LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER
SHREVEPORT

MISSION STATEMENT

The Mission of Louisiana State University Health Sciences Center is to serve the State of Louisiana as well as the Ark-La-Tex region by providing:

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

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

VALUES

**Patient Expectations** are those aspects of care most appropriately identified by the patient. We believe the patients 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 patients’ interests are allowed to affect patient treatment show 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 much expertise to contribute towards identifying and meeting the needs of the patient. We believe the patient has the right to expect that these needs will be coordinated in an atmosphere, which supports quality, interdisciplinary respect, and professionalism.

**Available Resources** are the facilities, equipment, supplies, and people that improve the health of the patient. Resources are limited in quantity. We believe 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. We believe this can best be accomplished within a culture of mutual trust, mutual respect, and appropriate empowerment of patients, physicians, and hospital employees.

Hospital Administrator

4/23/07
Date
IMPROVING ORGANIZATIONAL PERFORMANCE POLICY

Purpose:

To ensure patients are provided high quality care in an environment of minimal risks. LSUHSC-S has the responsibility for monitoring every aspect of patient care from the time the patient enters the hospital through diagnosis, treatment, recovery, and discharge, in order to continuously improve the effectiveness of LSUHSC-S performance.

Policy:

The leadership of LSUHSC-S University Hospital has the responsibility for monitoring organizational performance. Through such monitoring the leadership identifies systems and processes that may contribute to the occurrence of negative patient experiences/events. By investigating and understanding the causes that underlie such events, changes in the organization’s systems and processes are made to reduce the probability of future occurrences. There is a defined mechanism for ongoing monitoring of performance with a quarterly report to the Clinical Board. The attached organizational chart depicts the communication process between Medical Staff Committees, Functional Medical Staff Departments, Hospital Clinical and Support Departments and Specialty Clinics. (For more details please refer to the Hospital PI Plan.) Each department/clinic/nursing unit will have a written plan to monitor, evaluate, and improve their performance.

Processes for improvement will be accomplished using the the Joint Commission 4 Step Plan for ongoing performance monitoring. Review of all plans will be no less than annually and may be revised throughout the year as necessary. In addition, at least one high risk process, as identified by the Joint Commission (published periodicals of most frequently occurring sentinel events and patient safety risk factors), will be assessed annually using the Healthcare Failure Mode Effects Analysis (FMEA).

The objectives of the Performance Improvement Program are to assure the following:

1) Clinical and administrative staffs monitor and evaluate the quality of patient care and clinical performance, including proactive risk assessment of selected high-risk processes. Assess the intended
and actual implementation of the process to identify variations or potential “failure modes”, and report information to the Clinical Board for action.

2) Communication of identified failure modes and potential impact on patient care/safety among departments/services when opportunities for improvement are multidisciplinary.

3) Identified problems are tracked to assure improvement or resolution through redesign of the process.

4) Information from Departments/Services related to tested and implemented process findings of discrete performance improvement activities are used to detect trends, opportunities to improve, or potential problems.

5) The objectives, scope, organization, and effectiveness of the redesigned processes are evaluated annually and revised as necessary to ensure effectiveness is maintained over time.
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER
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ETHICS COMMITTEE

Purpose:

To define the functions of the Ethics Committee.

Policy:

1. MISSION

The Mission of the LSUHSC institutional Ethics Committee is to facilitate quality patient care and family/staff communication by providing a forum for ethics education, consultation, support and policy formation/review. The committee promotes a systematic approach to ethical decision-making that is consistent with the mission, philosophy, and ethical code of behavior at LSUHSC.

2. FUNCTIONS

The functions of the Ethics Committee shall include (but not be limited to) the following:

a. Serve as an advisory body to the professional staff and administration when formulating, monitoring compliance with, and revising policies and/or guidelines related to ethical issues in health care.

b. Serve as a resource for the medical, nursing, and allied health staff, and patients and/or families, in dealing with ethical questions related to treatment. Case review will be conducted offering recommendations as appropriate. A Committee member will be available on a 24-hour basis for individual staff consultation. Persons desiring to contact a committee representative should call the hospital switchboard. The switchboard will page the on-call committee member.

c. Provide a forum for the interdisciplinary discussion of ethical and moral questions and concerns.

d. Monitor legislation and relevant legal proceedings in an effort to determine the ethical consequences of legal developments in the field of bioethics.
e. Review and discuss the bioethics literature for the purpose of self-education and to assist in the development of educational programs.

3. **MEMBERSHIP**

Membership of the LSUHSC Ethics Committee shall consist of representatives of at least the following:

a. Medical Staff – 2 members (one of which shall serve as Chairman and one of which shall be a member of the Department of Psychiatry.)
b. Hospital Administration
c. Pastoral Care
d. Social Services
e. Legal Counsel
f. Nursing
g. Lay Members of the Community
h. Investigational Review Board Committee Member
i. Patient Representative
j. Veterans Affairs Medical Center – Shreveport Ethics Committee Member

4. **MEETINGS**

The Committee shall meet at least quarterly.

________________________
Administrator

________________________
6/21/07
Date

Clinical Board Approved: 2/15/98, 5/18/04, 6/19/07
Written: 10/94
Removed: 12/00
Reinstated: 4/04
Revised: 6/95, 2/98, 3/04
Reviewed: 2/98, 3/04, 5/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

POLICY GUIDELINES

Purpose:

To provide guidelines for initiating, preparing, and updating policies and procedures and to outline the mechanism for approval, authorization and distribution. To ensure that policies are developed in collaboration with associated departments.

Policy:

1. Hospital-wide policies/procedures are developed for significant organizational issues that are interdepartmental or mandated to be hospital wide by accreditation agencies or state/federal legislation.

2. The Hospital Policy Committee shall be:

   A. Composed of representatives from Hospital Administration, Nursing Services, Professional and Support Services, Human Resources and the Business and Reimbursement Division.

   B. Chaired by a member of the Hospital Administration Staff. The Chair shall maintain a current distribution list for all policies, distribute policies for review, and insure timely completion of the process.

3. Committee members shall be selected annually by the Hospital Administrator with recommendations from the Administrative Staff.

4. The committee will identify the appropriate entity for policy development, and insure that input is solicited and incorporated into a final policy statement. Once completed, the committee shall submit the policy, with verification of review, to the Clinical Board for final approval. Following approval, the policies shall be signed by the Hospital Administrator and distributed.

5. Documentation of the review process and revised policies shall be maintained in an historical file for legal and reference purposes in Hospital Administration.
6. The Policy Committee shall meet monthly unless otherwise directed.

7. Policies shall be:

A. reviewed in committee, obtaining committee input as needed.

B. submitted to individuals/departments for additional comments and revisions as needed. The chairperson shall review and compile comments/revisions; final policy will be determined by committee majority.

C. submitted to the Hospital Administrator for final comments, revisions and written approval and will be effective upon such approval.

D. placed on the LSUHSC-S web-site. Persons unable to access the web-site may obtain a copy of the policy by contacting Hospital Administration.

8. Requests for policy introductions, revisions, or deletions, may be made by Medical Staff committees, Hospital committees, Hospital Departments, Medical Center departments, or individuals on the Hospital Policy Committee.

9. All Hospital policies will be reviewed at least every three years and/or as needed.

10. Department Specific Policies
Department specific policies and procedures shall be reviewed and revised at least every three years and as needed, to ensure compliance with institutional practice.

ADMINISTRATOR

9/22/06

Date

Approved by Clinical Board: 9/18/01, 2/19/02, 10/21/03, 9/19/06
Written: 10/10/94
Revised: 2/28/95, 12/99, 8/01, 2/02, 9/03, 9/06
Reviewed: 8/28/97, 9/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

CONTRACT APPROVAL

Purpose:
To communicate the approval process and the execution of contracts.

Policy:
Professional, Personal and Consulting Service Contracts with values less than $20,000 can be executed and approved on the local campus. A Contract (form S/N 5241) shall be completed by the Department Head specifying the services being contracted for; the contracted company/individual shall sign the form, including their tax ID or social security number and address and a signed Code of Conduct. The completed contract shall be submitted to the Assistant Administrator for approval. If the Assistant Administrator concurs with the need for the contracted service and a funding source is identified, he/she shall sign off on the line labeled “Department Head.”

After approval by the Assistant Administrator, the contract shall be forwarded to the Hospital Administrator with explanation of the need for services and source of funding. If the Administrator concurs he/she will submit the completed contract (and the Code of Conduct) to the Office of Legal Affairs for approval. Requisitions for payment shall be sent to the Office of Legal Affairs for transmittal to Travel and Direct Pay.

Once contractual services have been rendered, the Assistant Administrator is responsible for ensuring the completion of an evaluation of services rendered.

Refer to Administrative Directive: 4.2 for contracts above this funding level.

_______________________
Administrator

9/17/08

Date

Approved by Clinical Board: 1/12/01, 6/18/02, 7/19/05, 9/16/08
Written: 4/95
Reviewed: 8/97, 1/01, 5/05, 8/08
Revised: 5/02, 6/05, 8/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER -
SHREVEPORT

ACCESS TO CARE

Purpose:

To define the right to access for patients presenting for care at LSUHSC - Shreveport.

Policy:

1. LSUHSC – Shreveport Compliance with COBRA Federal Statutes and amendments and applicable Louisiana State Statutes.

   It is the policy of LSUHSC - Shreveport to fully comply with the COBRA Statutes, as amended, regarding the assessment, receipt of transfer, transfer, and refusal to treat patients.

2. Rights of patients Presenting for Emergency and Trauma Care at LSUHSC - Shreveport:

   A. All patients presenting for emergency and trauma care shall be registered and evaluated through the Triage system for determination of the presence of an emergency medical condition. All patients determined to have an emergency medical condition as defined in the Triage protocol shall be provided care to stabilize and/or complete the level of care necessitated by the patient’s emergency condition.

   B. Non-emergency patients will be provided continued care according to their residency status and the availability of resources.

3. Rights of Residents of the State of Louisiana to Access Care at LSUHSC - Shreveport:

   It is the policy of LSUHSC - Shreveport to provide access to care to all residents of the State of Louisiana without regard to their ability to pay. Patients are required to adhere to established payment policies (i.e. co-pay, deposit for non-urgent visits).
4. Rights of Non-Residents of the State of Louisiana Access to Care at LSUHSC - Shreveport:

LSUHSC – Shreveport shall provide an appropriate medical screening to any person who presents to the facility requesting examination or treatment for a medical condition. The medical screening shall be used to determine if the patient has an emergency medical condition or is in active labor, without regard to state residency or ability to pay. An emergency medical condition means a patient with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the individual’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

5. LSUHSC - Shreveport maintains transfer agreements and relationships with organizations/facilities in order to provide patients with the appropriate care when such resources are not available at LSUHSC - Shreveport. A list of all affiliation agreements is maintained in Legal Affairs Office.
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

TREATMENT (Non-emergent) FOR NON-RESIDENT PATIENTS

Purpose:

To establish criteria and payment for non-residents treatment and/or admission to LSUHSC-S.

Policy:

1. Refer to Hospital Policy 2.9 - Transfer of Emergency Patients from Other Hospitals, 2.9.1 - Transfer of Non-Emergency Patients and 2.11.3 – Nonresident Pediatric Patient Registration.

2. Medical staff requesting to perform medical procedures on non-US residents shall contact the Hospital Administrator, or his/her designee, prior to scheduling the procedure.

3. Non-Louisiana residents who are United States Residents presenting for a routine office visit shall be required to make a $250 deposit in the clinic prior to receiving care.

4. Non-Louisiana residents who are United States Residents presenting for non-emergent/elective inpatient, observation, and/or outpatient surgery/procedure care at LSUHSC-S without insurance or other third party benefits (Medicare or Medicaid) shall be required to make a down payment prior to receiving services.

A. The Medicare DRG, Fee Schedule, or Outpatient APC will be identified based upon the planned in-patient, or outpatient, procedure/diagnosis.

B. Down payment is required prior to the patient being admitted or receiving services.
   Surgical cases: 80% DRG/APC
   Medical cases: 80% DRG/APC

C. Accrued charges above the deposit paid shall be discounted 20%; the discounted amount will be the total amount owed, which is payable in full within 60 days of discharge.
5. Non-United States Residents presenting for non-emergent inpatient care, outpatient surgery/procedure, outpatient observation, and outpatient care at LSUHSC-S shall contact the Hospital Administrator, or his/her designee, to make arrangements for payment of service. The patient will be required to pay a down payment prior to receiving services.

A. The Medicare DRG, or Outpatient APC, will be identified based upon the planned in-patient, or outpatient, procedure/diagnosis.

B. Down payment is required prior to the patient being admitted to the facility or Clinic services scheduled.
   Surgical cases: DRG/APC plus 45%
   Medical cases: DRG/APC plus 15%

C. Accrued charges above the deposit paid shall be discounted 20%; the discounted amount will be the total amount owed, which is payable in full within 60 days of discharge.

6. Non-Louisiana resident “teaching cases” shall not be approved for waiver of deposits or charges for hospital services.

_______________________
Administrator

_______________________
8/20/09
Date

Approved by Clinical Board: 7/17/01, 8/17/04, 4/18/06, 8/18/09
Written: 7/96
Reviewed: 5/98, 7/04, 3/06, 5/09
Revised: 11/98, 4/99, 5/01, 3/06, 5/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

MANAGED CARE TRANSFERS INTO THE FACILITY FROM NON-CONTRACTED PROVIDERS

Purpose:

To appropriately and responsibly manage patients whose funding source requires admission to LSUHSC-Shreveport.

Policy:

It is the policy of Louisiana State University Health Sciences Center - Shreveport to accept contracted managed care patients for transfer from an out of network hospital. The case manager of the managed health care provider should request the transfer. An LSUHSC staff physician must accept and approve the transfer and a bed must be available.

Managed Care Case Manager

The case manager, employed by the managed health care provider, evaluates the patient and determines that further hospitalization is required and that it should take place at a contracting facility (LSUHSC).

PRS or House Manager

When the patient and his attending physician approve the transfer to the contracting facility, the case manager or referring hospital staff, advises the Physician Referral Service (PRS), or the House Manager if after hours, of the impending transfer into LSUHSC Hospital. The referring physician is directed to call the appropriate LSUHSC “on-call” physician to discuss transfer.

Physician, PRS or House Manager

1. If the patient is accepted, the accepting physician notifies the PRS office or the House Manager, if after hours, and submits the admissions approval form to Bed Control/Admitting. Bed Control will fax a copy of the admission approval form to PRS or House Manager. PRS will obtain necessary demographic information and proof of LA residency and then will facilitate the transfer when a bed is available including any requirements for isolation.
2. The PRS or House Manager notifies the floor or unit where the patient will be housed.

3. The floor/unit is given an estimated time of arrival.

4. The referring hospital calls the floor/unit and gives report regarding patient’s condition.

5. The ER is notified of the patient transfer and estimated time of arrival. This will enable the ER staff to appropriately route the patient to the assigned floor, should the patient present to the ER first.

The managed care case manager is to advise the managed health care provider of the transfer in order that an authorization number be generated. The financial counseling department at LSUHSC-S will contact the managed care insurance company to verify benefits and obtain the telephone number to call when additional clinical information is needed in order to certify the patient’s stay. The pre-authorization number is to be recorded on the admission approval form; the PRS transfer form, if prepared by PRS, as well as the admission face sheet. The patient’s registration screen in the Invision computer system should also reflect the pre-authorization number.

LSUHSC Staff

Admission and further care are provided to the patient as any other patient admitted to the facility.

______________________________
Administrator

4/23/07
Date

Approved at Clinical Board 2/20/01, 3/16/04, 4/17/07
Written: 10/97
Revised: 12/00, 2/04, 3/07
Reviewed: 12/00, 2/04, 3/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

NON-RESIDENT PEDIATRIC PATIENT REGISTRATION

Purpose:

To define the policy for registration and appointing a non-resident pediatric patient for services at LSUHSC - Shreveport Hospital.

Policy:

1. Non-scheduled Ambulatory Care and Emergency Care

A non-resident pediatric patient presenting for acute care will be seen without an advance deposit. The adult person accompanying the patient shall be informed at registration that they will receive a bill for all services rendered and they cannot be classified as free care. Financial arrangements for further care, along with appropriateness of referral to the patient’s state of residency for continued care will be considered in consultation with the patient’s physician.

2. The office of each physician specialist will determine the insurance status and the financial ability of the parent(s) of a non-resident patient referred for an ambulatory care visit at the time the patient is accepted. The subspecialty faculty or designated staff will inform the parent(s) of the non-resident deposit requirement and will determine whether the requirement for a deposit will be waived. If the deposit is not waived, it will be collected at the time of registration.

3. Inpatient, Outpatient Observation and Day Surgery

Non-emergency pediatric admissions, outpatient observation, or ambulatory surgery care for non-residents without financial
resources shall require Hospital Administration approval in advance.

\[\text{Administrator}\]

\[11/27/06\]

Date

Approved by Clinical Board: 7/17/01, 8/17/04, 10/18/05, 11/21/06
Written: 5/99
Revised: 5/01, 8/05, 10/06
Reviewed: 8/04, 10/06
ACCESS TO EMERGENCY SERVICE WITHIN 250 YARDS OF MAIN CAMPUS

Purpose:

To establish the appropriate response by off site clinics (within 250 yards of the main LSUHSC-Shreveport Campus) to receive, screen and stabilize patients presenting with emergency medical conditions in compliance with Emergency Medical Treatment and Active Labor Act (EMTALA) standards.

Definitions:

**Medical Emergency Condition** means a patient with acute symptoms of sufficient severity (including severe pain) that in the absence of immediate medical attention could reasonably be expected to result in placing the individual’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

**Trained clinical personnel** may be physicians, registered nurses, licensed practical nurses, physician assistants, or nurse practitioners who are trained in Basic Life Support and designated by the department or clinic.

Procedure:

1. Off site clinics that are within 250 yards of the main campus shall have trained clinical personnel who can respond to patients with emergency medical conditions.

2. When a patient presents in a condition that appears to be emergent, the patient shall immediately receive a screening examination from the appropriate trained personnel. If, after the screening examination, it is determined that the patient has an emergency medical condition, the following procedure shall be followed:
a. Personnel shall immediately notify Shreveport Emergency Services at 911.

b. Provide the dispatch with the exact location of the individual and a brief description of the individual's condition.

c. Call the LSUHSC-Emergency Department (@ 675-4569) to communicate the emergency and for the purpose of providing telephone assistance to the clinical personnel in their stabilization efforts.

d. Continue stabilization efforts until Shreveport Emergency Medical Service arrive at which time the Emergency Medical Service technicians will assume treatment efforts.

