreveport is an Affirmative Action Equal Opportunity Employer and fully supports both in practice and in spirit, the full intent of Titles VI and VII of the Civil Rights Act of 1964, Executive Order No. 11246, and subsequent amendments. Qualified persons are employed and advanced without regard to race, color, religion, sex, national origin, age, handicap, marital status, or veteran status.

The Affirmative Action/Equal Opportunity Employment policy has been carried out through the development and maintenance of an Affirmative Action plan. The execution of this policy requires vigorous efforts to identify and attract qualified applicants from groups underutilized at all levels in the University. The policy further insures that all applicants receive fair consideration for employment and that all employees are treated fairly. Such action shall include, but not be limited to, the following: employment; promotion upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; selection for training; and tenure.

The Affirmative Action Equal Opportunity policy relates not only to employment but assures that no qualified person shall, on the basis of race, color, religion, sex, national origin, age, handicap marital status, or veteran's status, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any University program or activity. The provisions of this policy must be communicated to present and prospective employees and others by publication of the policy through campus policy statements, bulletins, catalogs; newspapers, magazines, annual reports, and other media; explanation in meetings of executive management, and supervisory personnel; communication to employees and any labor union with a collective bargaining agreement; inclusion where appropriate in every contract, lease subcontract, or purchase order; by posting on bulletin boards, and by listing in all recruiting material, including advertisements and application forms.

WORKPLACE VIOLENCE PREVENTION POLICY

Employees are the state's most valuable resource. Their safety and security at their job are necessary. Every employee should expect to perform his/her job in a place free of threats and assaults. The Governor of the State of Louisiana issued an executive order that workplaces for state employees should be free of violence. Louisiana State University Health Sciences Center – Shreveport is committed to a violence free workplace.

Workplace violence is, but is not limited to:

- (1) unwelcome name-calling, obscene language;
- (2) direct or indirect verbal threats that intimidate;
- (3) physically touching another employee in a way that intimidates, is hostile or is sexually harassing. This could be hitting, slapping, poking, kicking, pinching, grabbing, and pushing;
- (4) physically threatening others, such as obscene gestures, "getting in your face," fist-shaking, or throwing any object.

Employees at LSUHSC Shreveport must report to their immediate supervisor and/or department head all threats or incidents of workplace violence which they observe or of which they are informed.

An employee who has been threatened or assaulted by another by LSUHSC Shreveport should report the situation to his/her supervisor immediately. Depending on the severity of the incident, supervisors should do the following:

- (1) If the situation is dangerous, call University Police at #6165. Do not try to physically remove an individual.
- (2) Separate employees involved. Isolate them until they are interviewed and their statements are taken.
- (3) Document all actions and statement.
- (4) Contact the proper Administrative Staff and Human Resource Management to discuss further action.

Any employee found in violation of this policy may be subject to disciplinary action up to an including termination.

2.1.1 SEXUAL HARASSMENT

A. Policy

LSU Health Sciences Center – Shreveport is committed to providing a professional work environment that maintains equality, dignity and respect for all members of its community. In keeping with this commitment, the Medical Center prohibits discriminatory practices, including sexual harassment. Any sexual harassment, whether verbal, physical or environmental, is unacceptable and will not be tolerated. The purpose of this policy is to define sexual harassment and to establish a procedure whereby alleged sexually harassed employees, staff and students may lodge a complaint immediately.

B. Definition

Sexual harassment is illegal under federal (section 703 of Title VII of the Civil Rights Act of 1964), state and local law. It is defined as any unwelcome sexual advance, request for sexual favors or other verbal or physical conduct of sexual nature when:

1. Submission to the conduct is made either explicitly or implicitly a term or condition of individual's employment;
2. Submission to or rejection of such conduct by an individual is used as basis for an employment decision affecting the individual; or

The conduct has the purpose or effect of unreasonably interfering with the individual's performance or of creating an intimidating, hostile or offensive working environment.

Types of behavior that constitute sexual harassment may include, but are not limited to:

- unwelcome sexual flirtations, advances or propositions;
- derogatory, vulgar or graphic written or oral statements regarding one's sexuality, gender or sexual experience;
- unnecessary touching, patting, pinching or attention to an individual's body;
- physical assault;
- unwanted sexual compliments, innuendo, suggestions, or jokes; or the display of sexually suggestive pictures or objects

C. Procedures

Any member of the Medical Center Community who has a sexual harassment complaint against a supervisor, co-worker, visitor, faculty member, student or other person, has the right and obligation to bring the problem to Medical Center's attention. Any supervisor who witnesses such conduct or receives a complaint must report the incident to Human Resource Management, an appropriate administrator or the Dean of the respective school. It is the responsibility of all LSU Health Sciences Center employees in a supervisor capacity to insure that the work/academic environment is free from sexual harassment.