3. If a medical emergency occurs in a non-clinical setting including, but not limited to, parking areas within the 250-yard rule, personnel shall follow the guidelines listed below.

a. Immediately notify Shreveport Emergency Services at 911.

b. Provide the dispatch with the exact location of the individual and a brief description of the individual's condition.

c. Call the LSUHSC-Emergency Department (@ 675-4569) to communicate the emergency and for the purpose of dispatching appropriate personnel to assist.

d. Stabilization by LSUHSC personnel will continue until transportation occurs.

4. If transportation is required for any of the above stated conditions the patient will be transported to LSUHSC-Emergency Department. Patients treated under EMTALA will be accepted by the Emergency Department regardless of LSUHSC diversion status.

5. If an appropriate medical screening reveals no emergency medical condition, then EMTALA is no longer in effect. Clinic personnel shall utilize the following guidelines.

a. The patient is provided a follow-up appointment in the appropriate Ambulatory Care Clinic at LSUHSC.
b. The medical screening examination shall be filed in the patient’s permanent medical record.

[Signature]

Administrator

4/23/07

Date

Approved by Clinical Board: 2/20/01, 3/16/04, 4/17/07
Written: 2/01
Reviewed: 2/04, 3/07
Revised: 2/04, 3/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

APPROVED GUIDELINES AND MANUALS

Purpose:

To provide a listing of approved source documents, which may be referenced for specific policies and procedures regarding institutional operations.

Policy:

The following documents are recognized as approved guidelines and policies.

1. Hospital Policy Manual *
2. Chancellor's Memoranda *
3. Safety Manual *
4. Pathology (Clinical Laboratory Guidelines) *
5. Dietary Manual
6. Hospital Formulary *
7. Infection Control Manual *
8. Prohibited Abbreviations and Symbols *
9. Employee Handbook (Family and Medical Leave Act) **
10. Administrative Directives *
11. House Staff Manual *
12. Medical Staff Bylaws & Regulations *
13. Nursing Policy & Procedures Manual *
   a. Nursing Standards of Care *
   b. Wound, Ostomy, Continence Nursing Department
14. Information Management Plan *
15. Ambulatory Care Division Policy and Procedure Manual *
16. Compliance Program ***

* Access via the LSUHSC website at http://www.sh.lsuhsc.edu/adm.html
select Hospital Policy Manuals

Access via the LSUHSC website at http://www.sh.lsuhscl.edu/adm.html select Compliance Office

Approved by Clinical Board: 5/15/01, 6/15/04, 6/19/07
Written: 4/95
Reviewed: 9/97, 5/04, 5/07
Revised: 3/98, 5/01, 5/04, 5/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

ADOPTION PROTOCOL

Purpose:

To establish guidelines for hospital personnel to follow when providing referrals of potential adoption cases.

To provide instructions to adoption agencies and attorneys for private adoptions of the standard procedures required to facilitate the adoption process.

Policy:

When a mother expresses a desire to place her baby for adoption, the following procedures are necessary to assure that the adoption is completed in compliance with hospital requirements:

1. Clinical personnel shall contact Social Services if mother announces during routine clinic visit a desire to place infant for adoption.
   a. The social worker will discuss options and provide a list of adoption agencies for her to contact.
   b. If the mother has already made contact with an agency or an attorney, she will be instructed on what documents are needed.
   c. Social Services will make a notation in the mother’s clinic chart regarding the adoption plan.

2. Labor Unit personnel shall contact Social Services if the mother arrives in labor requesting to place the infant for adoption.
   a. Social Services will visit the mother.
   b. The mother will be asked if she desires to see the infant and/or requests visit by relatives to view the infant.
   c. A notation will be made in the mother’s chart regarding her requests.

3. Social Services will inform the nursery staff of adoption plans. A notation regarding the adoption will be made in the infant’s chart.

4. If the mother requests “no visitors”, hospital information clerks and nursery staff will be alerted to refrain from giving any information to callers and/or visitors regarding the mother and the infant.
5. The infant shall be kept out of view of the nursery window.

6. **Agency adoption**: If the mother desires placement through a particular adoption agency, that agency will be contacted by Social Services and advised of the following:
   
a. The agency representative will visit the mother to discuss placement plans and to obtain a consent authorizing the release of the infant to this agency for the purpose of adoption.
   
b. The original signed consent is placed in the infant’s chart. The Agency will receive a copy of this consent or may obtain a second original consent.
   
c. A notation will be made in the mother’s and the infant’s charts requesting that both discharges be delayed until the social worker informs floor nurses and nursery that all paperwork has been completed and is in the infant’s chart.

7. **Private Adoption**: If the mother desires placement through a private adoption agency, that attorney shall be contacted by Social Services and advised of necessary documents required before the infant’s release. The attorney will be given a copy of “Guidelines for Attorneys in Private Adoptions.” (See attached)
   
a. Any non-relative perspective adoptive couple must possess either:
      
      1). a certificate for adoption or
      2). A court order
      
      before the infant is cleared for adoption release.
   
b. The attorney will be given a copy of the hospital’s **Consent for Discharge Form** (see attached). This form must be signed in the presence of a notary following delivery.
   
c. The mother’s signed consent, releasing the infant to the attorney, shall be placed in the infant’s chart.
   
d. A notation will be made in the infant’s chart to delay discharge for adoption until a social worker informs the nursery and the mother’s nurses of the completion of needed paperwork.
   
e. A copy of the completed Consent for Discharge form shall be presented to the Billing Department by Social Services.
8. It is advisable that the infant’s release from LSU Health Sciences Center follow the mother’s discharge.

9. The attorney or adoption agency shall be notified of the infants discharge time.

10. Social Services will copy all medical data to accompany the infant.

11. Social Services will send a memo to Medical Records requesting that these admission records be labeled regarding restricted release of information.

12. In case of weekend delivery when the mother desires discharge to home without having completed adoption release forms, the following steps must be followed:
   a. Nursing personnel will have the Notification of Adoption Intent Form signed by the mother and placed on the infant’s chart.
   b. Nursery staff shall be contacted of plans for adoption.
   c. The OB social worker will provide follow-up.

References: See Nursing Unit Specific Policy Procedure NO.412.
GUIDELINES FOR ATTORNEYS IN PRIVATE ADOPTIONS

The following procedure is standard for all LSUHSC private adoptions. These guidelines must be followed to assure that the forthcoming adoption flows smoothly.

1. Attorney is contacted by either the mother or the social worker to inform him of the delivery and adoption intent. At this time, the attorney is advised of necessary required documents. These documents are: (1) infant discharge release consent; (2) financial responsibility statement from adopting couple; and (3) for non-relative adopting couples, a certificate for adoption or a court order must be presented.

2. Attorney should visit mother to obtain her signed consent authorizing release of infant to the attorney for the purpose of adoption. This consent must be signed in the presence of a notary public. An original of this consent is to be placed in the infant’s chart in the nursery.*

3. A financial responsibility statement must be signed by the adopting couple claiming their responsibility for the mother’s and infant’s hospital costs. This statement is to be submitted to the hospital billing department by the social worker. (This information could be included in the release statement if couple wishes to remain anonymous.)

4. Attorney is to be notified of planned discharge. Infant is to be discharged to attorney. Nursery staff must place infant in attorney’s arms.

5. Social Worker will copy all medical data on child and give to attorney at the time of discharge. Infant’s birth certificate shall be mailed to the address indicated with information submitted to Office of Vital Statistics. Attorney is to direct all inquiries to the social worker.

* See copy of Consent To Discharge of Infant and Release of Liability of LSUHSC-S.
PARISH OF CADDIO

CONSENT TO DISCHARGE OF INFANT AND RELEASE OF LIABILITY OF LSUHSC-S

BEFORE ME, the undersigned Notary Public, duly commissioned and qualified in and for the Parish of Caddo, State of Louisiana, therein residing, and in the presence of the witnesses hereinafter named and undersigned:

PERSONALLY CAME AND APPEARED:_________________________
(Mother’s name)

who declare that she is over eighteen (18) years of age, and that she is unmarried and that she is domiciled in ________________________________, and is the mother of a certain child, Baby ________________________________
born at Louisiana State University Health Sciences Center in Shreveport, Louisiana on the ________ day of ______________________, 20 ___.

Appearers further declared that the natural father of this child is not taking responsibility for this child and she is therefore signing this release alone for the purpose of releasing Baby _______________ to __________________________
(Attorney or Adoption Agency)
after he/she is released from the Louisiana State University Health Sciences Center in Shreveport.

Appearers further declares that she will execute an act of surrender not before five (5) days following the date of the birth of Baby ________________ which was ______________________ for the purpose of the adoption through said agent,
(Date)
______________________
(Attorney or Adoption Agency)
Appearer does hereby release LSUHSC-S, The Board of Supervisors of LSU, the State of Louisiana, its employees, agents, and assignees, from any and all liability of every kind and nature whatsoever which they may incur in connection with the release of the said minor child to the person or agency named herein, and I hereby authorize and direct the personnel of LSUHSC-S to deliver said child to ______________________________ and this document is to be considered for all purposes a full, binding and complete release.

I further authorize the release of the entire medical record of Baby ______________ to _________________________________.

I further acknowledge that I have read this instrument and understand its contents and have signed the same voluntarily and without representation coercion or inducement of any sort.

THUS DONE AND SIGNED in the presence of the undersigned witnesses and me, Notary Public, this ________ day of ________________________, 20 ______.

WITNESSES:

______________________________                             ________________
MOTHER OF BABY

______________________________

______________________________

______________________________                             ________________
NOTARY PUBLIC
NOTIFICATION OF ADOPTION INTENT

I, ________________________________, am hereby requesting to surrender for adoption my newborn child, born at LSU Health Sciences Center on the ______ day of ______________________, 20 ______. No prior adoption plans have been arranged. I have been informed of the medical center’s protocol on adoptions by the social worker.

I fully understand that adoption cannot be complete without my written authorization. As there is no available adoption agency contact over the weekend, I am aware that I must complete this process on the next business day. I am requesting my discharge to home today and will return to LSU Health Sciences Center on the next business day to sign the authorization consent. I have been informed that if I fail to contact the Nursery within 48 hours proceeding discharge, parish Child Protection Agency will be contacted regarding possible child abandonment.

I further acknowledge that I have read this notification and understand its contents and have signed that same voluntarily and without any representation or inducement of any sort with respect to the matters herein set forth.

WITNESSES:

___________________________   __________________________
MOTHER OF BABY
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
VISITATION POLICY

Purpose:

To communicate LSU Health Sciences Center – Shreveport visitation guidelines. To provide an access control that protects the rights of our patients, visitors, and employees to a safe, secure, and orderly environment.

Policy:

The Health Sciences Center recognizes the importance and the rights of patients to have visitors. A supportive Visitation Policy enhances the cohesiveness of the family unit and the patient’s support systems. Family waiting areas are provided on most Nursing Units, ICU’s, Operating Suites and Ancillary Departments. However, the Medical Center also recognizes that its primary purpose is to help improve the health of the patients entrusted to our care. On those occasions where situations of visitation potentially distract from the promotion of the healing process, actions may be taken which restrict or otherwise control visitation.

1. Visitation hours for general care units are from 6:00 a.m. to 9:00 p.m. daily. Visitation times for Special Care Units (ECC, OB/Peds, Critical Care and Psychiatry) are determined by each individual special care unit.

2. Only one approved person per patient may remain overnight on the General Care Unit after 9:00 p.m. Overnight visitors are not allowed on Women’s Health (fourth floor) unless there are extenuating circumstances, in which case visitation will be approved on an individual bases. All persons staying overnight with a patient after 9:00 p.m. or before 6:00 a.m. must be registered at the Information Desk located in the first floor front lobby. A visitor’s pass, specifying the nursing unit and date, shall be issued for one night only by the Patient Information Desk attendant who will instruct the visitor to remain on the assigned unit, and to wear the pass on the chest area where it is clearly visible at all times.

3. Children (under the age of 16) visiting patient care areas must be accompanied by an adult at all times. Children will not be allowed to stay overnight on a patient care unit or waiting area. Visitation by children may be restricted dependent upon the patient’s
condition and circumstances as deemed appropriate by the unit supervisor/charge nurse or Administrative House Manager.

4. Visitation shall be restricted or terminated for non-compliance with established visitor policies and/or declared emergency situations for the Hospital. If visitor control becomes a problem and cannot be managed by Unit personnel or the Administrative House Manager, University Police (6165) shall be contacted for assistance.

5. The University Police Department officers shall monitor all visitors entering the Hospital and determine if visitor security clearance has been met. Visitors not receiving security clearance shall be detained in the lobby and/or removed from the hospital premises.

Special Considerations:

1. Only one approved visitor may enter with the patient through the Emergency Care Center drive entrance at any time. All other ECC patients’ visitors must enter through the Kings Highway lobby, sign in and wait in the Triage waiting area or remain in the lobby.

2. Only two approved visitors may see a patient in the ECC area at a time. Only two approved visitors per patient may visit during posted visitation periods in the Critical Care Units.

3. All guarded prisoner-patients shall be denied visitors except terminal cases and those cases with special consideration as approved by the custodian authority and University Police Department. When special visitation privileges are authorized, prisoner-patient visitors shall be escorted by University Police.
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. Hats, bandannas, sweatbands, or headgear (including earphones, radios, cellular phones, or any entertainment device) are not allowed while on duty 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 or department policy. 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

__________________________
3/25/08
Date

Approved by Clinical Board: 9/18/01, 1/18/05, 3/18/08
Written: 3/95
Revised: 9/97, 12/99, 8/01, 10/04, 2/08
APPROVAL PROCESS FOR ACQUISITION AND IMPLEMENTATION OF 
PATIENT RELATED EQUIPMENT

Purpose:
To ensure that medical instrumentation under consideration for use within 
the medical center is evaluated prior to purchase, lease, or rental.

Policy:
1. Biomedical Engineering, in conjunction with nursing, medical staff, and 
other relevant departments will evaluate equipment prior to acquisition. 
The evaluation shall include an assessment of safety, infection control, 
and clinical effectiveness, conformance with the manufacturer’s 
specifications and applicable codes and standards, compatibility with 
existing systems, ergonomic and operational factors, and maintenance 
and operating costs throughout the equipment life cycle.

2. Requests for patient-related equipment will be forwarded to Biomedical 
Engineering through Hospital Administration for review. Biomedical 
Engineering will indicate whether technical service documentation is 
required as part of the equipment order and will complete their technical 
assessment. If problems or questions result from the review, Biomedical 
Engineering will communicate with the requesting department.

3. It is the responsibility of Biomedical Engineering, in conjunction with the 
requesting department, to develop purchase specifications when required, 
to develop installation requirements for stationary medical instrumentation 
systems, and to inform Physical Plant if construction or renovation is 
required, or if there are unusual or additional power requirements.

4. The Radiation Safety Committee shall review all requests for equipment 
that either utilize radioactive materials or electrically produce ionizing 
radiation (i.e. x-ray equipment, fluoroscopes, accelerators, etc.). It is the 
responsibility of the committee and the Radiation Safety Officer (RSO) to 
ensure that the equipment is to be used safely and in compliance with 
State of Louisiana (Department of Environmental Quality) and federal 
regulations. The equipment submission should be accompanied by:
a. Technical specifications including details of radiation producing components and/or materials. The RSO may require a physicists report in some cases.

b. Physicist shielding report if applicable.

5. If the equipment will require networking or interfacing to hospital systems (i.e. patient demographic data), the IT department shall review the request to ensure that the requisition/specifications include adequate provisions for networking and/or interfacing requirements.

6. Purchasing and Materials Management is responsible for ensuring that purchase specifications are met and that the required technical documentation is obtained.

7. It is the responsibility of the department manager to:

   a. develop an approved departmental procedure/policy for equipment use;

   b. develop a plan to document staff competency in use of the equipment; and,

   c. consult the Infection Control Practitioner prior to final development of departmental policy for input when the equipment will be used for direct patient care.

Administrator

4/23/07

Date

Approved by Clinical Board: 10/17/00, 3/16/04, 4/17/07
Written: 4/95
Reviewed: 4/98, 9/00, 2/04, 3/07
Revised: 4/98, 9/00, 2/04, 3/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER -
SHREVEPORT

MANAGEMENT OF EQUIPMENT SERVICE AND MAINTENANCE

Purpose:

To provide guidelines for obtaining maintenance and repair services for clinical equipment.

Policy:

1. Equipment used by LSUHSC-S for the provision of patient care shall be maintained by:
   A. Biomedical Engineering,
   B. Physical Plant,
   C. through the Asset Management Contract, or
   D. by contract or purchase order for services administered by the owning department.

2. It is the policy of LSUHSC-S that clinical equipment be properly maintained so that it functions as intended, and that services for maintenance and repair be obtained in a cost effective manner. Consequently, using departments should consider in-house sources for service if adequate resources are available.

3. If the using department determines that a service contract is required, a “Request for Service Contract” shall be submitted as per Hospital Policy 2.18.2. All contract requests must meet the requirements of the Asset Management Contract. Requests for “sole source provider” must provide adequate justification.

4. Biomedical Engineering shall serve as a resource for department managers in evaluating service needs, reviewing contract specifications and answering questions regarding the Asset Management Contract.

5. Purchasing shall provide assistance to department managers in preparing contract proposals.

6. Department managers shall send a copy of all documentation of services obtained by contract or purchase order by their department to Biomedical Engineering upon completion of the
service call. Biomedical Engineering and Physical Plant shall be responsible for documenting service on equipment for which they are responsible. The Asset Management contractor shall be responsible for service documentation on all equipment covered by that contract. Documentation shall include as a minimum the following information:

A. Equipment description (manufacturer, model and serial #)
B. Location
C. LSU number
D. Description of repairs
E. Description of maintenance and preventive maintenance

7. Each entity responsible for service documentation shall be responsible for compliance with laws and regulations governing the performance of equipment and shall be able to provide documentation of compliance.

8. It is the using department’s responsibility to notify Biomedical Engineering when clinical equipment is traded-in, turned-in to Surplus, or otherwise disposed of.

Administrador

_________________________
Adm inistrator

_________________________
3/27/07

Date

Approved by Clinical Board: 1/12/01, 2/17/04, 3/20/07
Written: 6/96
Revised: 11/98, 12/00, 12/03, 12/06
Reviewed: 12/03, 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

MAINTENANCE AND REPAIR
Single Vendor Contract Equipment

Purpose:

To provide a mechanism to appropriately access the single vendor service contract for maintenance and repair for specified equipment items.

Policy:

A. Access for Covered Items

1. Equipment items included in this contract shall have an assigned identification number. All service calls shall be governed by the specifications for each item referenced in the contract.

2. User departments shall identify a primary contact for reporting service calls. All calls will reference the identification number and a description of the nature of the problem.

3. Placing calls to the Site Coordinator:

   a. Repair and Service: Twenty-four hours a day, seven-days a week (24 x 7), please contact the Kinetic Biomedical Service hotline at 56335.

   b. If there is no response from the site coordinator, page the on-call Biomedical Engineering technician.

4. The Site Coordinator will arrange for repair or service of equipment by appropriate service personnel who will contact the department to arrange a specific time. In most cases a follow-up call by the Site Coordinator will be received.

5. Site Coordinator shall log and maintain all records for service and maintenance calls. Reports shall be generated on a scheduled basis concerning preventative maintenance inspections and service events.
B. Additions to Single Vendor Contract

1. Department complete the Single Vendor Service Contract Authorization Form: identifies equipment item, manufacturer’s service contract retail price, and specifications for repair and service; identifies object; forwards Authorization Form to Biomedical Engineering.

2. Biomedical Engineering forwards Authorization Form to the Site Manager for coverage cost and signature; the Site Manager returns the form to Biomedical Engineering; the Authorization Form is then forwarded to Hospital Administration and then to the Budget Office for adjustments to department budget.


4. Purchasing forwards a copy of the completed Authorization Form to department and Site Coordinator.

C. Deletions to Single Vendor Contract

1. Deletions are handled in the same manner as additions.

2. A service contract quote is not required for a deletion, however the site number form the equipment is required.

_______________________
Administrator

6/18/09

Date

Approved by Clinical Board: 2/24/97, 11/12/98, 1/21/00, 3/20/03, 4/18/06, 6/16/09
Written: 2/97
Reviewed: 0/00, 3/03, 4/06, 5/09
Revisions: 4/06, 5/09
Purpose:

To communicate the ethical code of behavior under which LSUHSC-Shreveport operates.

Policy:

LSUHSC shall carry out its operations in an ethically responsible manner. In conformance with the mission statement of the LSUHSC, all dealings with the patients and communities served through patient care, education, and research shall be conducted according to the organizational ethics noted below:

1. Marketing/Public Communications: LSUHSC shall not conduct or disclose misleading or inaccurate marketing or any other communications with the general public or governmental entities. All laws relating to regulatory disclosure of information shall be followed. Other public access to non-patient identifiable information may also be made available upon request to and approval from the Governing Body or its representative(s).

2. Admissions/Discharges/Transfers of Patients: LSUHSC shall maintain policies and procedures that address the ethical and lawful rights of patients as those rights relate to admission to, discharges from, and transfer to or from the facility. These policies are noted in Hospital Policy 2.11 “Access to Care”.

3. Billing Practices: The patient billing practices of LSUHSC require that all patients or their legal representative be responsible for timely payment of their bills by actively participating in financial counseling services necessary to determine third party coverage or free care eligibility (for qualified Louisiana residents only). Detailed billing policies and procedures are maintained by the Hospital and Physician Billing Departments.

4. Conflicts of Interest: All employees at LSUHSC are State of Louisiana employees and are subject to Louisiana Revised Statute
1950, Title 42, Chapter 15, “Code of Governmental Ethics.” As such, the requirements of this law prohibits employees from soliciting or accepting, directly or indirectly, anything of economic value as a gift or gratuity, from any person or firm who has or is seeking to obtain contractual or other business or financial relationship with LSUHSC. Further definitions and information regarding this law are contained in the Administrative Directives under “Code of Ethics For Louisiana State Employees.”

Purchasing Requirements: All acquisition of equipment, supplies, contractual services, and other expenditures of state appropriated funds must be in compliance with State of Louisiana Purchasing and Procurement Regulations. These regulations are described in the Administrative Directives section 3 “Purchasing” and additional information is available through the Purchasing Department.

LSUHSC Unclassified and Classified employees are required under Permanent Memoranda (PM) 11 to disclose any outside employment to the University. Specific regulations, documentation, and other information regarding outside employment may be obtained in PM-11 (copies of which are available in the Print Shop) or on-line at http://www.lsusystem.edu/policies/permanentmemoranda/. Employees who, by virtue of their position description, are authorized to purchase (or recommend the purchase of) goods and services on behalf of the Health Sciences Center are restricted from accepting offers of employment with vendors who the facility conduct business with. Employees pursuing such employment opportunities must, prior to accepting, request and receive, in writing, authorization to enter into said employment from the LA State Board of Ethics.

Faculty Members seeking to sell products or provide contractual services to LSUHSC must comply with the regulations specified in Permanent Memoranda (PM) 63. Specific regulations, documentation, and other information regarding outside employment may be obtained in PM-63 (copies of which are available in the Purchasing Department).

5. Louisiana Legislative Auditor Annual Review: The office of the Louisiana Legislative Auditor conducts an annual financial audit of the business records and practices of LSUHSC (which includes the business records of LSUHSC). The results of this review shall be reported to the governing body of LSUHSC and to the Division of Administration for the State of Louisiana. As a public entity, this annual audit is available for public inspection.
6. Other Ethical Issues: Other issues relative to the ethical behavior of LSUHSC staff are contained in the various sections of the Hospital Policy manual. Recognition of, compliance with, and providing services within the context of these policies form the code of ethical behavior by which LSUHSC seeks to accomplish its mission of providing the Ark-La-Tex community with quality patient care, a teaching environment for training future healthcare providers, and supporting research.

Reference: RI.1.4
http://www.lsusystem.edu/policies/permanentmemoranda/

Administrator

11/19/08

Date

Approved by Clinical Board: 5/01, 6/15/04, 6/21/07, 11/18/08
Written: 10/94
Reviewed: 5/95, 6/01, 4/04, 5/07, 10/08
Revised: 3/98, 6/01, 5/04, 5/07, 10/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

OBSERVATION BED POLICY

Purpose:

The purpose of observation beds is to provide facilities for those patients who require a period of observation to determine the need for further treatment or a possible admission to the hospital as an inpatient.

Definition:

Observation stays are generally twenty-four (24) hours or less. The time period begins when the patient enters the Observation Bed and ends when the Physician's Order to end the status is written. Such services may exceed twenty-four (24) hours only under extenuating circumstances, for which medical and safety issues prohibit release of the patient. Social issues, patient convenience, and transportation problems do not justify payment for observation services. Registrations of observation status must be ordered by a physician (or other individual with privileges to admit and order outpatient tests). The rationale for registrations to OBS must be clearly documented in the medical record. Observation status may NOT be used when a patient meets an acute level of care in accordance with the Hospital's admission criteria.

Policy:

Criteria for Observation Status:

1. Patients not meeting inpatient admission criteria but are exhibiting clinical signs/symptoms that would justify admission if they worsen or fail to resolve.

2. Standing orders for observation following outpatient surgery are not permitted.

   NOTE: Patients that are to undergo a procedure that should only be done as an inpatient procedure are NOT to be placed into Observation Status at any time during their stay.

3. The following patient unit/diagnosis SHOULD NOT be placed in observation status:

   A. Special Care units (BICU, MICU, NICU, PICU, SICU)
B. Head injury with loss of consciousness and frequent monitoring of neurological and vital signs
C. Suicide attempts
D. Delirium tremors
E. Respiratory isolation
F. Patients scheduled for an invasive procedure that should only be done on an inpatient basis.

5. Patients with the following obstetrical diagnoses may be registered as an observation Labor and Delivery patient (LDO). This list is not inclusive:
   A. Check for active labor
   B. Decreased fetal movement
   C. Abdominal trauma during pregnancy

6. Patients receiving intravenous services that last overnight or longer should be admitted as an inpatient. Observation should not be billed concurrently with therapeutic services such as chemotherapy.

**GUIDELINES/GENERAL COMMENTS**

1. No observation registrations for patients requiring an acute level of care (those meeting the Hospital’s admission criteria).

2. There must be a written order for observation status. In addition, the Admission Approval form must be checked off in the “Observation” box so the patient may be placed in observation status. Also, there must be documentation in the medical record addressing why the patient is in observation, and the treatment plan to be administered. All one-day stay admissions require review and approval of case manager prior to billing.

3. If the patient’s stay is longer than 23 hours, the record must reflect the extenuating circumstances that caused the discharge delay. Any observation stay greater than 24 hours for reasons that do not meet the definition of “extenuating circumstances” shall be referred to the Utilization Review Committee.

4. If at any point during observation status a patient meets acute level of care criteria, observation status must end immediately and the patient should be admitted.

5. If the patient’s status is changed to inpatient, the physician must write a new set of admit orders, including date and time, and document the specific reason(s) for admission.
6. Patients admitted for observation receive care according to the same hospital standards, policies and procedures as inpatients.

7. Observation is not to be used as a substitution for outpatient care.

8. Patients on observation status must not be allowed to leave the hospital on pass.

9. Observation beds status may not be used to place patients in house overnight, who are scheduled for inpatient surgery the next day, but have no place else to stay.

10. All exclusions for reimbursement for Observation Status are based upon Centers for Medicare and Medicaid Services (CMS) and other third party payer guidelines.

____________________
Administrator

9/17/08
Date

Approved by Clinical Board: 9/19/00, 12/17/02, 7/19/05, 9/16/08
Written: 2/95
Reviewed: 8/08
Revised: 10/97, 8/00, 1/03, 6/05, 8/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PRISONER - PATIENT

Purpose:

To provide and maintain a safe environment for all personnel and visitors during hospitalization of a prisoner-patient.

Policy:

1. All prisoners treated at LSUHSC shall be provided a guard by the law enforcement agency having custody of the prisoner.

2. Only commissioned police officers* shall be permitted to carry or possess firearms in the HSC. (* A member of a recognized municipal, Parish, State or Federal police force or agency).

3. No one shall be allowed to carry or possess firearms on the Psychiatric Unit – 10th Floor. A weapon lock box is available on the 10th floor at the entrance of the unit.

4. Admission of prisoner patients
   
   A. If the prisoner has been brought to ECC, Patient Processing shall obtain the patient information and complete the admitting process in the ECC area.

   B. If the prisoner is being admitted from another area, ie, clinic, the prisoner shall go to the detention cell while the guard accompanying the prisoner brings the following information to Patient Processing:

      Prisoner name
      Date of Birth
      Race
      Social Security Number, if available

5. Prisoner-patients who meet the chronological age requirement for Pediatrics, but who are admitted on prisoner status, shall not be admitted to the Pediatric Unit. These patients must be admitted to the appropriate adult unit, i.e. Medical, Orthopedic, etc. Juvenile and adult prisoners shall not be admitted to the same room.
6. Prisoner-patients shall not share a room or bathroom with any other patient except another prisoner patient and shall have a guard at his/her bedside at all times.

7. Prisoner-patients shall receive disposable flatware on their meal trays.

8. Prisoner-patients shall be shackled upon entering the hospital and shall remain shackled throughout their stay unless their medical treatment or condition dictates otherwise, as determined by a physician.

9. Prisoner-patients are not allowed telephone privileges.

10. When it becomes necessary to transport prisoner-patients within the medical center, the freight elevators shall be utilized.

11. All guarded prisoner-patients shall be denied visitors except terminal cases and those cases with special consideration as approved by the custodial authority and Hospital Administration. When authorized, the prisoner-patient visitors shall be escorted by the University Police. (See Hospital Policy 2.16).

12. The University Police shall be notified immediately by the patient care unit in the event of the death of a prisoner-patient. University Police shall notify the law enforcement agency having custody of the prisoner. Patient Processing shall notify the coroner’s office of all prisoner-patient deaths.

13. The daily census from each nursing unit shall indicate all those patients under guard so that the information desk personnel do not allow visitors for those patients.

14. The nursing staff shall contact Hospital Administration and University Police if the guard does not comply or stay at the bedside, or for any other problems with prisoner-patients.

15. Prisoners brought to the institution to be seen in a clinic shall remain in the detention cell until the clinic calls for them.

16. Upon discharge from the hospital, the guard will receive all discharge instruction/medication reconciliation paperwork, prescriptions, appointments and all other information regarding the prisoner patient’s follow-up needs.
Hospital Policy Manual
Policy number: 2.20
Effective Date: 4/01/09

Approved by Clinical Board 1/12/01, 3/16/04, 4/19/05, 4/15/08, 3/17/09
Written: 1/83
Reviewed: 10/95, 2/04, 3/05, 3/08, 2/09
Revised: 10/97, 2/00, 6/00, 1/01, 2/04, 3/05, 3/08, 2/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

FEE ASSESSMENT FOR ONSITE CLINICAL EDUCATION/TRAINING

Purpose:

Prior to the establishment of a contractual relationship between LSUHSC and an outside entity for the purpose of providing on-site education/training experiences, it is necessary to determine what, if any, fee(s) will be assessed. Fees will be assessed in order to offset expenses associated with such experiences.

Definition:

Public Entities - Defined as one in which a portion of its operation is dependent upon public tax support and is owned or operated as an entity of the state or another governmental agency. This may include quasi-governmental organizations.

Private Entities - Private entities are any other entities, including but not limited to, 501(c) 3’s, not-for-profit, proprietary, and all out of state establishments.

Policy:

The department director who will be responsible for the oversight and scheduling of the proposed education/training will consult with the Director of Patient Care Support (or designee) in order to inform/advise as to type and intensity of student training services required. The Director of Patient Care Support will, in collaboration with the respective department head and in accordance with institutional policy, determine the appropriate fee assessment. If there is a fee assessed it will be included in the contract and must be approved by the appropriate member of Hospital Administration.
Special considerations and/or exceptions to these guidelines may be made with approval of the Hospital Administrator.

_______________________
 Administrator

___4/23/07______________
Date

Approved by Clinical Board:  1/12/01, 3/16/04, 4/17/07
Written:  12/1/96
Revised:  2/96, 12/00, 2/04, 3/07
Reviewed:  5/98, 2/04, 3/07
UNIVERSITY REQUIREMENTS FOR CLINICAL ROTATIONS

Purpose:

To delineate the scope of responsibility/activity of students in the provision of patient care.

To define the responsibility of Hospital Departments for students that will be or are working in their Department.

Policy:

1. Responsibility of Department

LSUHSC Departments maintain the responsibility for quality patient care and evaluates the care given to all patients. The departmental staff shall retain total responsibility for providing and directing patient care as well as documenting in the patient’s record that care was provided.

2. Hospital and Department Policies and Procedures

Students shall abide by LSUHSC policies and procedures. Policy and Procedure manuals are located online and/or in each department for reference.

3. Coordination of Patient Care for Students

Patient care given by the student shall be coordinated between the faculty/instructor and the assigned departmental staff.

4. Faculty/Instructor Supervision of Student

A student shall be under the supervision of a readily available faculty/instructor.

5. University Responsibilities

All schools/universities having student affiliations with LSUHSC will comply with the following:
• Must have a current, signed contract on file in Legal Affairs before they start.

• Will ensure competence of each faculty/instructor on the premises.

• Will submit a request for a clinical site to the Department Student Coordinator, the Department Head, or the Manager of the department at least six weeks prior to clinical rotation for the semester. The request must include the following information:
  o Units/Departments to be used during the rotation
  o Date rotation begins and ends
  o Days of the week and shift/time of rotation
  o Approximate number of students
  o Faculty/Instructor’s name

• Ensures completion and appropriate documentation for students and instructors of the following requirements as per contract:
  o Current immunizations as required in the contract.
  o Criminal background check. If a background check is conditional, the university will provide a copy of the conditions to the student coordinator.
  o HIPPA training, confidentiality statement, and hospital orientation information.

• Completes and submits all student documentation at least two weeks prior to students starting their clinical rotation.

• When clinical assignments are finalized, will submit a list for each clinical area including clinical location, date of rotation, instructor’s name, and each student’s name, understanding that all requests are subject to availability.

6. **Required Documents**

All schools/universities will be given a packet of information, which includes the following:

• Information letter to faculty/instructors detailing student requirements.
• Immunization spread sheet for completion by faculty/instructors.

• Documents stating immunization requirements.

• Current HIPAA self study packets and HIPAA acknowledgement forms to be completed and signed by each student/instructor.

• Confidentiality Statement forms to be completed and signed by each student/instructor.

• Orientation packet and acknowledgement or receipt form to be signed by each student/instructor.

The packet of information may be obtained from the Nursing Student Coordinator. Additional forms/documents are available on the LSUHSC-S Manuals, Documents and Resources web site. (http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms_word/home.htm)

7. Procedure for Nursing students and Any Student not in the Professional Services Division:

The Nursing Student Coordinator will:

• Ensure that the requesting school has a current contract with LSUHSC.

• Approve requests and make assignments for clinical rotations for inpatient and outpatient nursing services, paramedics, anesthesia, and the operating room; all other clinical rotations will be made by the department manager. Every effort will be made to honor clinical requests as submitted.

• Notify school of clinical rotation assignment.

• Provide the school/instructor with the packet of information and assign a deadline date for all student documents, at least two (2) weeks prior to rotation.

• Review documents and ensure that all student/instructor requirements/documentation are met prior to any student starting the clinical rotation.
• Send a copy of all students'/instructors' signed HIPAA and Confidentiality forms to the Nursing Student Coordinator prior to the start of the clinical rotation.

• Document the completed requirements on an Excel spreadsheet. Spreadsheets will be maintained by the Nursing Student Coordinator for three (3) years. At the end of the school year, all other documents related to the clinical rotations may be shredded.

8. **Procedure for Professional Services Division Students:**

The Department head or designee will:

• Ensure that the requesting school has a current contract with LSUHSC-S.

• Approve requests and make assignments for clinical rotations and notify school of rotation assignment.

• Provide the school/instructor with the packet of information and assign a deadline date for all student documents, at least two (2) weeks prior to the rotation.

• Review documents and ensure that all student/instructor requirement/documentation are met prior to any student starting the clinical rotation.

• Send a copy of all students'/instructors' signed HIPAA and Confidentiality forms to the Assistant Administrator for Professional Services prior to the start of the clinical rotation.

• Document the completed requirements on an Excel spreadsheet provided by the Nursing Student Coordinator. The Professional Services department head will maintain the spreadsheet for three (3) years. At the end of the school year, all other documents related to the clinical rotations may be shredded.
9. **Non-University Student Observers**

- Any requests for observers will be handled according to Administrative Directive 2.6.8.

- All requests to observe patient care when the observer is not a University Student shall be directed to Human Resources at 5-5610.

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Administrator

3/19/09  
Date

Approved by Clinical Board: 2/21/06, 3/17/09  
Written: 12/05  
Revised: 2/09  
Reviewed: 2/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

VARIANCE REPORTING/SENTINEL EVENT POLICY

Purpose:
To establish clear systems for hospital-wide online reporting of information related to medical/health care errors. To provide a confidential mechanism of identification, tracking, trending, and follow-up of all incidences that pose an actual or potential safety risk to patients, families, visitors and staff. Variances include events ranging from “falls” to near misses or sentinel events with serious adverse outcomes, occurring in the hospital setting.