A staff member who believes he or she has been sexually harassed, should immediately report the incident to the Assistant Director or Employee Relations, Human Resource Management (318-675-5611) or to the Director of Human Resource Management (318-675-5620) or to an appropriate administrator or the Dean of the

respective school. In addition, staff members may report the incident to any supervisor. Any recipient of such a complaint shall notify Human Resource Management.

The Department of Human Resource Management will be responsible for investigating complaints of sexual harassment occurring between staff members; complaints made by staff students; and complaint made by staff against other third parties. Human Resource Management will either investigate or assist those responsible for investigating complaints made by or against faculty members, students or Residents.

Action taken to investigate and resolve sexual harassment complaint shall be conducted confidentially to the extent practicable and appropriate in order to protect the privacy of persons involved. An investigation may include interviews with the parties involved, and if necessary, with individuals who may have observed the incident or conduct or who have other relevant knowledge. The individuals involved in the complaint will be notified of the results of the investigation.

The Medical Center will not tolerate discrimination or retaliation against any individual who makes a good-faith sexual harassment complaint, even if the investigation produces insufficient evidence to support the complaint, or any other individual who participates in the investigation of a sexual harassment complaint. If the investigation substantiates the complaint, appropriate corrective measures and/or disciplinary action, up to and including termination, will be taken swiftly.

LSU Health Sciences Center – Shreveport will make every reasonable effort to insure that all members of the Medical Center Community are familiar with this policy. You are encouraged to address questions or concerns regarding this policy with the Assistant Director for Employee Relations, Human Resource Management.

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

SMOKING POLICY

Purpose:

To set forth the policy mandating LSUHSC a "Smoke Free" Facility.

Policy:

LSUHSC shall prohibit the sale and use of smoking materials throughout the facility. Exception: The Hospital recognizes that for some patients there may be medical reasons to permit a patient to smoke while hospitalized. A written physician's order must be obtained and the following criteria met.

CRITERIA FOR AUTHORIZATION OF SMOKING BY PATIENT
(Inpatient only; no outpatients are considered)

1. Physician must document reasonable cause for exception which may include the following:
 - a. terminally ill patient.
 - b. patient is undergoing detoxification for substance abuse.
2. The physician shall discourage smoking by the patient and explain the potential health hazards. No adolescent patient shall be approved for smoking as an inpatient.
3. No oxygen or flammables shall be allowed in the room.
4. The patient must be in an isolation room with no other patients.
5. The patient must be capable of sitting in a chair without assistance. Patients cannot smoke in bed.
6. There must be documentation of the patient's acknowledgment of the hazards of smoking in the progress notes, which should be signed by the patient, physician, and a witness.

ALL OF THE ABOVE CRITERIA MUST BE MET PRIOR TO AUTHORIZATION OF THE PATIENT TO SMOKE.

Administrator

3/27/07

Date

Approved by Clinical Board: 1/12/01, 3/16/04, 3/20/07

Written: 3/95

Reviewed: 9/97, 4/98, 12/00, 2/04, 1/07

Revised: 9/97, 4/98, 12/00, 2/04, 1/07

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

**TRANSFER OF UNSTABLE EMERGENCY AND TRAUMA PATIENTS
FROM OTHER HOSPITALS**

Policy:

To provide a mechanism to facilitate the appropriate transfer of Emergency patients as defined by the Emergency Medical Treatment And Active Labor Act (EMTALA) statutes from other hospitals. As a Level I Trauma Center, LSUHSC will accept all requests for trauma patient transfers regardless of residence. LSUHSC-Shreveport never goes on diversion for trauma patients.

Definitions:

- (1) The term “emergency medical condition” means,
 - a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
 - 1) placing the health of the individual (or, with respect to a pregnant women, the health of the woman or her unborn child) in serious jeopardy, or
 - 2) serious impairment of bodily functions, or
 - 3) serious dysfunction of any bodily organ or part
 - b. With respect to a pregnant women who is having contractions:
 - 1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - 2) that transfer may pose a threat to the health or safety of the woman or the unborn child.
- (2.) The term “stabilized” means with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to a woman in labor, she has delivered (including the placenta).

Procedure:

1. Requests from other health care providers to transfer patients who have an emergency medical condition as defined by EMTALA and require emergency and tertiary level medical care not available at that facility should be immediately approved when services, space, facilities, and personnel are available to provide appropriate care.
 - A. When the facility making the transfer request is capable of providing the necessary care, that facility must stabilize the emergency medical condition as defined by EMTALA prior to transfer (See the Hospital Policy 2.9.1 for transfer of stable non-emergent patients.)
 - B. When the transferring facility is requesting the transfer of an unstable patient, the following conditions must be met:
 1. Physician certification that the expected benefits of transfer outweigh the risks of transfer;
 2. There must be patient or family consent when possible;
 3. Attempts made by the transferring hospital, within its capability, to stabilize the patient in order to minimize any risks of the individual during transfer;
 4. Agreement by LSUHSC to accept the transfer, assuring our capacity and capability to treat the transferred patient;
 5. Delivery of all appropriate medical records to LSUHSC;
 6. The transfer must be made with qualified personnel and transportation equipment.
 - C. When the resources are not available at LSUHSC, the transfer should be denied with appropriate recommendations to contact another facility with comparable capability.
2. If an emergency patient requires services not available at LSUHSC, the transfer shall be refused with a recommendation to contact another facility with the necessary capability.
3. Transfer of patients shall be made by the referring physician contacting an active member of the medical staff of LSUHSC.
4. The LSUHSC staff member will obtain the details of the patients' emergent medical condition and contact Admitting. Admitting/ Administrative House Manager will verify that resources are available, and will notify the accepting physician that the transfer may be accepted.