Definitions:

Variance - defined as any event or circumstance not consistent with the standard routine operations of the hospital and its staff or the routine care of a patient/visitor.

Near Miss - any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a near miss falls within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by the Joint Commission under its Sentinel Event Policy.

Sentinel Event - an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof to a patient, visitor, or an employee. Serious injury specifically includes loss of limb or function. The phrase, “or the risk thereof”, includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Policy:

1. A Variance Report shall be submitted via on-line or on paper. A Variance Report form, located on the Quality Management web page, https://www.medcom.lsuhsc-s.edu/cfdocs/QM/ shall be completed when a Variance/Sentinel Event occurs involving an employee, patient, or visitor. The web page can be accessed via MS Internet Explorer browser or selected from the listing on the Hospital Home Page under Administration, Hospital Administration, then “Quality Management Variance Reporting Form”.

1
Note: For on the job injuries refer to Administrative Directive 7.2.

2. The attending physician shall be notified immediately when the variance involves a patient.

3. If a patient or visitor is injured in a common area (i.e. sidewalks, stairwell, elevator, waiting area, etc.) the University Police Department shall be responsible for completing a Variance/Sentinel Event Report.

4. The employee identifying the Variance/Sentinel Event, or the employee to whom the Variance/Sentinel Event is first reported, shall be responsible for initiating the completion of the Variance Report Form prior to the end of their scheduled shift of duty.

Note: If the Variance/Sentinel Event occurrence is a potential Sentinel Event or Near Miss the individual responsible for reporting the variance shall notify their Supervisor immediately. The Supervisor shall then notify the Administrator on-call during normal business hours (Monday-Friday, 8:00am to 5:00pm). If the event occurs after hours, on weekends or holidays, the individual reporting the variance is responsible for printing a copy of the variance and delivering it to the House Manager, in addition to submitting the on-line form to Quality Management. If the House Manager determines the occurrence to be a potential Sentinel Event or Near Miss, the House Manager shall notify the Hospital Administrator on-call immediately.

5. Upon completion of the online Variance/Sentinel Event Report form:
   - The on-line form shall be simultaneously e-mailed to the manager for the unit on which the event occurred. (Enter the manager’s email address in the space located above the “submit” box at the end of the Variance Report.)
   - If the hospital Internet service or Microsoft Outlook is non-functional, a paper copy of the variance shall be submitted to the Quality Management Department prior to the end of the scheduled shift of duty.

6. The individual generating the report shall receive immediate notification via e-mail receipt that the Variance/Sentinel Event Report was received.
7. The Quality Management staff screens all variances and assigns a Harm Score Distribution based on a six-point classification scale (Attachment A). The Quality Management Department also summarizes each variance and refers them to the department(s) involved for investigation and resolution as needed. A resolution / corrective action related to conducting proactive risk reduction activities and the patient outcome shall be forwarded to the Quality Management Department for reporting to the Quality Leadership Team within fourteen (14) days.

8. A Sentinel Event Root-Cause Analysis shall be considered when an occurrence meets any of the following criteria:

- The occurrence involves an unanticipated death or major permanent loss of function.

- The occurrence is associated with significant deviation from the usual process(es) for providing health care services or managing the organization.

- The event has undermined or has significant potential for undermining the public’s confidence in the organization.

Occurrences that potentially meet the above criteria shall be forwarded to the Hospital Administrator and the Vice Chancellor for Clinical Affairs for advisement and approval for a Root-Cause Analysis to be completed. The Hospital Administrator and the Vice Chancellor for Clinical Affairs shall direct the reporting of this occurrence to The Joint Commission and/or Centers for Medicare and Medicaid (CMS).

9. Quality Management shall coordinate the completion of a credible Root-Cause Analysis in conjunction with the assistance of the Assistant Hospital Administrator(s), Department Directors(s) and staff of the involved area(s). The Department Directors will also provide support, as appropriate, for staff who are directly involved in a sentinel event.

10. A thorough written summary of the Root-Cause Analysis of a Sentinel Event shall focus primarily on organizational systems and processes. The Root-Cause Analysis must include:

- Determination of the direct or “proximate” cause of the Sentinel Event and the processes and systems related to its occurrence.
• Analysis of the related systems and processes.

• Analysis of special causes in clinical processes and common causes in organization processes.

• Determination of appropriate risk reduction activities in order to minimize the likelihood of such risks in the future, or a determination that no such improvement opportunities exist.

• Establishment of a plan to address identified opportunities for improvement or formulation of a rationale for not undertaking such changes.

• Identification of who is responsible for implementation and how the effectiveness of the actions shall be evaluated.

11. When monitoring performance of specific clinical processes, certain events always elicit intense analysis. Based on the scope of services provided, intense analysis is performed on the following:

• Confirmed transfusion reactions

• Significant adverse drug reactions

• Significant medication errors and hazardous conditions

Hazardous conditions refer to any set of circumstances (exclusive of disease or condition for which the patient is being treated), which significantly increases the likelihood of a serious adverse outcome.

12. An intense analysis may also be performed when the following events occur:

• Major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic diagnoses, including those identified during the pathologic review of specimens removed during surgical and invasive procedures; and

• Significant adverse events associated with anesthesia use.

13. The Hospital Administrator and the Vice Chancellor for Clinical Affairs choose performance improvement priorities and are
responsible for overseeing the delegation and empowerment of staff to implement priorities for proactive reduction in patient risk.

14. Quality Management shall coordinate monitoring the effectiveness of the implemented improvements and reporting of the progress to the Hospital Administrator and Vice-Chancellor for Clinical Affairs as requested.

15. Quality Management shall forward Variance/Sentinel Reports received to the appropriate areas by Variance type:

- Environmental Variances involving falls or injuries, material safety handling or damage/lost patient property shall be forwarded to the Safety Department, equipment malfunctions shall be forwarded to BioMed, utility outages and pest control issues shall be forwarded to Physical Plant, bed/rooms not ready shall be forwarded to Environmental Services for investigation.

- The Safety Department shall investigate patient outcomes, assignment of a Harm Score Distribution Classification; perform regulatory reporting, and identification of changes that will lead to improved patient safety, or tracking and trending. Numbers of the subsections and a description of Environmental Variances shall be forwarded to the Quality Leadership Team monthly.

- A Clinical Patient Safety Report shall also be forwarded by Quality Management to the Quality Leadership Team on a quarterly basis. This report will identify the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.

- Medication Usage Variances (Adverse Drug Reactions, Medication Errors, and Controlled Substance/Narcotic Discrepancy) shall be forwarded to the appropriate department manager for investigation. Cases shall be referred to the Pharmacy and Therapeutics (P&T) Committee as appropriate. Results shall be tracked and trended by the Pharmacy Department and reported to the P&T Committee at least quarterly. The P&T Committee shall proactively review how errors occur and make recommendations to reduce patient risk. In addition, a Medication Variance Report is forwarded by Quality
Management to the Quality Leadership Team monthly and quarterly.

- Clinical and Department Specific Variances shall be reviewed and investigated by Quality Management for possible input into the Medical Staff and Resident Peer Review Profiles and/or other areas as appropriate to proactively identify how errors occur and reduce risks relevant to the management of the patient’s condition. The data is utilized to generate a monthly and quarterly Patient Safety Report for the Quality Leadership Team and the Clinical Board.

- Disruptive Behavior Variances shall be investigated and action taken when indicated by the appropriate department manager and Hospital Administrator’ variances involving members of the medical staff, residents or fellows shall be forwarded to the appropriate Department Chairman and the Vice-Chancellor of Clinical Affairs for review and action.

16. The Quality Management Department shall maintain the information of all Variance/Sentinel Event Reports received in the department’s database management program. In addition to the above reports, ad hoc reports for other appropriate departments, committees or management are generated as needed.

Administrator

4/22/09
Date

Approved by Clinical Board: 1/12/01, 1/20/04, 6/15/04, 3/15/05, 2/21/06, 4/21/09
Written: 8/95
Revised: 10/97, 2/98, 12/00, 12/02, 11/03, 5/04, 2/05, 1/06, 3/09
Reviewed: 3/09
Harm Score Distribution for Variances

A classification will be applied to each variance report by the Assistant Director of Quality Management. All safety variances will be classified by the Safety Office.

0. No Harm
1. Potential Harm/Injury
2. Injury
3. Near Miss
4. Harmful Event/Sentinel Event
5. Unknown

Definitions:

No Harm – an event occurring in which the patient is not injured, or otherwise harmed.

Potential Harm/Injury – an event in which a physician order was not followed or a medication was not administered.

Injury – physical harm, damage, or pain not otherwise classified as a Near Miss or Harmful Event/Sentinel Event.

Near Miss – an occurrence which did not affect the outcome, but for which the recurrence carries a significant chance of a serious adverse outcome.

Harmful Event/Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

Unknown – an event occurring in which the actual or potential risk of harm is unidentified.

Developed by QM: 8/6/03
Revised: 10/03, 5/04, 12/04, 1/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PATIENT/VISITOR COMPLAINTS

Purpose:

To provide a mechanism which identifies and addresses patient/visitor complaints in a timely and efficient manner.

To improve the delivery of quality healthcare services and protect patient health and safety by ensuring complaint is reviewed/investigated, tracked and trended.

To provide a mechanism through which every patient complaint is reviewed by an administrator, responding on an individual basis, and that a feedback and appeal mechanism is available to the complainant.

Definition:

Patient complaint – a formal, written or verbal grievance that is filed by a patient, or on behalf of a patient who is incapable of doing so themselves, when a patient issue cannot be resolved promptly by present staff.

Policy:

1. All patient complaints, written or verbal (including telephone complaints), and regardless of point or origin, are recorded on a patient complaint form (SN #1136) and forwarded to the Social Services Counselor, or the Director of Patient Relations located in Hospital Administration. Complaints are immediately logged into a computer database and assigned a tracking number.

2. Once logged, the Director of Patient Relations shall review each complaint and route to the appropriate administrator and department manager. The date and time of the review and routing (to whom and when) will be entered into the computerized database.

3. Within three (3) days of receipt of the complaint, the Director of Patient Relations shall generate a letter to the complainant stating that their complaint has been received and is being investigated, providing a follow-up contact name.
4. If a complaint is of a nature that the Director of Patient Relations or the Social Services Counselor can address them, they shall be contacted immediately to meet with the patient/visitor.

5. In any case, where the individual filing the complaint is offensive or agitated, the Director of Patient Relations is contacted immediately and meets with the patient/visitor.

6. If the complaint presents apparent issues of legal liability or media involvement, the Director of Patient Relations shall immediately notify the responsible Administrator and/or the Hospital Administrator on call.

7. All complaints alleging the release of protected information will be forwarded to the Hospital Privacy Officer for review and follow up.

8. In cases where there is an alleged adverse patient outcome, at the discretion of the Assistant Hospital Administrator responsible for Patient Relations, the matter may be referred for other internal review in addition to resolution through the patient complaint process.

9. In all routine cases (those not meeting the criteria set forth in #6 above), complaints once logged, assigned a tracking number and reviewed by the Director of Patient Relations, will be routed as follows:
   
a. Billing complaints – Compliance Officer & Managed Care Director

b. Clinical complaints – Assistant Administrator, Professional Services

c. Operational complaints - Hospital Administrator to whom the involved department reports.

10. Billing complaints shall be immediately reviewed by the Director of Managed Care for the purpose of compliance risk identification and trending, and then referred as appropriate for investigation, follow-up and decision.

11. Clinical complaints shall be immediately reviewed for the purpose of risk assessment, need for urgent intervention, administrative
awareness of complaint issues pending investigation for appropriate routing and follow-up oversight.

12. Operational complaints shall be immediately reviewed by the Hospital Administrator to whom the concerned division reports for the purpose of tracking and trending, administrative awareness of issues pending in their divisions and for appropriate follow-up.

13. The Director of Patient Relations shall generate a weekly report detailing each patient complaint that remains active. This report shall be distributed to the Administrative staff and Medical Directors.

14. Upon resolution, and in no case later than thirty (30) days, the individual filing the complaint shall be sent a follow-up letter from the responsible Administrator. The letter shall outline the resolution of the situation, and advise the complaining individual of their right to a hearing if they are not satisfied with the outcome of the review, and the mechanism by which that hearing may be obtained.

15. Upon receipt of the resolution letter, the complainant has 30 days to request a grievance hearing with the PIC. This request must be made in writing and received within 30 days of the date of the follow-up letter.

16. Follow-up letters in matters involving an alleged adverse patient outcome shall be reviewed and approved by the Assistant Hospital Administrator responsible for Patient Relations and Legal Affairs if necessary.

17. A Patient Issues Committee (PIC), appointed by the Medical Director, shall meet monthly to review complaints, appropriateness of action taken and delinquent responses. The Committee shall also hear any grievances brought forward by patient/visitors in regard to action taken in response to their complaint.

18. Patient Relations shall generate a report monthly of all unresolved complaints. Said report shall be by tracking number only and patient identity shall not be disclosed.

19. Upon receiving notification of a request for a grievance hearing, the Director of Patient Relations shall coordinate the hearing.
Hospital Policy Manual
Policy Number: 2.23
Effective Date: 7/01/07

ADMINISTRATOR

6/21/07
Date

Approved by Clinical Board: 8/15/00, 7/15/01, 7/15/03, 6/15/04, 6/19/07
Written: 7/00
Reviewed: 5/01, 6/01, 6/03, 6/04, 5/07
Revised: 5/01, 6/01, 6/03, 6/04, 5/07
REQUESTS FOR EDUCATIONAL PROGRAMS

Purpose:

To provide guidelines for departmental requests for the development of educational programs including in-services by the Hospital Education and Standards Department.

Policy:

1. Educational Requests:
   a. Educational program requests may be submitted to the Hospital Education and Standards Department Director or Clinical Instructor(s) who will review the request and discuss the following information:
      1). Program content and/or objectives
      2). Available resources
      3). Feasibility
      4). Time Frame
      5). Type of Credit to be awarded
   b. Requests can be made from the following persons:
      1). Nursing Directors
      2). Nursing Managers/Supervisors
      3). Nursing Staff
      4). Ancillary Departments
      5). Non-LSUHSC-S Employees

2. Learning Needs Assessment

The Hospital Education and Standards Department determines educational goals and priorities on an ongoing basis. Educational needs are prioritized based on:
a. Ongoing formal needs assessment surveys  
b. Performance Improvement data  
c. Requests from Directors  
d. Requests from Staff  
e. New policies, procedures, and technology  
f. Peer review activities  
g. Safety Issues  
h. Infection Control Issues

3. Documentation of Educational Programs

A Department Education Record (SN 1100) is to be initiated prior to the implementation of an in-service or unit-based competency assessment by the Program Coordinator.

Approved by Clinical Board: 4/17/01, 5/18/04, 5/15/07
Written: 7/86
Reviewed: 10/96, 5/98, 3/01, 3/04, 4/07
Revised: 3/04, 4/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

REFERRAL POLICY FOR POST DISCHARGE SERVICES/CARE

Policy:

It is the policy of LSUHSC-S to use a rotation system for licensed healthcare providers who supply post discharge services/care to patients not provided by the hospital. Providers for service shall be screened and referral information maintained relating to type, location, level and quality of service provided. Per the Balanced Budget Act of 1997 the hospital shall provide a list of all available agencies to each patient. The agency must submit a written request to be placed on the list.

Procedure:

1. Referrals for Service

   All patients shall be given the option of selecting a provider of their choice for a particular service. Provider selection by a patient shall not be biased by staff solicitation for a particular provider.

   If patients have an established relationship with a provider then they shall be referred back to that provider, unless they specifically request otherwise.

   A physician may order a particular provider if documentation and justification is present that a particular provider supplies a unique service or specialty. This justification must be documented.

   All other patients not meeting one of the above criteria shall be provided, by the case manager, with a list of agencies located within their area of residency. If the patient refuses, or is otherwise unable to make a decision, a surrogate decision maker will be contacted for preference and if no preference is stated, the referral rotation list shall be implemented.

2. Referral Rotation List

   Case Management shall maintain the list of all approved healthcare providers who supply post discharge services/care.

   Providers may solicit to be on the rotation list for a service by submitting a request to the Assistant Administrator for Patient Care
Services or their designee to include the following: description of service; education, experience, and certifications of staff; evidence of certifications; licensure of business; references from current users.

** Any other solicitation for business including distribution of literature, on site patient contact, or incentives for hospital staff or physicians shall be considered grounds for non-placement or removal from the rotation list.**

Once a provider is deemed appropriate for referrals they shall be notified in writing and added to the rotation list for that service.

Separate rotation lists, for all types of services, shall be maintained within service regions.

All providers are expected to notify the Assistant Administrator of Patient Care Services or their designee in writing if there is a change in the ability to deliver a particular service. (Examples might include a change in the level of staffing for a specialty area, or lack of equipment available.)

3. **Removal from Referral Rotation List**

Providers, who do not provide a high quality level of service; who lose their CMS and/or JCAHO accreditation and/or refuse to accept indigent patients may be removed from the rotation list. Clinical practice and treatment is to be within the National Standard of Care for the providers’ classification, i.e. Home Health, Rehabilitation Hospital, etc., current licensure must be maintained. This process shall include: documentation by staff of variances in patient care delivery, patient complaints, billing, and documentation. Variances shall be completed at the time they occur by hospital staff and physicians. Copies of the variances shall be maintained on file and mailed to the providers for correction and response. If it is determined that the severity and/or number of variances is excessive, or there is a failure to respond to variances, then the provider may be removed from the rotation list. Serious violations shall include clinical practice and treatment that does not meet the National Standard of Care; CMS or JCAHO regulations and has a high probability of causing patient harm.

Prior to their removal, the agency shall be notified in writing. A hearing may be requested by the agency. This hearing shall be before the Administrator or his designee, and two Associate or
Assistant Administrators. The provider may be represented by a
person of their choosing. The hearing shall be held promptly, and
shall be informal in nature, and the rules of evidence shall not
apply. The decision of this panel shall be final.

Depending on the violations, and if the provider is removed from
the list, they may solicit to be placed back on the list by submitting
a plan of correction which shall be reviewed and approved or
denied by Administration and LSUHSC Legal Affairs Office.

4. Department Referral Rotation Tracking

Patient referrals based on patient request, previous relationship
with the provider, or physician request because of provider
specialty, shall not be a part of rotation referral.

Patients who do not fall into one of the previous categories shall be
referred to the next provider on the list.

Certain types of provider referrals shall be centralized within the
Case Management Department. All personnel making referrals
shall contact the Case Management to determine the next provider
on the rotation.

The Case Management Department shall be able to demonstrate
by the referral log that a rotation system is used and provide
monthly reports of provider referrals.

_________________________
Administrator

5/20/09

Approved by Clinical Board: 9/19/00, 5/15/01, 11/18/03, 3/21/06, 5/19/09
Written: 12/96
Revised: 11/97, 11/03, 2/06, 4/09
Reviewed: 8/00, 4/01, 11/03, 2/06, 4/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

SUPPLY INVENTORY
(Special Orders)

Purpose:

To ensure Hospital inventories for patient medical supply items are accurately valued on the financial statements for the LSUHSC-S campus.

Policy:

1. Prior to the conclusion of the fiscal year, Hospital Administration shall require all Hospital budget areas with special order patient care item inventories in excess of a diminutive amount to conduct a physical inventory and report the value of these inventories. For areas with perpetual inventories in excess of the diminutive amount, the value of the perpetual inventory on hand at fiscal year end shall be reported.

2. Detailed procedures for conducting the annual physical count will be developed and distributed to the required budget areas prior to the date of the count. Compliance with the established procedures is mandatory.

Definitions:

1. “Special order patient medical supply items” are defined as: “All medical supply items not included in the general Hospital inventory (i.e., CMS, Pharmacy or Warehouse).”

2. A “diminutive amount” shall be a specified dollar amount of special order patient supply items inventory determined by Hospital Administration (in consultation with Accounting Services and the Internal Audit Departments) to be an amount that, if not included in the inventory valuation reported on the fiscal year financial statements, would not result in the Hospital inventory value to be materially misstated.
Hospital Policy number: 2.27
Effective Date: 4/01/06

_______________________
Administrator

3/29/06
Date

Clinical Board Approval: 3/18/03, 3/21/06
Written: 5/97
Reviewed: 2/00, 3/03, 3/06
PHOTOGRAPHING, VIDEO RECORDING, AUDIO RECORDING OR CINEMATOGRAPHY OF PATIENT AT LSUHSC

Purpose:

To provide specific criteria for obtaining permission to document a patient digitally, on film or audio tape while being treated at LSUHSC-S.

Policy:

1. A HIPAA Authorization Form for Media Purposes must be signed by the patient (or in the case of a child or incompetent patient, by a parent, guardian or any person authorized to give consent for medical treatment) before photography, videography, audio or cinematography recording of the patient will be permitted. During regular working hours (Monday - Friday) the HIPAA Authorization Form shall be obtained from Hospital Administration. After regular working hours, the Administrative House Manager shall be contacted for the form.

2. When LSUHSC-S Video Services and Telehealth is videotaping on behalf of LSUHSC-S employees, a release form provided by Video Services and Telehealth shall be completed and signed by the patient or parent/guardian, as appropriate, before videotaping commences. Video Services and Telehealth may be contacted at extension 55268.

3. Where photographs, video, or audio recordings are requested by news media, television production crews or others for the purpose of publication or broadcast to public audiences, such requests shall be referred to the Office of Information Services, extension 55408. After hours, nights and holidays, ask the hospital switchboard to contact the Director of Information Services. HIPAA forms as well as media consent forms specific to the use intended are obtained by the Office of Information Services. A copy of the signed forms are kept on file in the Office of Information Services.

4. The signed HIPAA authorization form, as well as any other media consents, shall be filed in the patient’s medical record as part of the designated record set.
5. Recording equipment of any type, including cellphones, is not allowed unless authorized under one of the conditions above and will be monitored by the University Police Department.

6. Patients may withdraw consent for recording, photographing, etc., at any time and such will immediately cease.

7. Any equipment that will touch the patient or his/her bed, bedside tables or immediate environment must be wiped with a hospital approved disinfectant before and after use, or be appropriately processed for the setting, (i.e.: sterilization or high level disinfection of video equipment used in the surgical setting). Unit specific policies must be followed.

8. The photographer or videographer must use aseptic technique appropriate for the setting (i.e.: OR, ER, nursing unit) and sanitize their hands using soap and water or alcohol gel prior to and after contact with the patient or the patients’ immediate environment.

Clinical Board Approval: 3/18/03, 3/21/06, 2/20/07
Written: 9/90
Revised: 8/95, 11/97, 2/00, 3/03, 3/06, 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

LICENSURE, CERTIFICATION, AND REGISTRATION POLICY

Purpose:

To define LSUHSC’s compliance with all applicable state, federal, regulatory and accrediting agencies governing licensing, certification, and registration for its professional staff.

Policy:

LSUHSC will not allow any employees to work in any position that requires license, certification, and/or registration without first obtaining primary source verification of employee’s current valid license, certification, and/or registration. Current licensure/certification or registration is verified with the Primary source at the time of hire and at renewal prior to expiration.

Any individual unable to show proof of such will be placed on Leave Without Pay (LWOP) for a maximum of 30 days and not permitted to work until proof of such can be verified. After 30 days administrative termination may be initiated. It is the employee’s responsibility to provide proof of license, certification, and/or registration. It is the employee’s responsibility to notify their manager and HR immediately of any change to the status of the license, certification, and/or registration.

Procedure:

1. Employees who are required by job description to be certified, registered, and/or licensed shall present proof of current status of such at the time of hire to LSUHSC Department of Human Resources. Status will be verified with the primary source by Human Resources at the time of hire. Primary source verification will be obtained from state licensing boards or a primary source of information to be verified may designate to an agency the role of communicating credentials information. Primary source verification will be obtained through a secure electronic communication. If a licensing board cannot provide this type of verification, a letter from that board must be obtained.

2. The department head must verify on an ongoing basis, current license,
certification or registration as required by the position description qualifications. Verification will be made with the primary source and will be completed prior to the expiration of the license.

3. In the event that any employee is in a position that requires license, certification, or registration has their license, certification, or registration revoked, suspended or rendered invalid, LSUHSC may administratively terminate their employment with LSUHSC.

_______________________
Administrator

_______________________
1/28/08
Date

Approved by Clinical Board: 4/17/01, 5/18/04, 6/19/07, 1/15/08
Written: 5/98
Revised: 3/01, 3/04, 5/07, 1/08
Reviewed: 3/04, 5/07, 1/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER -  
SHREVEPORT  

COURTESY BEDS

Purpose:

To provide overnight accommodations as a convenience for self-care patients who have been scheduled for an outpatient test, procedure or surgery the following morning.

Criteria:

1. The patient must be ambulatory and able to take care of himself/herself or someone must be able to stay with the patient to assist him or her as required. In any case, no assistance from the nursing staff must be required or requested. Only one significant other (guest) per patient will be allowed.

2. The patient’s condition must be stable so that inpatient hospitalization is not indicated.

3. The patient must live greater than a 60-mile radius from the hospital.

4. The patient must be pre-registered.

Policy:

1. When available, a courtesy bed shall be provided for patients who meet the above criteria.

2. The following items are not permitted in the room:
   
   a. Firearms or weapons of any kind
   
   b. Pets (except those trained to assist the disabled)
c. Alcoholic beverages
d. Illegal drugs
e. Electric appliances
f. Food

3. Smoking is not permitted. Certain areas outside the building have been designated as smoking areas.

4. Towels and soap are provided.

5. The patient must purchase meals and other nourishments. No food is allowed in the room.

6. No nursing staff is provided.

7. LSUHSC assumes no responsibility for individuals using courtesy beds.

Procedure:

1. The attending physician, or his designee, shall contact Outpatient Surgery, to request a courtesy bed. The physician, his designee, or the Administrative House Manager, shall provide:
   
   a. Physician’s name
   b. Patient’s name
   c. Patient’s address
   d. Reason courtesy bed is requested (example – having surgery for total hip replacement, etc. in the morning).
   e. Name and relationship of any person who will be visiting with patient.

2. Patient shall be instructed at time of booking to come to the Information Desk in the front Lobby any time between 7 p.m. and 9 p.m., the evening before scheduled surgery is to be performed. The Information Desk clerk will give directions to assigned room. The combination to the room will be given at this time as well.

3. A daily list of Day Surgery/Courtesy Bed assignments will be sent to the Information Desk, UPD, Administrative House Managers, and Environmental Services.

4. Statement of responsibility must be signed by the patient and witnessed by an employee of LSUHSC prior to use of the courtesy bed. (See form below).
5. Rooms must be vacated no later than 5 a.m. for Environmental Services to clean if the occupant is not a Day Surgery patient.

6. UPD will make frequent rounds on the Outpatient Surgery Unit.

_____________________
Administrator

__5/2107________________
Date

Approved by Clinical Board: 4/17/01, 5/18/04, 5/15/07
Written: 1/99
Reviewed: 3/01, 3/04, 4/07
Revised: 3/04, 4/07
Louisiana State University Health Sciences Center – Shreveport

Courtesy Beds

STATEMENT OF RESPONSIBILITIES FOR BOARDER

I, ____________________________, have chosen to be a boarder at LSU Health Sciences Center on the following date ___________ and have received written or verbal instructions and responsibilities:

A) As a boarder, I am not entitled to any nursing care. This will change if I am admitted as a patient to LSU Health Sciences Center.

B) I can purchase meals or other nourishments from the hospital cafeteria or vending machines at regular prices. **No food is allowed in the rooms.**

C) I retain responsibility for maintaining the security of any personal possessions I bring to LSU Health Sciences Center.

D) I must obey all LSU Health Sciences Center policies and procedures regarding visitation hours, fire and electrical safety, etc., as brought to my attention by the nursing staff or other hospital personnel.

E) I am responsible for any damages and/or loss of property that may occur during my stay.

______________________  ________________________
WITNESS      SIGNATURE

________________________
DATE

ROOM _________________  COMBINATION LOCK # ____________
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

VENDOR SOLICITATION POLICY

Purpose:

To assure vendors entering LSUHSC for the purpose of conducting business, do so in such a manner as to not interfere with the normal operations of the institution, and comply with institutional requirements regarding confidentiality of information.

Definition:

Vendor – bonafide representatives of companies providing goods or services to the healthcare industry for the purpose of profit; for the purpose of this policy, vendors with contracts for services with LSUHSC, (i.e., elevator repair, construction or maintenance) are excluded.

Policy:

1. All vendors conducting business within the medical center complex have a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. By completion of the vendor registration process, the individual agrees to comply with all rules and regulations set forth in this and any other applicable institutional policy or directive.

2. All vendors, in order to be approved for sales or service access within the LSUHSC, must register and maintain a current data file in the Purchasing Department. Such registration data shall include but not be limited to the following:

   Vendor name
   Company, which the vendor is representing
   Vendor address
   Vendor telephone number
   Signed Confidentiality Statement
   Official business card

The Purchasing Department shall maintain a database of all authorized vendors; information contained in the database shall be made accessible to Patient Information, University Police and Hospital Administration.
3. Under no circumstance shall a vendor proceed directly to a hospital department or physician office. Vendors are not allowed in patient care areas of the hospital or clinics without specific permission from Hospital Administration. While in a patient care area, the vendor must be accompanied by an employee of the institution at all times.

4. Supplies or equipment are never left for evaluation or sample purposes without specific permission from the appropriate Hospital Department. In the case of equipment to be used for evaluation purposes, written permission must be granted by the Biomedical Department. As per hospital safety requirements, no equipment is to be used without a safety inspection.

5. LSUHSC assumes no responsibility for supplies or equipment left by vendors for the purpose of evaluation.

6. Food shall not be brought into the hospital or patient care areas by vendors.

Procedure:

All vendors seeking access to any LSUHSC department shall follow the following procedure:

1. Obtain approved vendor status from the Purchasing Department; process includes signing confidentiality statement.

2. Schedule appointment(s) with individual or groups with whom the vendor would like to meet. This shall be done directly with the individual(s) involved. Purchasing will not schedule vendor appointments.

3. Upon arrival, shall check in at the Patient Information desk located in the hospital lobby (King’s Highway entrance).

4. Patient information shall verify by phone the vendor appointment with the office, department or Biomedical engineering, issue a vendor badge and direct the representative to the office/department.

5. Upon completion of the appointment, the representative shall return to the Patient Information desk, returning the vendor badge.

6. In the event that there is no one available at the Information desk, the vendor shall check in through the University Police station located adjacent to the lobby.
7. Vendors selling or performing maintenance service on medical equipment must proceed to the Biomedical Engineering Department to sign in and out.

8. Vendors performing maintenance service on medical equipment shall leave service reports; indicating services provided Biomedical Engineering, upon completion of work. After hours service reports are to be left in the appropriate box outside Biomedical Engineering.

Failure to comply with this policy shall result in action taken against the vendor, including possible banning from the institution and reporting to parent company.

Hospital Administrator

5/21/07

Date

Approved by Clinical Board: 2/20/01, 5/18/04, 5/15/07
Written: 1/1/90
Reviewed: 2/04, 4/07
Revised: 12/00, 4/04
AUTHORIZATION FOR RELEASE OF INFANT/CHILD TO OTHER THAN PARENT/LEGAL GUARDIAN

Purpose:

To provide a mechanism for authorization for release of an infant/child to anyone other than the parent or legal guardian.

Policy:

It is the policy of LSU Health Sciences Center in Shreveport that:

1. No infant/child shall be released to anyone other than the parent/legal guardian without authorization.

2. All pediatric/adolescent patients shall be screened on admission by a Registered Nurse for any potential custody/security issues related to their care.

3. Custody/security issues will be noted on the Patient History/Assessment and Discharge Record (SN 1048) and an authorization for release of infant/child to other than parent/legal guardian form will be placed on the front of the medical record.

4. The authorization for release must be signed by parent or legal guardian and witnessed by two LSUHSC employees prior to discharge of infant/child to anyone other than the parent/legal guardian.

5. Proof of identification must be provided by the person designated by the parent or legal guardian before the child is released to their care. Examples of identification may include: Drivers license or other type of photo ID.

6. Should there be any question regarding legal guardianship of an infant/child staff shall contact the Administrator on Call for direction prior to proceeding with discharge.

_______________________
Administrator

6/21/07
Date

Approved by Clinical Board: 5/15/01, 7/20/04, 6/19/07
Written: 04/01
Reviewed: 6/04, 5/07
Revised: 6/04, 5/07
AUTHORIZATION FOR RELEASE OF INFANT/CHILD TO OTHER THAN PARENT/LEGAL GUARDIAN

I, ____________________________, do hereby grant my permission for my child, ____________________, ____________, to be released to:

Name                                          DOB
________________________, _________________

Name                                                               Relationship

This release does not constitute an adoption or change in custody. My child is to remain in this person’s care until such time as the parent(s) are able to resume care or is revoked by grantor.

The child will be physically located at the following address:

________________________________________
________________________________________
________________________________________
(Phone)________________________

LSU Health Sciences Center-Shreveport is held as blameless in this release.
I am signing this form of my own free will.

________________________________________
Mother’s Signature                        or                        Father’s Signature

________________________________________
Date

Witnesses:  __________________________________
            __________________________________
            __________________________________
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

RELINQUISHMENT OF NEWBORN SAFE HAVEN LAW

Purpose:

To provide a mechanism for compliance with the revised Louisiana Children’s Code, Articles 1701 - 1706, allowing for a parent to relinquish the care of her newborn infant to the state in anonymity and without fear of prosecution or persecution at a designated emergency care facility.

Definitions:

Newborn infant – for the purpose of this law, any infant less than 30 days of age.

Emergency care facility – any state licensed hospital, public health unit, fire or police station, or pregnancy crisis center.

Policy:

1. Any employee of the hospital shall receive a newborn infant relinquished by the mother and shall not question the parent regarding her/his identity; the employee receiving the newborn infant shall immediately transport the infant to the Pediatric Emergency Care Center (ECC)

2. The infant shall be examined and admitted by a pediatrician to the appropriate unit, based upon level of care needed. Options include Newborn Nursery, PICU or Pediatric Unit.

3. When a newborn infant is relinquished during normal business hours:
   a. The ECC shall notify the Administrator On Call and the Pediatric Case Manager that a newborn relinquishment has occurred.
   b. The Case Manager shall notify the Louisiana Department of Social Services (DSS), Office of Community Services (OCS) of the relinquishment within twenty-four hours of the infant’s arrival.
c. The Case Manager shall notify the MAP office for follow-up, as newborns relinquished shall immediately be qualified for Medicaid.

4. When a newborn infant is relinquished after hours and weekends:
   a. The ECC shall notify the Administrative House Manager (AHM).
   b. The AHM will notify the Administrator On Call and DSS/OCS.
   c. The AHM shall complete an Administrative Occurrence report and forward it to the Case Management office for follow-up.
   d. On the next business day, the Pediatric Case Manager shall verify contact was made with the DSS/OCS and notify the MAP office of the admission.

5. DSS shall take custody and control of the newborn with 24 hours of notification provided the infant is medically stable.

[Signature]
Administrator

3/25/08
Date

Approved by Clinical Board: 11/20/01, 1/18/05, 3/18/08
Written: 09/01
Revised: 09/04, 2/08
DISCLOSURE OF UNANTICIPATED OUTCOMES

Purpose:

To define the role of the healthcare provider in communicating the outcome of any treatment, procedure, or diagnostic test, to the patient, and/or the family/legally authorized representative, whenever the outcome differs significantly from that which was anticipated.

Definitions:

1. **Adverse Event** – any event which is not consistent with routine patient care or the routine operation of the facility, and which adversely affects or has the potential to affect the health, life or comfort of the patient and is not caused by the patient’s underlying disease.

2. **Disclosure** – communication of information regarding the results of a diagnostic test, medical, surgical or other interventional treatment.

3. **Unanticipated Outcome** – a result that differs significantly from what was anticipated to be the result of a diagnostic test, medical treatment or surgical/invasive procedure. A known complication or side effect is not an unanticipated outcome, but information about such outcomes should also be disclosed to patients as a routine course of their treatment and care.

4. **Medical Error** – an act or omission with potential or actual negative consequences for a patient that, based on standards of care, is considered to be an incorrect course of action.

5. **Sentinel Event**—an unexpected event as defined by the Joint Commission on Accreditation of Healthcare Organizations and/or regulatory agencies as an adverse event or unexpected occurrence involving death or serious physical or psychological injury or the risk thereof.

Procedure:

A. Notification

1. An unanticipated outcome shall be reported immediately upon recognition to the Hospital Administrator/Administrator On Call.
The Administrator/designee shall contact the Vice Chancellor for Clinical Affairs/Medical Director and any other appropriate parties relative to the nature of the occurrence. Some unanticipated outcomes arise from events (such as medication variances, patient safety issues, falls, or sentinel events) that are reported under other policies; those reports shall be filed as required. In all cases a Variance Report shall be completed (see hospital policy #2.22, Variance Reporting/Sentinel Events).

2. The Vice Chancellor of Clinical Affairs/Medical Director is responsible to assure that the process of disclosure occurs in a timely and appropriate manner.