5. All departments who receive requests for transfer of patients are requested to maintain this policy and procedure statement in a place accessible to faculty, residents, and other personnel to ensure that physicians who are involved in transfers adhere to its content. Questions should be referred to Hospital Administration.

Administrator

Date

Approved by Clinical Board 9/21/99, 8/15/00, 6/15/04, 1/17/06

Written: 2/95

Revised: 9/1/96, 5/98, 8/00, 5/04, 12/05

Reviewed: 9/99, 5/04

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

TRANSFER OF STABLE PATIENTS

PURPOSE:

To provide a mechanism to facilitate the “appropriate transfer” of stable, non-emergent patients who are residents in the State of Louisiana.

DEFINITIONS:

An “appropriate transfer” is defined as one in which:

- the patient has received an appropriate medical screening exam and it has been determined that no emergency condition exists or that the patient has received stabilizing treatment.
- the receiving facility has available resources and agrees to accept the transfer and provide necessary treatment, and
- the transferring facility provides the receiving hospital with a complete copy of the patient’s records and other information (such as copies of X-rays, etc.), and
- the transfer is effected through qualified personnel and transportation equipment, including use of necessary and medically appropriate life support measures during the transfer.

POLICY:

1. It is the policy of LSUHSC to accept the transfer of stable, non-emergent patients when space, facilities, and personnel are available and eligibility guidelines are met (See Policy 2.11 - “Access to Care”). Every effort shall be made to accept patients when the sending facility does not have the space, facilities or personnel to provide safe and appropriate care.
2. Transfers of stable, non-emergent patients to LSUHSC may be made by contacting an active or courtesy member of the medical staff or by contacting the Physician Referral Office during weekday business hours. In addition, transfers of patients attended by the departments of Surgery, Obstetrics/Gynecology, and Ophthalmology at E.A. Conway Hospital in Monroe, Louisiana may be facilitated by contacting the senior resident of that service at LSUHSC.
3. Decisions to refuse a transfer shall be made by or in consultation with an active faculty member.

4. Stable, non-emergent transfers should be directly admitted to hospital units. Arrangements for direct admissions shall be made by the accepting physician through the Admitting Office. **Exceptions to direct admissions should be rare and must be approved by the Emergency Department faculty.**
5. The accepting physician for a direct admission to a patient care unit must ensure that report regarding the patient's medical condition is given to an RN on the patient care unit where the patient will be admitted.
6. Patients for which referrals are sought through the Physician Referral Office will require the acceptance of an active or courtesy member of the medical staff.
7. Active and courtesy members of the medical staff may designate other members of the medical staff to accept transfers on their behalf.
8. Acceptance of stable, non-emergent patients for transfer to LSUHSC shall be made contingent upon verification of available resources through Bed Control and patient eligibility for access to care at LSUHSC.
9. For non-emergent, non-state residents see Hospital Policy 2.11.1.
10. LSUHSC shall not assume liability as the guarantor for further hospitalization or treatment for patient to be transferred from LSUHSC unless approved by the Hospital Administrator or his/her designee.
11. Transportation arrangements for patients to be transferred from LSUHSC shall be made through the department of Case Management.

 Administrator

 9/22/06

 Date

Approved by Clinical Board 9/21/99, 8/15/00, 10/21/03, 9/19/06
 Written: 11/86
 Revised: 6/95, 5/98, 8/00, 1/02, 10/03, 9/06
 Reviewed: 9/99, 9/06

INFECTION CONTROL DEPARTMENT

REDUCING THE RISK OF INFECTION FOR PHYSICIANS

Hospital-acquired infections occur in health care institutions. Approximately 50% of these infections are preventable when resident uses proper technique.

As the team leader, you make a difference. You are a role model for the health care team; your actions determine their technique.

The following principles of asepsis reduce the risk of infection for your patient and for you.