3. The disclosure process shall not be initiated until the Vice Chancellor of Clinical Affairs/Medical Director and Administrator/designee have been contacted.

B. Disclosure Process

1. The attending physician (faculty) responsible for the patient’s care or his designee appointed by the Vice Chancellor of Clinical Affairs/Medical Director shall serve as the primary communicator of an unanticipated outcome to the patient and/or family/legal guardian.

2. The intent of disclosure is to provide necessary medical information, not to provide the basis for legal liability. The act/documentation of disclosure is not to place blame or discuss fault.

3. Subjects to be communicated:
Generally the physician managing the communications should presume that all information, which describes the specific event affecting a patient, can and should be disclosed, with the exception of identifying the specific staff members involved in the adverse event if unknown to the family. During discussions, the following subjects may be discussed, although discussion of each item is not required nor is discussion limited to these topics:

- That LSUHSC and its staff regret and apologize that an unanticipated outcome has occurred
- The nature of the adverse event
- The time, place and circumstances of the occurrence
- The proximal cause, if known
The known, definite consequences for the patient and potential or anticipated consequences
Actions taken to treat or ameliorate the consequences or outcome
Who will manage ongoing care of the patient
Planned analysis or review of the occurrence
Who else has been informed of the occurrence (internal hospital departments, review agencies, etc)
Actions taken, if any, to identify system issues which may have contributed to the occurrence and to prevent the same or similar occurrences from occurring
Who will manage ongoing communications with the family; names and phone numbers of individuals in the hospital to whom complaints or concerns may be addressed

C. Documentation

1. The person designated as the primary communicator with the patient/family shall document in the progress notes of the patient’s medical record what was communicated to the patient/family and any response or other discussion.

2. Confidentiality of peer processes shall be maintained. Patients/families shall not be given official reports of those processes.

3. The Hospital Administrator shall be responsible for completion and filing of any mandatory reports to outside regulatory agencies, such as the Centers for Medicare and Medicaid (CMS), Joint Commission on Accreditation of Healthcare Organizations (TJC), etc.

Administrator
3/25/08
Date
References:
University HealthSystem Consortium. Oak Brook, Illinois; *Shining the Light on Errors: How Open Should We Be?*; 2002


International Journal for Quality In Health Care; *The JCAHO patient safety event taxonomy: a standardized terminology and classification schema for near misses and adverse events*; February 21, 2006.


The Joint Commission, Oak Brook, Illinois; *Hospital Accreditation Standards (HAS)*; 2008.

Approved by Clinical Board: 2/19/02, 3/15/05, 3/18/08
Written: 12/01
Revised: 2/05, 2/08
NOTIFICATION OF FAMILY FOR EMERGENCY CARE AND/OR DEATH

Purpose:

To insure appropriate and timely notification of family members of patient’s arrival to LSUHSC-S for emergency care, acute change of medical condition and/or death of patient.

Policy:

1. On the arrival of patients to LSUHSC-S who are unable to notify family of their medical condition such as in massive trauma, cardiac arrest, change in medical condition the unit charge nurse will be responsible for initiating efforts to contact family.

2. Upon the pronouncement of a patient’s death, the physician will notify the family immediately. Notification shall be documented in the physician progress notes of the medical record, and will include who was notified and at what time notification occurred.

3. In cases of emergency or acute/critical change in the patient’s condition, the primary nurse or designee, will make all reasonable efforts to locate family by using all available resources, i.e.: Invision, patient’s wallet or personal identification. If unable to locate family notify the charge nurse and Administrative House Manager. The AHM may request UPD to contact local law enforcement agencies to assist with location and notification of family members.

4. The charge nurse or designee is responsible to provide to the physician the contact information so that the physician may talk to family either on the phone or in person. The individual contacting family should emphasize only that there is a change in the patient’s condition and location, if appropriate or that they have arrived at LSUHSC-S. All family contact must be documented in the medical record.

5. UPD shall be notified of the death or change of medical condition of a prisoner patient. They are responsible for notifying the appropriate law enforcement agency that has custody of the prisoner.
6. The deceased patient's medical record shall be completed and sent to the Admitting Office within two hours of pronouncement of death.

7. Admitting will verify family member notification is documented in the progress note. If such is not present, Admitting will contact the physician and request completion of the documentation.

8. If the physician has failed to notify the family with appropriate documentation noted in the medical record within two hours, Admitting will contact the Hospital Administrator/Administrator on Call.

9. The Administrator/designee will contact the physician or Department Chairman to ensure that every effort has been made to contact the family.

____________________________
Administrator

5/20/09
Date

Approved by Clinical Board: 4/16/02, 6/21/05, 3/21/06, 5/19/09
Written: 3/02
Reviewed: 5/05, 3/06, 4/09
Revised: 3/06, 4/09
PHYSICIAN CONSULTATION

Purpose:

To delineate policies and procedures for the timely completion of consultations. To provide guidelines for the interaction between attending physicians and consultants to ensure quality patient care.

Policy:

1. A request for a consultation shall be noted in the physician’s orders or the progress notes.

2. The consultation request form shall be completed by the requesting physician 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, hospital service, and beeper number. A copy of the ED record will be placed in the chart with the written consult.

3. The physician (or designee) requesting an ED or inpatient consult shall contact the service to be consulted by telephone through the Hospital paging system.

   a. Routine inpatient consults should be answered within 24 hours. Routine outpatient consultations shall be answered within the time frame requested. All requests for consults shall be immediately communicated, other than those for routine clinic appointments and accompanied by a legible written consultation request form. Consult forms are never to be sent via campus mail; consults are delivered by hospital staff to the appropriate area/department.

   b. Emergency or stat consultations shall 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 Clinical Service directly of the need for the consultation, giving the patient’s name and location.
c. Emergency Department consults should be answered within ONE HOUR. Once the consult service writes orders or sends admission papers the patient becomes the responsibility of the consult service. The consult service should notify the ED physician of their plan BEFORE leaving the ED. In the event of a conflict as to which services is the most appropriate one for the patient, the Attending Physicians of the involved services should be contacted. If the Attending Physicians do not agree, the Hospital Medical Director or designee will determine the final disposition of the patient.

4. A monthly listing of designated consultants for each clinical service is published and available at the Switchboard.

5. Problems obtaining consultations should be directed to the attention of Hospital Administration or Hospital Medical Director.

6. The consultant physician shall evaluate the patient and complete the consultation form in a timely manner. Consults determined to be inappropriate (patient’s medical condition not consistent with, or services needed not provided by, the consult service) are returned to the referring service with an explanation.

7. The consultant shall make recommendations regarding testing, medications, and subsequent management.

8. The consultant should stipulate his plan of continued involvement and sign off the case when appropriate.

9. If additional input from a consultant is needed at a later date, a new consultation order should be initiated.

Administrator
10/23/09
Date

Approved by Clinical Board: 2/17/04, 2/20/07, 10/20/09
Written: 2/04
Revised: 12/06, 9/09
Reviewed: 12/06, 9/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER -
SHREVEPORT

PATIENTS ON NON-LSU PATIENT CARE EQUIPMENT

Purpose:

To delineate the roles and responsibilities of personnel in the provision of care of patients arriving at the LSU-HSC Hospital on equipment that is not the hospital property.

Policy:

1. LSUHSC assumes total care and responsibility for all patients upon arrival. A report of the patient’s status and pertinent medical information must be provided by those transporting patients to the facility. This report shall be given to the patient care area receiving the patient.

2. The patient will be assessed by an RN immediately following transfer. Assessment shall include heart rate, respiratory rate, blood pressure, temperature and, if the patient is receiving supplemental oxygen and/or ventilator support oxygen saturation. The RN will document the patient’s assessment in the medical record.

3. As a general rule, patients shall be transferred to hospital equipment upon arrival to LSU-HSC. However, the attending physician may determine that it is in the best interest of the patient to leave them on their personal equipment rather than change them to hospital equipment for the duration of their visit. Factors considered in making this decision shall include the availability of clinically equivalent equipment, length of time the patient has used the equipment, clinical history and stability of the patient and competency of personnel to properly maintain and monitor the equipment. Should the decision be made for the patient to remain on their personal equipment, Biomedical Engineering must be contacted to certify the equipment for use in the hospital. The physician must write an order in the patient’s medical record stating they are to remain on their personal equipment rather than be transferred to hospital equipment.

4. The patient registered as an outpatient with life-supporting equipment shall be allowed to remain on the equipment for the...
duration of the outpatient clinic visit. The patient shall be assessed by an RN upon arrival and monitored for the duration of the visit; the ventilator shall be checked by Respiratory therapy to ensure appropriate functioning. Both the patient and equipment assessment shall be documented in the patient’s medical record. Hospital gases and/or electrical sources shall be made available to the patient as needed.

5. Hospital personnel shall be responsible for facilitating safe transportation of patients on the premises, including, but not limited to the necessary equipment and gas sources needed for transport. Transport of the patient on life support equipment shall be minimized; testing and treatment shall occur in the patient care area whenever possible. In those cases where these patients must be transported to a non-nursing care area, an RN shall accompany the patient. Respiratory therapy personnel shall assist with the transport of ventilator patients. The RN is responsible for assessing the patient and for ensuring that the appropriate level of monitoring is performed based upon clinical indications and the patient’s medical history.

Approved by Clinical Board: 5/17/05, 4/15/08
Written: 3/05
Revised: 3/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

INCREASED CONTROLS FOR RADIOACTIVE SOURCES

Purpose:

LSUHSC-Shreveport shall control access at all times to radioactive material quantities of concern and devices containing such radioactive material, and limit access to such radioactive material and devices to only approved individuals who require access to perform their duties.

Policy:

A. Access control

1. Unescorted access to restricted areas (and the radioactive sources) will be limited to approved individuals who require access to perform their duties.

2. Approved individuals are defined as those persons who, after proper review of their background as defined in this document, are deemed “trustworthy and reliable” (T&R) by the Hospital Radiation Safety Committee.

3. In order for an employee to be granted access to a restricted area, a Radioactive Material Access Request form must be completed by the department director and submitted to Hospital Administration for processing. A designated T&R Official will review the completed form and background information to determine if access is required and that the employee meets the T&R requirements. The T&R Official will then submit the request to the Radiation Safety Committee for review and approval.

4. The Hospital Radiation Safety Committee chair shall maintain a current file of all applicants who have been approved for access to restricted areas. Approval for access shall be limited to those personnel with job duties that require access.

5. Personnel requiring access to perform a job duty, but who is not approved by the RSC for unescorted access must be escorted by an approved individual. The approved individual
must remain with the unapproved individual for the duration of job.

6. All unapproved individuals entering the restricted area must sign in on the visitor log book; required information includes their full name, purpose for entering, date and time of both entering and leaving the area; the approved individual escorting the visitor must also sign the logbook, verifying date and time.

7. Information used by third-party service providers (service and/or maintenance personnel) used to determine their own employees T&R will be used as a basis for LSU-HSC, Shreveport, and determination of the trustworthiness and reliability of the same service providers. Exception: individual is on an M&D license. If this information is not available, all service personnel and others requiring access to restricted areas will be escorted during the extent of their access to the unit by an approved individual.

B. Physical Security Measures

1. Access to all restrictive areas containing radioactive sources will be secured.

2. Access to the keys will be limited to approved individuals and controlled by the Assistant Administrator of Professional Services.

3. Restricted areas shall remain locked when not in use by an approved individual.

4. In the event of an alarm, the University Police protocol will be activated (see UPD department specific policy for response procedures). The following individuals shall be notified:

   a. Administrative house manager (if after normal business hours)
   b. Administrator on call
   c. Radiation safety officer

5. The Radiation Safety Officer (or designee) shall notify the DEQ at 225-765-0160
C. Documentation

1. Each unauthorized incident of attempted or successful access will be fully documented and filed. Each incident will be reviewed by the Radiation Safety Committee and any necessary corrective actions will be taken and documented to prevent future instances.

2. T&R documentation on employees will be maintained for three years after the individual’s employment ends.

3. Each time the list of approved individuals is revised, the previous documentation will be kept for three years after the revision.

4. Each time changes are made to the physical security program. The previous documentation will be kept for three years after the revision.

5. After the license is terminated, the Hospital shall retain all documentation required by these increased controls for three years.

D. Protection of Information

Detailed information describing the physical protection of the restricted areas and radioactive sources is considered sensitive information and shall be protected from unauthorized disclosure.

____________________
Administrator

7/27/09
Date

Approved by Clinical Board: 7/18/06, 7/21/09
Written: 5/06
Revised: 7/09
Reviewed: 7/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PATIENT VALUABLES

Purpose:

To define the process for acquisition, storage and return of patient valuables. To define the disposal process for unclaimed patient items in accordance with the statues of the state of Louisiana.

Definition:

Valuables are money, jewelry, prescription medications, documents, and items of monetary or sentimental value that can be stored in a safe deposit box with dimensions: 4 3/4 “W x 5”H x 18”L.

Policy:

1. LSU Health Sciences Center – Shreveport is not responsible for patient valuables/property that is not deposited with the University Police Department (UPD) for safekeeping.

2. Nursing staff will evaluate each patient admitted to LSUHSC-S to determine if there is a need to store patient valuables for safekeeping.

3. Nursing staff encourages the patient/family on admission to send identified valuables and patient property home. If not feasible, the patient/family is informed of LSUHSC-S patient valuables policy and is encouraged to store valuables in the University Police Department’s (UPD) safe deposit boxes.

4. Patients who refuse safekeeping and/or have large items, clothing, etc. that can not be stored in the safe deposit box will be asked to sign the valuables section on the Patient History/Assessment and Plans for Discharge record (S/N 1048) releasing LSUHSC-S from the responsibility of loss. A nursing staff member shall sign as witness to the patient/family signature.

5. Nursing staff notifies UPD that patient valuables need to be secured.
6. A UPD officer is dispatched to the patient area and in the presence of the nurse and patient (as appropriate) performs an inventory of the items to be secured. The UPD officer will complete a property sheet listing the patient’s valuables, with the patient (if able) and nurse signing the property sheet.

7. The patient valuables are placed into an envelope that is sealed in the presence of the patient, nurse and officer. UPD officer gives valuable identification stickers to nursing staff.

8. Nursing staff records a brief description of patient’s valuables and/or disposition on the Patient History/Assessment and Plans for Discharge record (SN1048). Nursing staff will place “Valuables in UPD” sticker on the bottom of the Medication Assessment History Form.

9. A nursing staff member accompanies the UPD officer to the safe deposit area where the patient valuables are placed into the safe deposit box and appropriate patient information is recorded in the UPD log. UPD gives a key/property envelope to the nursing staff member.

10. The nursing staff member delivers the key/property envelope to Patient Processing B1-5 (Central key storage area across from UPD) and signs the patient-processing logbook.

11. Patient processing staff records the appropriate patient valuables information and maintains the key and property sheet envelope in a locked file cabinet.

12. When patients’ valuables are required, nursing staff notifies UPD at extension 6165. Nursing staff informs patient processing of the patient’s name (or valuable key number) and receives the property envelope. Nursing Staff and Patient Processing Staff documents transaction. Nursing Staff delivers the property envelope/key to UPD office.

13. The UPD officer accompanied by the nursing staff member will take the safe deposit box contents to the patient. The UPD officer will release all inventoried items to the patient in the presence of the nursing staff member. The patient, nursing staff member, and UPD officers will sign the property sheet copies releasing the hospital of further responsibility.
14. For hospitalized patients requiring a portion of their valuables, the procedure identified in #12 and #13 shall be followed. The patient may redeposit any remaining valuables for safekeeping. Appropriate documentation and signatures on the original property sheet should be obtained. The steps identified in #7, #9, #10, and #11 would be followed. (Note: Step #8 is omitted in the redeposit procedure.)

15. In the event of the patient’s death, the University Police will release the contents of the patient’s safe deposit box to the authorized person(s) designated on the property sheet (with proper identification) or to the House Manager/Hospital Administration, as appropriate.

16. UPD will check inpatient discharge computer printout daily and contact patients/families via telephone or if no response will send a certified letter within 30 days requesting pick up of unclaimed valuables and property. Unclaimed valuables remaining 60 days after attempts to notify or notification of patient/family will be disposed of according to statues of the State of Louisiana.

17. In the event that valuables are lost or cannot be located, Nursing shall complete and submit a Variance Report to the QI Office.

_______________________
Administrator

7/19/07
Date

Approved by Clinical Board: 7/17/01, 8/17/04, 7/17/07
Written: 2/95
Reviewed: 9/97, 7/04, 6/07
Revised: 4/99, 5/01, 6/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

TISSUE PROCUREMENT, STORAGE, AND DISPOSITION

Purpose:

To provide guidelines for tissue procurement, storage and disposition at LSUHSC. All areas procuring, storing and dispensing tissue shall follow these guidelines as well as all unit/area specific policies.

Definitions:

Tissue specimens may include but are not limited to: bone, cornea, skin, heart valves/conduits, tendons, fascia, dura mater, bone marrow, veins, arteries, cartilage, sperm, embryos, eggs, stem cells, cord blood, synthetic tissue (artificially prepared, human and nonhuman based), and other cellular- and tissue-based transplant or implant products.

Policy:

1. The Safety Department has responsibility for oversight of the tissue program throughout the hospital.

2. The Safety Department will receive and maintain documentation regarding areas of tissue procurement, source facility, credentials of source facility, storage and coordinator of area and details of the recall process.

3. Units/area Procuring, Storing and Dispensing Tissue:

   A. Operating Room
   B. Burn Unit
   C. Clinical Lab (storage area for Out-patient clinic using tissues)
   D. Bone Marrow Transplant Lab
   E. Diabetic Limb and Wound Care Clinic

   See unit specific Policy and Procedure for details.

4. All contracts for tissue shall require the supplier to notify The Safety Department of all tissue/organ recalls.
Procurement

All units/areas shall have qualified staff assigned to perform the following duties:

1. Validate that source facilities whom supply tissues are licensed by state agencies and/or registered as a tissue establishment with the Food and Drug Administration (FDA).

2. Transport, handle, store, and use tissue according to the source facilities' or manufacturers' written directions.

3. Verify at receipt that package integrity is met and transport temperature was controlled and acceptable.

4. Quarantine any tissue that does not meet requirements for transplantation and will notify source vendor.

Storage

1. Each unit/area shall maintain records documenting the source facility, the original numeric or alphanumeric donor and lot identification, all recipients or other final dispositions of each tissue, and expiration dates. Log in all incoming tissue including but not limited to date of receipt, description of tissue, and person completing log.

   At the time of issuance for patient care, include medical record number, name of patient, date of use and other pertinent information based on unit/area specific policy.

   These records are retained for a minimum of ten years beyond the date of distribution, transplantation, disposition, or expiration of tissue.