1. Use standard precautions for all patients — treat all patients the same.
2. Wash your hands before and after each patient contact with soap and water. Use an antiseptic soap before performing an invasive procedure, when hands have been heavily contaminated, and/or when working with a patient with a resistant microbe. Since the patient's diagnosis may be unknown, good handwashing techniques between all patients is a protective practice.
3. Wear clean gloves when handling all patients' body fluids. You never know what infections the patient may have before the work-up. Remove gloves after each patient contact, after contact with a contaminated area of the patient's body, and before contacting another part of the patient's body. Wash your hands thoroughly. Do not wash gloved hands.
4. The Bloodborne Pathogens Exposure Control Plan and the TB Control Plan found in the *Infection Control Bit* are available from your Department Chairman, the Infection Control Department, or the nursing unit. It is your responsibility to practice these protective measures.
5. If a patient has a history of coughing, "think TB". Hospital-related TB epidemics occur when patients are not diagnosed quickly. Assure patient has tissue to use for coughing and teach patients how to cover their mouth. Place a submicron mask on the patient if the patient has no breathing difficulty, but, do not leave the mask on the patient for more than 15 minutes. Place patient in a single room, preferably with negative pressure, as quickly as possible. If you are exposed to TB, consult Occupational Health for appropriate follow-up.
6. Place the patient in appropriate isolation when you suspect any infectious disease; do not wait until the diagnosis is confirmed.
7. When ordering isolation precautions, follow the hospital's isolation guidelines. These guidelines are located on each nursing unit in the *Infection Control Bit*. An isolation manual is available upon request from the Infection Control Department.
8. Perform a surgical scrub and wear sterile gloves when performing invasive procedures, especially when placing central lines. Chlorhexidine is the most

effective antiseptic. When in doubt, consult the nursing manager or the Infection Control Practitioners for the appropriate standard.

9. Remove invasive devices as quickly as possible. Patients are at increased risk of infection when they have invasive devices. The answer is to remove them as quickly as possible.
10. Stay healthy. If you are sick, take care of yourself and do not work until you are well. When you are ill, you are at risk of causing nosocomial infection. Also, while you are susceptible, you can contract a disease. Do not work if you have cuts, abrasions, or lesions that are leaking body fluid, especially on your hands and arms. You must not perform invasive procedures and/or surgery if you have cuts, abrasions, or infected wounds.
11. Do not eat or drink in a patient care area. Eating and drinking is allowed only in break rooms.
12. Do not treat employees; send them to the Occupational Health Clinic for job-related injuries or possible infectious diseases. Other health problems should be addressed by their private physician or the Ambulatory Care Clinic. Many difficulties have occurred from casual treatment of employees.
13. If there is a possibility of splashing of body fluids, wear appropriate PPE, (gloves, goggles, mask, and splash-proof gown). If you are exposed to any body fluids, contact the Occupational Health Clinic (6281) for appropriate follow-up.
14. Obtain the hepatitis vaccine. The influenza vaccine is also recommended for all physicians. This should be taken in late fall. These vaccines are available in the Occupational Health Clinic.
15. Acquaint yourself with the Infection Control policies for each patient care practice. These guidelines are current and approved by the Infection Control Committee. These procedures are located on each nursing unit.
16. When you have any questions, consult the Infection Control Practitioners at 5110.

Do your part to reduce the risk of nosocomial infection and be careful.
Protect your patient as well as yourself with a conscious-careful attitude.

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER -
SHREVEPORT

MEDICAL RECORDS CONTENT/DOCUMENTATION

Purpose:

To define the definitions, capture, analysis, transformation, transmission and reporting of individual patient specific data and information related to the process(es) and/or of the outcome(s) of the patient's care. The organization has a complete and accurate medical record for every individual assessed or treated. Every medical record entry is dated; its author identified and when necessary, treatment noted.

Policy:

A. Content of the Medical Record

1. Hospital inpatient medical records and outpatient surgery records are required to contain at least the following:
 - a. The patient's name, address, date of birth, sex and name of any legally authorized representative;
 - b. The legal status of patients receiving mental health services;
 - c. Emergency care provided to the patient prior to arrival, if any;
 - d. Documentation and findings of the patient's assessment;
 - e. Conclusions or impressions drawn from the medical history and physical examination;
 - f. The diagnosis, diagnostic impression or condition;
 - g. The reason for admission or care, treatment and services;
 - h. The goals of treatment and the treatment plan;
 - i. Evidence of known advance directives;
 - j. Evidence of informed consent when required;
 - k. Diagnostic and therapeutic orders;
 - l. Diagnostic and therapeutic procedures and test results relevant to the management of the patient's condition;
 - m. Operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;

- n. Progress notes made by authorized individuals;
- o. Reassessments and plan of care revisions, when indicated;
- p. Relevant observations;
- q. Response to care, treatment and services provided;
- r. Consultation reports;
- s. Allergies to food and medicine;
- t. Every medication ordered or prescribed;
- u. Every medication dispensed on discharge;
- v. Every dose of medication administered and any adverse drug reaction;
- w. All relevant diagnoses/conditions established during the course of care, treatment and services;
- x. Documentation of referrals and communications made to external or internal care providers and to community agencies;
- y. Conclusions at termination of hospitalization;
- z. Discharge instructions to the patient and family; and
 - aa. Discharge summaries or a final progress note or transfer summary.
- 2. Ambulatory care records generated in one of the hospital sponsored clinics require the following:
 - a. Patient identification
 - a. Relevant history of the illness or injury and of physical findings
 - b. Diagnostic and therapeutic orders
 - d. Clinical observations, including the results of treatment
 - e. Reports of procedures and tests and their results
 - f. Diagnosis or impression
 - g. Patient disposition

- h. Immunization status (pediatrics & adolescents) as appropriate to the patient's age & needs
 - i. Allergies
 - j. Growth charts (pediatrics) for Pediatrics Clinic and/or the Family Medicine Clinics whereby the facility serves as the source of primary care
 - k. Referrals, when necessary and/or appropriate
 - l. Communication to and from external practitioners or providers
 - m. Weight/length (pediatrics) as appropriate to the patient's age & needs
 - n. Developmental status (pediatrics & adolescents) as appropriate to the patient's age & needs
 - o. For those patients who are receiving continuing outpatient (ambulatory) services, a list of the following will be made upon initial presentation, if possible, however, no later than the third visit (third visit – when more complete information can be listed due to continuing care):
 - 1) Known significant medical diagnosis and conditions
 - 2) Significant operative and invasive procedures
 - 3) Adverse and allergic drug reactions
 - 4) Known long term medications (including current prescriptions, over-the-counter drugs and herbal preparations)
3. Emergency/Urgent/Immediate care records should contain the following:
- a. Time and Means of Arrival
 - b. Pertinent history of the illness/injury and physical findings, including the patient's vital signs
 - c. Emergency care provided to the patient prior to arrival
 - d. Diagnostic and therapeutic orders
 - e. Clinical observations, including the results of treatment
 - f. Diagnostic impression
 - g. Procedures performed
 - h. Conclusion at the termination of treatment, including final disposition and follow-up care instructions.
 - i. Whether the patient left against medical advice
 - j. Notation that a copy of the record is available to the practitioner or medical organization providing follow-up care.
- B. Chart Rules and Regulations
- 1. History and Physical Examination

a. A complete history and physical examination shall be completed and filed on the patient's medical record within the first 24 hours of admission and prior to the performance of any surgery. A durable, legible original or reproduction of a medical history and a completed physical examination – obtained in the physician's office or through an oral and maxillofacial surgeon on the medical staff – that is completed or thoroughly updated within 30 days before admission is acceptable, if the patient's condition did not significantly change during the period between documentation of the history and physical and admission to the hospital. In the case of emergency a preoperative note is recorded prior to the surgery/invasive procedure. In addition, the preoperative diagnosis & indicated diagnostic tests are completed and recorded in the patient's medical record before surgery/invasive procedure. The history should include the following:

- 1) Chief complaint
- 2) Present illness
- 3) Relevant past, family, and social histories, appropriate for age
- 4) Inventory of body systems
- 5) Evaluation of patient's developmental age (pediatric/adolescent records only)
- 6) Consideration of education needs and daily activities (Pediatric/adolescent records only)
- 7) Immunization status (Pediatric/adolescent records only)
- 8) Family and/or guardian's expectation for and involvement in, the assessment, treatment, and continuous care of the patient (Pediatric/adolescent records only)
- 9) Head circumference until fontanelles close (pediatric) as appropriate to patient's age & needs
- 10) Length/weight within the past 7 days (pediatric/adolescent)
 - b. The physical examination should reflect a comprehensive current physical assessment. The recorded history and physical examination must be authenticated by a physician or when appropriate, by a qualified oral surgeon member of the medical staff.

c. When a patient is readmitted within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available.

2. History (Inpatient Pediatric & Adolescent) – up to age 18.

Refer to Section 1 for other assessment requirements

The history for all pediatric patients must include the following:

a. Psycho-social Assessment documented, objectively reporting the family history and current living situation and assesses family dynamics and their impact on the patient's current needs, identifies those areas that may

need to be addressed in treatment and evaluates family dynamics for discharge planning.

b. The medical history should include relevant past, social, and family histories appropriate to the patient's age. A clinical assessment of each patient's needs, based on a social assessment is documented. Document social history of significance different from present.

c. Evaluation includes patient's developmental age as compared with chronological age. Document behavior or activities appropriate or inappropriate for chronological age, noting major areas of discrepancy, e.g., speech, gross motor, or fine motor.

d. Documentation of consideration of educational needs and daily activities. Play and other daily activities are relevant indices of children's and adolescents developmental level of functioning and psychological health. The need for a tutor or home bound instructions should be addressed.

e. Documentation of patient's immunization status. The hospital is responsible for requesting and recording information from the parents and/or guardians on the patient's immunization status. If the immunization status is unknown, this should be documented in the patient's medical record.

f. Documentation of evaluation of family's expectation for, and involvement in the assessment, treatment and continuous care of the patient. The medical record should document family and/or guardian contacts, both face to face and by telephone, with the patient and clinical staff. Document the parent's understanding of the prognosis and the anticipated length of stay.

g. Documentation of periodic review of the planned course of action, as appropriate. The treatment-planning process is completely individualized, based on current patient needs and clinical status. The treatment plan is updated when the patient's needs and response to treatment change. Document good daily progress notes with appropriate annotation of the parent's response to changes in the patient's progress.

h. Adolescent obstetric patients are assessed in the outpatient clinics during the initial obstetric assessment or at the time of admission to the hospital.