2. Maintain continuous temperature monitoring for storage refrigerators, freezers, and cabinets. Storage equipment must have functional alarms and emergency back up (exception: ambient storage cabinets).

3. Maintain daily records to show that tissues were stored at the required temperatures.

Main types of tissue storage are:
A. “Ambient” room temperature (for example, freeze dried bone)
B. Refrigerated, frozen (for example, deep freezing colder than -40°C)
C. Liquid nitrogen

Disposition

1. Documentation shall be made in the recipient’s medical record of tissue use, including documentation of the unique identifier of the tissue.

2. Each unit/area shall ensure the receiving facility returns tissue information cards to the source facility.

3. Each unit/area must maintain a detailed log containing information that allows LSUHSC-S to trace the tissue from the source to the patient and vice versa.

Recall

1. Tissue recall will be handled using Hospital Safety Department Recall Policy.

2. The Safety Department shall notify all areas involved (i.e. OR, BMT, Clinical Lab, Diabetic Limb and Wound Clinic), the Quality Leadership Team and the Infection Control Department of recalls or incidents of implanted tissue found to have HIV, HTLV-I/II, viral hepatitis, or other infectious agents known to be transmissible by tissue which are reported to them by the supplier or other entities.

3. The Safety Department will receive and maintain documentation of the recall process from all areas involved.

4. When discovered, each unit/area shall promptly report cases of post-transplant infections or adverse events first to Quality Management, Hospital Administration, Hospital Safety and Infection Control Departments.

   The source facility shall be notified by the direction of the Quality Leadership Team.

5. Each unit/area shall notify the Infection Control Department of adverse events (such as breaks in sterile technique), which occur
at the unit level that may adversely affect the integrity or sterility of the implanted tissue.

6. Any notification to Infection Control from unit/area involved in recall or adverse event shall include all pertinent information including but not limited to: the patients name, medical record number or social security number, date of implantation, and the suspected disease process or infecting organism, or description of other adverse event.

7. The Infection Control Department will determine the length of follow-up, the scope of the epidemiologic investigation, surveillance techniques, and organizational reporting in accordance with LSUHSC-S Infection Control guidelines and nationally recognized guidelines. The Infection Control Committee, the Infectious Disease Department and Hospital Administration will be consulted as necessary for guidance in surveillance and reporting.

8. It is the responsibility of the Infection Control Department to investigate adverse events involving implanted tissue that either have contributed to an infection or may contribute to an infection in the future, and to report findings to the appropriate department managers, directors, hospital administration and chiefs-of-service.

9. All stored organs/tissues from donors that are recalled or found to be contaminated with HIV, HTLV-I/II, viral hepatitis, or other infectious agents should be retrieved and quarantined immediately, under the direction of the Safety Department. This tissue may only be used for research purposes, destroyed or returned for credit, except when transplantation of an indispensable organ/tissue is necessary to save a patients life.

10. Notification of recipients of tissue from donors who are subsequently found to have HIV, HTLV-I/II, viral hepatitis, or other infectious agents known to be transmissible by tissue shall be under the direction of the Quality Leadership Team. Recipients shall be informed of infection risk.

References:

AATB Standards

JCAHO Standards PC17.10, PC17.20, PC17.30 Moore, Debra T., (August 2005). Clinical Issues. AORN.
CDC Guidelines for Preventing Transmission of Human Immunodeficiency Virus Through Transplantation of Human Tissue and Organs, MMWR 43 (RR-8); 1-17.


Administrator

9/22/06
Date

Approved by Clinical Board:  9/19/06
Written: 7/06
Reviewed:
Revised:
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

FREE CARE DETERMINATION POLICY

Purpose:
To standardize the method in which LSUHSC-S facilities determine a patient and/or family unit to be “financially indigent” thus qualifying for free care which has been determined to be medically necessary by a member of the LSUHSC-S medical staff.

Policy:
I. SCOPE AND ELIGIBILITY
A. The LSUHSC-S Free Care Determination Policy will apply to all in-patient and outpatient services which there is a charge to the patient. This applies to both hospital and physician charges.

B. Those persons who are determined not to be financially indigent shall be processed in accordance with LSUHSC-S billing and collection policies.

C. Persons seeking free care treatment shall furnish all required information requested by LSUHSC-S in accordance with federal and state law pertaining to the provision of services to the indigent. (R.S. 46:6)

1. The Federal Poverty Income Guidelines will be used as the basis for determining whether a person or family is financially eligible for assistance.

2. Eligibility established by LSUHSC-S Patient Financial Services will be applicable throughout LSUHSC-S facilities.

II. DEFINITIONS
The following definitions shall apply to the LSUHSC-S Free Care Determination Policy:

A. Identification - All persons must present a valid government issued picture identification card and/or photo identification (school/work ID) at the time of registration/ admission.
Exception: Minor children accompanied by a parent/guardian, residents of a care facility (facility must verify identification of patient)

B. Residency - Persons applying for Free Care must be a Louisiana resident and a citizen of the United States of America. A person is considered a resident of the state of Louisiana when they actually live in the state and can provide proof of Louisiana residency by showing a Louisiana State issued Driver's License, a Louisiana State issued Identification Card, or a utility bill, in the person's name, with home address listed in addition to appropriate photo identification.

C. Financially Indigent – As used herein means any person whose family unit income is at or below two hundred percent (200%) of the Federal Poverty level for the size of the family unit, rounded to the nearest dollar, and who is uninsured for the portion of the bill for which the patient has financial responsibility. Patients with a third party payer source may be eligible for free care services. If such patient is determined to be financially indigent, the patient will be responsible for any applicable co-payments as defined in Managed Care Contracts.

D. Gross Income - As used herein means sum of income from salaries, Social Security benefits, pensions, rents, stocks, bonds, mutual funds, child support, self-employment and any other source of income applicable to the family unit. This income shall be rounded to the nearest dollar when applied to the LSUHSC-S scale for Free Care Determination.

E. Family Unit/Dependent – A family unit is any group of individuals related by blood, marriage, adoption or residence, whose income can be legally applied to the patient's medical expenses. Individuals over eighteen (18) years of age, emancipated minors and children living under the care of individuals, not legally responsible for their support shall not be considered in the family unit, unless they are claimed on their Federal Income Tax. For minor children, in the event there is a separation or divorce in the family unit, a legal document is required to verify which parent is the responsible party. If no legal document is present, then the parent accompanying the child at the time of service is responsible for the bill until such documentation is obtained. In case of a minor not claimed as a dependent, such as, new birth or new custody, for income tax purposes, the parents are still responsible for payment based on the free care qualification table but may increase the dependent deductions by the patient(s) in question.
F. Responsible Persons - As used herein, “Responsible Persons” means the patient's parent(s) or legal guardian(s) if (1) the patient is under the age of eighteen or (2) the patient has been declared mentally or medically incompetent. If the patient is over eighteen, the patient is responsible for his/her contribution based on his/her gross family income and allowed deductions, unless claimed is a dependent, in which case the claimant becomes responsible for the charges toward the cost of care based on the claimant's family income.

G. Third Party Payer - As used herein shall mean any party other than the patient and/or family unit who is or may be legally liable for payment of incurred charges.

H. Co-Pay – As used herein shall mean the amount a patient must pay at the time of service as determined by their Third Party Payer contract.

III. REGULATIONS

A. A person, who fails to supply the information necessary for accurate Free Care Determination shall be registered/admitted as self-pay and will be billed for all services rendered. Applicable deposits will be requested per departmental specific policies.

Acceptable Forms of Financial Information include:

- The most recent tax return
- A copy of pay check stub indicting time period covered by check
- A copy of SSI, SSD, or AFDC award letter or check
- A bank statement showing a monthly direct deposit of SSI or SSD
- A legal document showing the amount of child support/Alimony
- A statement from person providing financial support

Emergency treatment shall not be denied to anyone. Emergency cases will be advised of their financial responsibility prior to discharge.

B. Patients who choose to apply for free care will be given a deadline of 120 days from the date of discharge to provide the information to be evaluated for Free Care Determination.
1. If information is supplied within the 120 days from the date of discharge and free care eligibility is verified; the account will be appropriately classified as Free Care. Free Care Determination will be retroactive for services 120 days prior to the application date and will remain effective for the next twelve month (12) period.

2. If the patient fails to provide the required information within the 120 day time frame, the account will be appropriately classified as self-pay and billed accordingly.

   If the information is provided after the 120 day designated time frame, and Free Care Determination is verified, the effective eligibility will be for future cases only and not retroactive for previous services. Free Care Determination will remain effective for the next twelve (12) month period.

3. If a patient, or family unit, is determined to be ineligible for Free Care and their financial circumstances change, the patient/family unit may re-apply for Free Care ninety (90) days from the notification of denial.

4. Any person who is potentially eligible for Medicare, Medicaid, or Commercial Insurance and cannot or refuses to provide evidence of application or follow through with application for said benefits shall be presumed to be able to pay the applicable charge for services rendered and shall be billed accordingly.

C. Eligibility for Free Care will be verified in accordance with this policy based on household income and number in the family unit. The responsible person shall be advised of their responsibility to report any change in the family unit income, employment, composition, etc.

D. Patients with a third party payer source may be eligible for free care services. If such patient is determined to be financially indigent, the patient will be responsible for any applicable co-payments as defined in Managed Care Contracts.

E. Upon completion of the twelve (12) month Free Care Determination period, a patient/family unit must reapply for Free Care status.

IV. MEDICAL SPEND DOWN EXCEPTION
Patients presenting documented previously incurred medical expenses for the twelve (12) months immediately preceding treatment, from any health care provider, which are equal to or above twenty percent (20%) of the gross income of the family unit, will be provided medical treatment at no additional cost to the family unit for the next twelve months from the date of service.

V. FREE CARE QUALIFICATION TABLE

A. Family income shall be determined in accordance with monthly or annual income information provided by the patient/guarantor at the time of screening.

B. Except as previously defined, any individual or family unit whose income is at or below two hundred percent (200%) of federal poverty level is financially indigent as defined in this policy and shall be eligible for treatment/services in any LSUHSC-S facility at no cost to the family unit.

C. Any family unit whose gross income is greater than two hundred percent (200%) of the Federal Poverty Income Guidelines for that family unit will be responsible for the applicable charges for medical services. The gross income and the Poverty income guidelines are rounded to the nearest dollar when determining eligibility.

D. The Free Care Determination Table will be revised each year to the changes in the Federal Poverty Income Guidelines that are published annually in the "Federal Register". The effective date of the annual update will be the first day of each new fiscal year.

__________________________
Administrator

__________
8/20/09

Date

Approved by Clinical Board: 11/15/05, 8/18/09
Written: 8/05
Revised: 7/09
Reviewed: 7/09
TISSUE PROCUREMENT, STORAGE, AND DISPOSITION

Purpose:

To provide guidelines for tissue procurement, storage and disposition at LSUHSC. All areas procuring, storing and dispensing tissue shall follow these guidelines as well as all unit/area specific policies.

Definitions:

Tissue specimens may include but are not limited to: bone, cornea, skin, heart valves/conduits, tendons, fascia, dura mater, bone marrow, veins, arteries, cartilage, sperm, embryos, eggs, stem cells, cord blood, synthetic tissue (artificially prepared, human and nonhuman based), and other cellular- and tissue-based transplant or implant products.

Policy:

1. The Transfusion Service has responsibility for oversight of the tissue program throughout the hospital.

2. The Transfusion Service will receive and maintain documentation regarding areas of tissue procurement, source facility, credentials of source facility, storage and coordinator of area and details of the recall process.

3. Units/area Procuring, Storing and Dispensing Tissue:
   A. Clinical Lab, Transfusion Service
   B. Bone Marrow Transplant Lab

4. All contracts for tissue shall require the supplier to notify The Safety Department and Transfusion Services of all tissue/organ recalls.

Procurement

All units/areas shall have qualified staff assigned to perform the following duties:
1. Validate that source facilities whom supply tissues are licensed by state agencies and/or registered as a tissue establishment with the Food and Drug Administration (FDA).

2. Transport, handle, store, and use tissue according to the source facilities’ or manufacturers’ written directions.

3. Verify at receipt that package integrity is met and transport temperature was controlled and acceptable.

4. Quarantine any tissue that does not meet requirements for transplantation and will notify source vendor.

**Storage**

1. Each unit/area shall maintain records documenting the source facility, the original numeric or alphanumeric donor and lot identification, all recipients or other final dispositions of each tissue, and expiration dates. Log in all incoming tissue including but not limited to date of receipt, description of tissue, and person completing log.

2. At the time of issuance for patient care, include medical record number, name of patient, date of use and other pertinent information based on unit/area specific policy.

3. These records are retained for a minimum of ten years beyond the date of distribution, transplantation, disposition, or expiration of tissue.

4. Maintain continuous temperature monitoring for storage refrigerators, freezers, and cabinets. Storage equipment must have functional alarms and emergency back up (exception: ambient storage cabinets).

5. Maintain daily records to show that tissues were stored at the required temperatures.

Main types of tissue storage are:
A. “Ambient” room temperature (for example, freeze dried bone)
B. Refrigerated (2-8°C)
C. Frozen (<-40°C)
D. Liquid nitrogen
Disposition

1. Documentation shall be made in the recipient’s medical record of tissue use, including documentation of the unique identifier of the tissue.

2. The Transfusion Service shall ensure that tissue information cards are returned to the source facility.

3. The Transfusion Service must maintain a detailed log containing information that allows LSUHSC-S to trace the tissue from the source to the patient and vice versa.

Recall

1. Tissue recall will be handled using Hospital Safety Department Recall Policy.

2. The Safety Department shall notify Transfusion Service, the Quality Leadership Team and the Infection Control Department of recalls or incidents of implanted tissue found to have HIV, HTLV-I/II, viral hepatitis, or other infectious agents known to be transmissible by tissue which are reported to them by the supplier or other entities.

3. The Safety Department will receive and maintain documentation of the recall process from all areas involved.

4. When discovered, each unit/area shall promptly report cases of post-transplant infections or adverse events first to Quality Management, Hospital Administration, Hospital Safety and Infection Control Departments. The source facility shall be notified by the direction of the Quality Leadership Team.

5. Each unit/area shall notify the Infection Control Department of adverse events (such as breaks in sterile technique), which occur at the unit level that may adversely affect the integrity or sterility of the implanted tissue.

6. Any notification to Infection Control from unit/area involved in recall or adverse event shall include all pertinent information including but not limited to: the patient’s name, medical record number or social security number, date of implantation, and the suspected disease process or infecting organism, or description of other adverse event.
7. The Infection Control Department will determine the length of follow-up, the scope of the epidemiologic investigation, surveillance techniques, and organizational reporting in accordance with LSUHSC-S Infection Control guidelines and nationally recognized guidelines. The Infection Control Committee, the Infectious Disease Department and Hospital Administration will be consulted as necessary for guidance in surveillance and reporting.

8. It is the responsibility of the Infection Control Department to investigate adverse events involving implanted tissue that either have contributed to an infection or may contribute to an infection in the future, and to report findings to the appropriate department managers, directors, hospital administration and chiefs-of-service.

9. All stored organs/tissues from donors that are recalled or found to be contaminated with HIV, HTLV-I/II, viral hepatitis, or other infectious agents should be retrieved and quarantined immediately, under the direction of the Safety Department. This tissue may only be used for research purposes, destroyed or returned for credit, except when transplantation of an indispensable organ/tissue is necessary to save a patients life.

10. Notification of recipients of tissue from donors who are subsequently found to have HIV, HTLV-I/II, viral hepatitis, or other infectious agents known to be transmissible by tissue shall be under the direction of the Quality Leadership Team. Recipients shall be informed of infection risk.

References:

AATB Standards

JCAHO Standards: TS.03.01.01, TS.03.02.01, TS.03.03.01

CDC Guidelines for Preventing Transmission of Human Immunodeficiency Virus Through Transplantation of Human Tissue and Organs, MMWR 43 (RR-8); 1-17.


LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER-
SHREVEPORT

PATIENT DISCHARGE APPEAL PROCESS FOR MEDICARE PATIENTS
IMPORTANT MESSAGE FROM MEDICARE

Purpose:
To document delivery and demonstrate compliance in providing Medicare recipients the *Important Message From Medicare About Your Rights* (CMS-R-193) and information related to patients rights during the hospital stay as well as and their Medicare appeal rights related to their hospital discharge.

Procedure:

A. **Admitting** - Deliver Important Message (CMS-R-193) to all Medicare patients within 2 calendar days of admission.
   1. Provide explanation of information to patient
   2. Obtain signature (Follow LSUHSC-S protocol if patient unable to provide consent).
   3. Provide beneficiary the original document.
   4. Retain hospital copy. Scan, archive, and place yellow copy on the chart under the “Admission” tab of the medical record located on the inpatient unit. Send the pink copy of the form to the Case Management Office for distribution to the appropriate case manager.
   5. Record action in log, monitor completion and follow-up with non delivered messages

B. **Case Management secretary** - Distribute the pink copies of the Important Message from Medicare (IMM) form to the appropriate Case Manager.

C. **Case Manager** - Provide IMM follow-up, preferably two (2) days prior to discharge or on the day of discharge only when unavoidable. (NOTE: If given on discharge day allow 4 hours to consider rights.)
2. Refer patient to their original document and/or LSUHSC-S patient handbook.

D. Nurse/MD/CM - Contact the Hospital Administrator on call or the Administrative House Manager (AHM) after hours, weekends, and holidays if the patient/family expresses concern about readiness for discharge.

Appeals Process:

A. Patient - If patient appeals discharge, the patient is responsible for notifying LHCR (Louisiana Healthcare Review) via the number on the IM from Medicare form.

B. LHCR - LHCR will notify the LSUHSC-S Admission’s office (675-7060) of patient’s appeal.

C. Admitting - Shall notify the Administrator on-call (5-5060) and the CM office (5-7074) of LHCR’s notification of patient’s appeal. After hours, weekends, and holidays, contact the AHM and provide them the LHCR information.

D. Case Manager (normal work hours) or AHM

1. Shall provide the patient a copy of the “Detailed Notice” Form (CMS 10066).
2. Shall provide to LHCR copies of requested documents:
   a. Medical record
   b. Copy of “Detailed Notice of Discharge” (Form CMS 10066)

E. Hospital Administration/AHM - Shall notify the Attending Physician of the pending Discharge Appeal and advise as to required documentation needed for the appeal process.

F. Attending MD - Shall document in the Medical Record the following:

1. Progress notes to include pertinent information supporting the decision for discharge.
2. Orders for the continued stay while case is being reviewed.
G. **LHCR** - Shall notify the patient and LSUHSC-S of its decision within 1 day after receiving all necessary information relating to the patient’s medical condition and discharge information.