3. History and Physical Examination (Outpatient Surgery)

a. The history and physical information for outpatient surgery may be completed by a qualified physician or oral surgeon, but the individual performing the procedure **MUST** document (at minimum):

1) An evaluation note regarding the patient's overall condition and

- 2) Information regarding the operative/procedure site
 - b. The history and physical must be completed **within 30 days prior to the procedure** unless an unstable medical condition exists. If the patient is medically unstable, the history and physical examination must be completed within 72 hours of the procedure.
 - c. The outpatient history must include the following for outpatient surgery:
 - 1) Indications/symptoms for surgical procedure;
 - 2) Current medications (dosages/frequency)
 - 3) Any known allergies, including medication reactions, latex
 - 4) Existing co-morbid conditions, if any.
 - d. The extent to which the patient's physical status must be documented is to be reflective of the type of anesthesia planned and/or given, according to the following:
 - 1) No Anesthesia or Local/Topical or Regional Block:
 - a) Assessment of mental status; and
 - b) An examination specific to the procedure proposed to be performed and any co-morbid conditions.
 - 2) Moderate Sedation:
 - a) Assessment of mental status; and
 - b) An examination specific to the procedure proposed to be performed and any co-morbid conditions.
 - c) Examination of heart and of lungs by auscultation.
 - d) Allergies
 - e) Family History of Anesthesia problems
 - f) Medication History
 - g) Abnormal lab results
4. General, Spinal or Epidural Anesthesia:
 - a. **Complete Physical Examination**
 - b. Refer to Sections 1.B & 2.B for Pediatric & Adolescent requirements.

c. **Note:** Anesthesia combinations require a physical relevant to the highest level of anesthesia provided.

5. Post Operative Documentation

Post operative documentation includes:

- a. Patient's vital signs;
- b. Level of consciousness;
- c. Medications (including intravenous fluids), blood and blood components; any unusual events or post operative complications and management of such events;
- d. Name of providers of direct patient care nursing services or the names of people who supervised that care if it was provided by someone other than a qualified RN;
- e. Patient's discharge from the Post sedation or post anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria;
- f. If discharge criteria are used, they are approved by the medical staff. Compliance with discharge criteria is documented, and
- g. If the patient is discharged by a licensed independent practitioner, the practitioner's name is recorded in the post operative documentation.

6. Progress Notes

- a. The admission progress note should summarize the present illness, pertinent past history, the pertinent physical and laboratory findings, the initial impressions of the physician and the initial diagnostic and therapeutic plan.
- b. Progress notes (reassessments) should give a pertinent chronological report of the patient's course in the hospital and should reflect any change in condition and the result of treatment. An authenticated legible progress note is required daily to document medical necessity and acute level of care. All progress notes must be signed and dated.

7. Consultations

- a. A request for a routine consultation shall be noted in the physician's orders. The consultation request form shall be completed and placed on the patient's medical record. The form should indicate the current date, time, reason for consultation, requesting physician's signature, **printed name**, and hospital service and beeper number. The physician or his/her designee requesting the consultation is responsible for contacting the service to be consulted. A monthly listing of designated consultants for each Clinical Service is published and distributed each month to all patient care areas for utilization by the requesting physicians. Problems obtaining consultations should be directed to the attention of Hospital Administration.
- b. For outpatient consults, the physician shall submit consultations to the appropriate service.
- c. Emergency or 'stat' consultations should be requested only when there is an emergency or urgent need for the consultation. The consultation form

will remain on the chart. The physician will notify the Switchboard or the Clinical Service directly of the need for the consultation, giving the patient's name and location. Emergency or "stat" consultations should be answered within one hour of notification.

8. Informed Consent

Informed consent implies that the patient has been informed of the procedure to be performed, the risks involved, any alternative procedures and the intended outcome. Informed consent is documented by making 1) appropriate notes in the patient's medical record and 2) by obtaining the signature of the patient or his/her legal representative on the approved consent form. **The progress notes should reflect the content of the discussion with the patient and the physician's evaluation of the patient's understanding and response to the information provided.** All notes should show the date and time of the discussion.

9. Operative Reports

a. A legible comprehensive operative progress note should be entered in the medical record immediately after surgery to provide pertinent information for use by any practitioner who is required to attend the patient. A complete operative report should also be dictated immediately after surgery and should include the following:

- 1) A description of the findings;
- 2) Procedures performed and a description of the procedure;
- 3) The specimens removed;
- 4) The postoperative diagnoses;
- 5) Names of the primary surgeon and any assistants;
- 6) Estimated blood loss

b. The surgeon must authenticate the completed operative report as soon as possible following surgery.

10. Pre and Post Anesthesia Evaluation

a. There must be a pre-anesthesia note in the patient's medical record prior to administering anesthesia that is reasonably expected to result in loss of protective reflexes. The note shall specifically include:

- 1) a history and physical exam,
- 2) any abnormal lab
- 3) anesthesia plan for the procedure
- 4) patient's previous drug history
- 5) other anesthetic experiences
- 6) any potential anesthetic problems

b. The medical records shall also reflect a post anesthesia visit.

11. Diagnostic and Therapeutic Orders (DNR, Verbal and Telephone Orders)

a. These orders include those legibly written by medical staff members, residents and other practitioners within the scope of their professional practice.

b. "Do not Resuscitate" (DNR) orders must be countersigned by a faculty

physician.

c. Verbal and telephone orders shall be accepted by the following healthcare professionals – registered nurses, registered pharmacists, licensed respiratory therapists, certified/registered EEG technologists and physical therapists. Verbal and telephone orders are tagged upon receipt by authorized staff when transcribing the order into the chart. The tag serves as a reminder to the responsible physician that the order needs to be signed when he/she visits the floor. The physician shall countersign verbal and phone orders within 72 hours.

12. Transfers

When a patient is transferred within LSUHSC-S, from one level of care to another (for example, from hospital to residential care), and the caregivers change, a transfer summary may be substituted for the discharge summary (clinical resume'). A transfer summary briefly describes the patient's condition at the time of transfer and the reason for the transfer. When caregivers remain the same, a progress note may suffice.

13. Discharge Summary

a. The discharge summary should be completed before or shortly after the time of inpatient discharge from the facility and should follow the following approved format:

- 1) Patient Name:
- 2) Medical Record Number:
- 3) Hospital Service:
- 4) Attending Physician:
- 5) Resident Physician:
- 6) Referring Physician or Clinic:
- 7) Admission Date:
- 8) Discharge Date:
- 9) Discharge Diagnosis (**documented without the use of abbreviations**)
- 10) Reason for Hospitalization:
- 11) Significant Findings (physical and laboratory):
- 12) Hospital Course:
- 13) Procedures Performed:
- 14) Condition on Discharge (measurable comparison with condition on admission - able to swallow with minimum difficulty; afebrile and ambulating with crutch, no signs of infection, etc.):
- 15) Discharge Instruction (Diet, Activity, Medication, Follow-up):

b. A final progress note can be substituted for the discharge summary only for those patients with problems and interventions of a minor nature who require less than a 48-hour period of hospitalization and in the case of normal newborn infants and uncomplicated obstetric deliveries. The progress note documents the patient's condition at discharge, discharge instructions and required follow up.

c. In the case of death, the discharge summary is replaced by a death summary stating essentially the same information, plus a summary of

events immediately prior to death, including the cause of death as well as the date and time.

d. In the case of a patient leaving “Against Medical Advise” (AMA), the summary or progress note should include the same information, including events leadin up to the patient’s departure.

14. Signature Stamps/Electronic Signatures

a. Rubber signature stamps are not authorized for use in the patient’s medical records. Printed legible stamps are acceptable to provide interpretation of illegible signatures.

b. The Sunquest Information System allows for the use of electronic signatures. The Department of Pathology utilizes this function to authenticate reports. Security of the electronic signature function is maintained by “linking” the electronic signature to the Sunquest password of the pathologist who is authorized to use it. Passwords are assigned only by the System’s Manager or the Assistant System’s Manager.

c. The Radiology Management System allows for the use of electronic signatures for Radiology Results. Security of the electronic signature function is maintained by “linking” the electronic signature to the Radiology Management System password of the Radiologist/ Radiology Resident. The USER assigns passwords. (Radiologist/Radiology Resident) No one has access to their password and they are not known to anyone other than the user.

d. Electronic signatures/access to the Peritronics system is protected by password. Each user of the system has been given an individualized, secret password. Each person has a limited access code and the system is protected by access code level. System administrators are responsible for assigning access code levels, as deemed necessary and appropriate by medical staff and management.

e. The MUSE (Cardiology Information System) allows for the use of electronic signatures for Cardiology Results. Security of the electronic signature function is maintained by “linking” the electronic signature to the MUSE System password of the Cardiologist/Cardiology Resident. The USER assigns passwords. (Cardiologist/Cardiology Resident) No one has access to their password and they are not known to anyone other than the user.

f. SoftMed’s Electronic Signature Authentication (ESA) may be used to sign dictated medical record reports transcribed in the ChartScript application; these reports include discharge summaries, operative reports, history and physical exams, outpatient clinic notes, and some ancillary service reports. Physicians are given individual passwords, editing access and training on ESA prior to activation; each physician is required to sign a confidentiality statement. The users are prompted to reset passwords every thirty (30) days and the passwords are known only to the user.

g. The Department of Emergency Medicine utilizes the Drs. Choice Program to allow for authenticated reports in the use of electronic signatures regarding patient charting. Security of the electronic signature function is maintained by linking the electronic signatures to the Drs. Choice Program

password of the Emergency Medicine user who is authorized to use it. Passwords are assigned by the Business Manager or the Department Coder. Each person has a profile and the profile describes that user by ER Physician, Attending, Resident, PA, Nurse, Scribe, Other and Technician. Individual passwords are not known to anyone other than the user.

Reference: IM.6.10 – IM.6.60

Hospital Policy 6.13 – Telephone and Verbal Orders

Hospital Policy 5.16 – Informed Consent

Hospital Policy 5.19 - DNR

Hospital Policy 5.22 – Advance Directives

Hospital Policy 5.24 – Discharge Policy

Hospital Policy 5.26 – Conscious Sedation

Hospital Administrator

10/22/03

Date

Approved by Clinical Board: 8/15/00, 10/21/03, 1/16/07

Written: 10/94

Revised: 9/97, 11/97, 5/98, 8/00, 10/03, 7/04, 12/06

Reviewed: 12/06

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT
UNIVERSITY HOSPITAL

UNIVERSITY HOSPITAL DRESS GUIDELINES

Purpose:

To establish minimal acceptable standards of dress for employees of Louisiana State University Health Sciences Center-Shreveport.

Policy:

1. LSUHSC-S identification badges must be worn while on duty, displayed on the front portion of the outer garment, clearly visible and not obscured in any way. (See Hospital policy 3.9)
2. No sweat suits, shorts, athletic wear or non-approved lab jackets/scrub suits may be worn (see individual department policy for definition).
3. No hats, bandannas, sweatbands or headgear including earphones, radios, etc. may be worn unless required for safety or as part of the uniform.
4. No sleeveless (muscle) shirts may be worn. T-shirts may be worn in some departments (see department dress code) but must be free of slogans and objectionable language.
5. Halter or low-cut tops are not permitted.
6. See through apparel is not allowed.
7. Jeans, including colored jeans, may be worn if the employee has no patient contact as part of their duties. They should be neat, clean and free of holes or patches. Individual departments may elect to ban jeans.
8. No shorts or spandex attire shall be permitted. Skorts and culottes are permitted if they are appropriate in length and present a professional appearance.
9. Shoes are to be neat and clean. Tennis shoes are acceptable unless not permitted by safety regulations. Open toed shoes may be worn unless prohibited by Infection Control or Safety regulations. Thongs are prohibited.
10. Make-up, jewelry, and cologne/perfume shall not be excessive so as to cause disruption to patients or co-workers. Jewelry that poses a safety or infection risk shall not be worn.

11. Novelty buttons and badges with slogans are prohibited.
12. Hairstyles, beards and mustaches are to be clean, well groomed and conform to infection control and safe work practices.
13. Dress and personal hygiene which are considered in poor taste or disruptive to an organization, may be addressed by the supervisor as a violation.
14. Fingernails shall be kept short, clean, neatly manicured, and not extend past the fingertips. Artificial nails and nail extenders are prohibited during patient care for high-risk patients including: ICU's, BMT, OR, L&D, and when caring for patients in neutropenic isolation. Nail polish is prohibited in all operating rooms, NICU and the LU.
15. Specific departmental requirements shall be followed.

Administrator

Date

Approved by Clinical Board: 9/18/01, 1/18/05
Written: 3/95
Revised: 9/97, 12/99, 8/01, 10/04

OFFICE OF INFORMATION SERVICES

The Office of Information Services works closely with all areas throughout the LSU Health Sciences Center in public relations matters, including media relations.

We ask, as a matter of institutional policy, that our office be notified of any interview requests by the media made directly to an employee before the interview is granted. Any request to bring cameras or videotaping equipment into the hospital or medical school by the media must be cleared by the Office of Information Services, except for the Emergency Room where the University Police have guidelines we have established for that area.

Please call us at extension 55408 if we can be of assistance to you. If you have a matter that occurs after regular business hours (8:30 a.m. to 5:00 p.m.), the switchboard can contact me for you.

Information Services

I acknowledge receipt of a copy of the Louisiana State University Health Sciences Center-Shreveport Resident Manual. I understand that it is my responsibility to read and understand its contents. Any questions I may have about its contents should be directed to my program director. I understand that the information in the Resident Manual is not all-inclusive and that the Medical Center or an individual department may establish additional policies and procedures necessary for the orderly fulfillment of its responsibilities. I understand that it is also my responsibility to learn and follow the policies and procedures established by my department that are not included in the Resident Manual.

I recognize the Medical Center may, at its discretion, amend, add or eliminate policies when circumstances so require, and that I have a responsibility to do my best to keep apprised of any changes as they occur.

I agree to follow the Medical Center's policies and I am aware that failure to do so may result in disciplinary action up to and including termination.

Resident Name **(PRINT)**

Resident Signature

Resident Social Security Number

Date Received

**THIS DOCUMENT SHOULD BE PLACED IN THE MEDICAL EDUCATION FILE
PLEASE RETURN TO ROOM A1-19**