1. If the LHCR finds the patient is not ready for discharge, the attending physician will be notified by the Administrator on Call or AHM; appropriate orders for continuing care will be written by the physician.

2. If the LHCR finds the patient ready for discharge, the patient will be notified by the LHRC that Medicare will continue coverage of services only until noon of the following day.

Approved by Clinical Board: 11/20/07
Written: 6/07
Reviewed:
Revised:
Scope:

LSUHSC-Shreveport which includes facilities and providers at all Shreveport, EA Conway, and Huey P Long Campuses.

Purpose:

As an issuer of credit to recipients of its healthcare services, LSUHSC-Shreveport adopts an Identify Theft Prevention Program (Program) to assist in identifying, detecting, and mitigating risks of identity theft affecting patients of the Hospital. This policy is intended to comply with requirements of Federal Trade Commission’s Identity Theft Prevention Red Flag Rules - 16 C.F.R. Section 681.2 (2008) which is a result of the Fair and Accurate Credit Transactions (FACT) Act of 2003.

Policy:

It is LSUHSC-S intent to provide safeguards to protect patients by detecting Red Flags and preventing or mitigating Identity Theft without impacting appropriate care of patients or compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA).

Definitions:

I. Identity theft - fraudulently using the identifying information of another person.

II. Medical Identity Theft - When an individual assumes or attempts to assume the identity of another person through fraudulent means or false pretenses and obtains or attempts to obtain medical service or goods, or to make false claims for medical services or goods.

III. Red Flag - a pattern, practice, or specific activity that indicates the possible existence of Identity Theft.

Procedure:

I. IDENTIFICATION OF RED FLAGS

   A. Activities involving Identity Theft generally fall within one of the following general types of red flags:
1. Suspicious documents
2. Suspicious personal identifying information, such as a suspicious address
3. Unusual use of – or suspicious activity relating to – a covered account
4. Alerts from others (e.g. customer, identity theft victim, or law enforcement)

II. DETECTION OF RED FLAGS

A. LSUHSC-S has adopted the following procedures to aid in the detection of red flags for identity theft:

1. New Patient Accounts
   Obtain appropriate identifying information and insurance information. This should include the following:
   a. Full legal name
   b. Date of Birth
   c. Address
   d. Government issued or other valid picture ID
   e. When applicable, patient’s insurance card, etc. (when possible, verify the insurance company’s information)

2. Existing Patient Account
   a. During each return patient registration have patient show a picture ID, and update the personal and insurance information listed above.
   b. Verify validity of requests for changes of billing addresses.
   c. Verify identification of patients before releasing any personal information.

3. Emergency Care – No Delay
   Providing identification is not a condition for obtaining emergency care. The process of confirming a patient’s identity must never delay the provision of an appropriate medical screening examination or necessary stabilizing treatment for emergency medical conditions.

III. PREVENTION AND MITIGATION OF IDENTITY THEFT

A. If a patient notifies LSUHSC-S of possible identity theft in regard to their medical record or bill, an investigation will be coordinated
with the appropriate department(s) (e.g., Patient Financial Services and Medical Records) pursuant to LSUHSC-S established departmental procedures.

B. In determining an appropriate response to a red flag or other threat of identity theft, LSUHSC-S will consider aggravating factors that may heighten the risk of identity theft, such as a data security incident that results in unauthorized access to a patient’s account records, or notice that a patient has become aware of someone fraudulently claiming to obtain medical services in the name of the patient.

C. Appropriate responses may include:

1. Monitoring a covered account for evidence of identity theft;
2. Contacting the patient;
3. Changing any passwords, security codes, or other security devices that permit access to a covered account;
4. Reopening a covered account with a new account number;
5. Not opening a new covered account;
6. Closing an existing covered account;
7. Notifying law enforcement; or
8. Determining that no response is warranted under the particular circumstances.

D. Internal Notifications:

Any LSUHSC-S employee who becomes aware of a potential or actual breach of personal information should report it to their manager for follow-up. The Compliance Office should be notified of all breaches and resolutions.

E. External Notification:

The Compliance Office will work with the appropriate department(s) to determine if any reports to outside agencies are required.

IV. UPDATING THE PROGRAM

LSUHSC-S will evaluate and update policies and procedures as necessary to reflect changes in risks to patients or to the organization from identity theft.
V. PROGRAM OVERSIGHT

The Compliance Office shall report to the Board, at least annually, on LSUHSC-S’s compliance with the identity theft program.

_______________________
Administrator

8/20/09
Date

Approved by Clinical Board: 8/18/09
Written: 7/09
Revised:
Reviewed:
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

UTILIZATION REVIEW

Purpose:

The Utilization Management Program is to assure appropriate allocation of hospital resources to achieve optimal patient care in the most cost effective manner.

Policy:

1. Federal and State regulations and Hospital Policy establish criteria used to perform preadmission (when applicable), admission, concurrent and retrospective reviews.

2. Reviews are also performed for insurance companies to certify admissions as well as continued stays.

3. Cases not meeting established criteria are referred to a designated physician advisor from the Utilization Review Committee. Potential quality of care issues, are referred to the Quality Management Department.

4. Utilization Management is a dynamic process that involves incorporation of changes from governing bodies and regulatory agencies and is an integral part of the Quality Improvement program. The Utilization Committee meets every other month and on an as needed basis, to review cases deemed inappropriate for admission to the acute care setting, determine appropriate billing status, and make recommendations for taking corrective actions geared towards optimizing the use of facility resources.

Administrator

5/01/07

Date

Approved by Clinical Board: 3/20/01, 4/20/04, 4/17/07
Written: 1/90
Revised: 1/95, 9/97, 3/04, 3/07
Reviewed: 1/01, 3/04, 3/07
USE OF ALIAS NAMES

Purpose:

To promote patient safety by protecting patients whose identity, if revealed, might jeopardize the well being of said patient, visitors or staff.

Policy:

The Administrator on Call or Administrative House Manager on duty at the time of receipt of the request will be responsible for initiating the process.

Procedure:

1. Requests received to change a patient’s given name to an “alias name” should be referred to the Administrator on Call or Administrative House Manager on duty at the time of the request.

2. The Administrator on Call or Administrative House Manager, in consultation with the patient’s physician, will review the request and make the decision to change the patient’s identity to an alias. Once the determination to utilize an alias has been made the Administrator on Call/Administrative House Manager will notify the Admitting Office Supervisor, University Police and the responsible Nursing Director. Admitting shall notify Patient Information and Medical Records Director or Office Manager on duty immediately of the name change. Nursing Director/Unit Charge Nurse shall notify the patient/family, primary physician and Information Services of the alias and visitation restriction limiting entrance to a spouse, parents and children only.

3. The Admitting Office will change the patient’s given name to an alias name in the computer system. A new arm band, hospital card and Face Sheet with the alias name will be sent to the floor. A copy of the Face Sheet with the alias name will be routed to Medical Records who will be responsible for changing the name back to the patient’s given name after the patient is discharged. The specific names to be used are maintained on file in the Admitting Office and in Medical Records.
4. Medical Records Department staff will correct all of the documents maintained in the medical record at the time of discharge to reflect the patient’s given name and will change the alias name back to the given name in the computer system.

5. Any inquiry for information regarding a patient using an alias name shall be referred to University Police. Media inquiries shall be directed to Information Services.

Approved by Clinical Board: 7/17/01, 8/17/04, 11/21/06, 11/20/09
Written: 4/93
Reviewed: 3/95, 12/95, 3/98, 5/01, 7/04, 10/06, 9/09
Revised: 6/97, 6/99, 10/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

NAME CHANGE

Purpose:

To set forth the policy permitting change of a patient’s name once the clinic registration, admission procedure or emergency room registration has been completed.

Policy:

1. Prior to initiating a name change at least one form of the following identification, with picture, must be presented to the Registration Clerk:

   a. Driver’s License
   b. State issued Identification
   c. Current Passport
   d. Valid US Military ID
   e. Marriage License

2. Name changes can be made for the following reasons:

   a. Adding of a first and middle name to newborn.
   b. Identifying Jane and John Doe.
   c. Changing a newborn’s last name.
   d. Marriage
   e. Divorce
   f. Changing a patient’s name that has been admitted under another name.

3. The Admitting Office staff enters the newborn’s names into the facility’s information system.
4. Medical Records staff adds first and middle names to the face sheet of newborn records and the computerized database.

5. After positive identification of Jane or John Doe has been made the Admitting Department will be notified so that the face sheet and addressograph card may be immediately corrected. The same procedure shall be followed for a patient registered or admitted under a different/incorrect name.

6. At the completion of the name change in the computerized system, the registration tech is responsible for completing the Request for Change/Deletion of Medical Record Patient Identifiable Information and forwarding to the Health Information Department.

7. For patients needing to have alias name reference policy number 2.6.
POSESSION AND DISPOSITION OF WEAPONS, ALCOHOL OR ILLICIT DRUGS ON STATE PROPERTY

Purpose:

To ensure a safe environment for employees, patients and visitors to the LSUHSC campus.

Policy:

The introduction of weapons, alcohol or drugs on grounds or into buildings of LSUHSC or any other state property is prohibited by Louisiana Law. It is clear that weapons (firearms, explosives, knives with blades six or more inches in length, straight razors, etc.) constitute an unacceptable threat to the safety of employees, patients and visitors. Accordingly, it is the policy of the Health Sciences Center that discovery of such unlawful items will be addressed as follows:

1. Contact the University Police Department immediately upon discovery.

2. University Police Department shall:
   
a. confiscate the weapon, alcohol or drugs;

   b. lodge a criminal complaint with Caddo Parish/Shreveport Police authorities as appropriate;

   c. report the incident to the Hospital Administrator/Administrator on Call and Director of Human Resources (if employee involved). If faculty is involved, the Medical Director or Associate Dean for Academic Affairs shall be notified. Based on the University Police Department report, the appropriate disciplinary action, up to and including termination, may be taken.
Introduction or possession of such contraband is chargeable as "Deliberately or carelessly endangering the safety of, or causing injury to personnel or patients" for which the maximum civil service penalty is dismissal.

Reference: Employee Handbook, pg. 101

Administrator

3/25/08
Date

Clinical Board Approved: 11/20/01, 1/18/05, 3/18/08
Written:  1/87
Revised: 9/97, 12/99, 8/01, 10/01, 10/04, 2/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

INCLEMENT WEATHER POLICY

Purpose:

To insure adequate levels of appropriately trained personnel for the provision of consistent, quality care to all patients during periods of inclement weather. Additionally, to provide appropriate supervision and support services in order for LSUHSC-S to continue operations.

Policy:

1. LSUHSC-S will operate in accordance with Administrative Directive 2.8.2 Inclement Weather.

2. Upon declaration of a weather emergency by the Chancellor or the Chancellor’s designee; Hospital Administration (or, after hours or on weekends, the Administrator on Call) shall be contacted. Hospital Administration shall initiate the Hospital Administration Emergency Call List. Each Administrator shall also be responsible for contacting each of their department heads to communicate the issuance of the declaration. Personnel who are required by their Departmental Weather Plan to work on weather emergency days are not excused for any reason other than illness.

3. The LSUHSC-S Information Services Department shall notify Shreveport television and radio stations that an official weather emergency declaration has been issued. Employees shall be responsible for monitoring the local media for information.

4. Each Hospital Department head will maintain a department specific inclement weather plan for the provision of services. This plan will be reviewed for appropriateness, not less than annually, and approved by the Hospital Administrator.

5. Due to limited resources of the Hospital, it is not possible to provide transportation for all personnel during a weather emergency. Personnel shall be responsible for managing their own transportation needs. Should it appear likely that roads might become hazardous, consideration of calling personnel in before transportation becomes a problem should be made, and personnel should also be advised of the need to consider staying over following completion of their shift. Employees are not to leave their assigned work areas until relief has been arranged.
6. When weather conditions improve and surface transportation is no longer hazardous, Hospital Administration shall issue an official notice to all hospital departments terminating the weather emergency.

_______________________
Administrator

_______________________
Date

Reference: Adm. Directive 2.8.2
Written: 1/91
Revised: 3/94, 3/03
Reviewed: 8/97, 11/99, 2/00, 3/03
Clinical Board Approval: 3/18/03
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.

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 by 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

4/22/09

Date

Approved by Clinical Board 9/21/99, 8/15/00, 6/15/04, 1/17/06, 4/21/09
Written: 2/95
Revised: 9/1/96, 5/98, 8/00, 5/04, 12/05, 3/09
Reviewed: 9/99, 5/04, 3/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

TRANSFER AND ACCEPTANCE OF STABLE PATIENTS TO LSUHSC-S

Purpose:

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

署名及日期

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Administrator
7/27/09
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批准日期

Approved by Clinical Board 9/21/99, 8/15/00, 10/21/03, 9/19/06, 7/21/09
Written: 11/86
Revised: 6/95, 5/98, 8/00, 1/02, 10/03, 9/06, 7/09
Reviewed: 9/99, 9/06, 7/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

HELI.CO.PTER TRANSPORTED PATIENTS
(Received at LSUHSC-S)

Purpose:

To establish guidelines to be utilized by all Hospital personnel when receiving a patient via helicopter.

Policy:

Patients may be transported via helicopter for either a direct transfer to an inpatient unit or to the Emergency Care Center (ECC).

A. Transfer patients for Direct Admit to inpatient units.

1. The physician for the Medical/Surgical Service who is receiving patient via helicopter shall be responsible for:

   a. Verifying bed availability and notifying admitting unless an ECC admit.

   b. Completing an admission approval form.

   c. Notifying the ECC of impending patient arrival by helicopter, and reporting the following information:

      1) Name of person calling and official position
      2) Number of patient(s)
      3) Condition of patient(s)
      4) Type of life support equipment needed
      5) Estimated Time of Arrival (ETA)
      6) Admitting physician and service
      7) Admitting unit

2. The ECC faculty is responsible for notifying the ECC Charge Nurse of the pending arrival and pertinent patient information.

3. The ECC Charge Nurse will be responsible for:

   a. Notifying Admitting/Bed Control and the receiving patient care unit of patient estimated arrival time as soon as information is received via Biotel or direct communication with air ambulance service.
b. Notifying University Police Department (UPD).

c. Notifying any other ancillary department, which may be necessary to render care.

4. The transport team will consist of UPD officers and the helicopter crew. Any additional personnel requested by the Helicopter crew will be added, i.e., Physician, RN or CNA (Certified Nurse Assistant).

5. All transfer patients (except those with trauma less than 24 hours) will be taken directly to the unit admitting the patient. Trauma (less than 24 hours) patients will be taken to the ECC, unless accepted to unit by trauma service.

B. Transfer patients for direct admit to the ECC. Biotel or air ambulance service will notify the ECC of patients being directly admitted to the ECC.

1. The ECC Charge Nurse shall be responsible for:

   a. Notifying any other ancillary department, which may be necessary to assist or render care.

   b. Notifying UPD.

C. The UPD shall be responsible for:

1. Assigning officers to the Transport Team.

2. Unlocking all doors between the helicopter and hospital.

3. Monitoring communication between the helicopter and the hospital.

4. Providing elevator operator.

5. Securing the helipad after departure of the helicopter.

D. Any information regarding revised ETA’s or patient condition received by the accepting service or UPD should be relayed to ECC/Registration staff as rapidly as possible.
E. The ECC shall provide any necessary medical and transportation equipment needed for the arriving patient or from direct communication with air ambulance service.

F. Information regarding Military Assisted Transport (MAST) patients can be obtained by phoning:

   Clearing House       (225) 389-3300
   Hotline              (337) 531-4797
   Information          (337) 531-4803 (Emergency)
   (Ft. Polk)           (337) 531-7928 (Questions)
   Louisiana State Police (318) 741-7411

G. Information related to LifeAir flights may be obtained by phoning:

   BioTel (Shreveport-Bossier) (318) 675-2135
   Schumpert ER          (318) 681-4223
   Willis Knighton       (318) 632-4698

Approved by Clinical Board: 5/21/02, 7/19/05, 9/18/07
Written: 11/98
Reviewed: 5/05, 8/07
Revised: 4/02, 6/05, 8/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

ORIENTATION, INSERVICE AND UNIT-BASED COMPETENCY ASSESSMENT EDUCATION

Purpose:

To provide specific guidelines for orientation, ongoing inservice education, and ongoing unit-based competency assessment training that has been identified as essential in maintaining employee competency necessary to provide services.

Policy:

1. LSU Health Sciences Center personnel shall have a comprehensive medical center and department-specific orientation program with evidence that responsibilities will be performed safely and efficiently in respective work environments. Volunteers shall have orientation as appropriate to patient care, safety, infection control and other activities in which they will be expected to perform in a competent manner.

2. Department heads shall be responsible for the following for each new employee:
   a. Ensuring attendance at hospital orientation and providing documentation of such in the employee's file.
   b. Organizing, completing, and documenting department-specific orientation for each new employee.
   c. Assessing and documenting initial competency.

3. Department heads shall be responsible for ongoing education of staff to improve their performance. The Department Education Record (Hospital Policy 3.1.1) should be completed for each educational offering by the program coordinator and it shall be maintained in departmental files to document response to learning needs.
4. Specific competency assessment tools shall be maintained in the department with results of employee competency assessment in their departmental personnel file.

5. Hospital Administration shall assess staff competence and report patterns, trends and competence levels to the governing body on an annual basis. These reports will be utilized to identify staff learning needs.

_______________________
Administrator

4/22/09
Date
LSUHSC – Shreveport
Departmental Orientation Essentials

Name: ________________________   Fiscal Year: _____________________
Department: ___________________

<table>
<thead>
<tr>
<th>Qualified Observer Initial/Date</th>
<th>Check-in procedure</th>
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<tbody>
<tr>
<td></td>
<td>Human Resource paperwork/requirements</td>
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<tr>
<td></td>
<td>Parking/access to Medical Center (UPD)</td>
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<td></td>
<td>ID Badge (UPD)</td>
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<tr>
<td></td>
<td>Verify license/certifications and review individual responsibility in maintaining licensure</td>
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<tr>
<td></td>
<td>Attended Human Resource Campus-wide Orientation</td>
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<tr>
<td></td>
<td>New Employee Health Evaluation Completed (Ex: TB Skin Test, Immunizations, etc.)</td>
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</table>

**Department/Organizational Issues**
Review organizational structure and available resources (library, interpreters, etc.)

Mission statement, goals of institution and department (Hospital Policy 1.1)

Discuss Joint Commission, JC standards and the Center of Medicare and Medicaid Services, CMS regulations, importance and the employee’s role and responsibility

Review Performance Improvement plan: purpose, monitoring, employee’s role and responsibility

Review state laws:
- Consent
- Practice Act
- Advance Directives
- Travel
- Organ Procurement
- Purchasing Procurement
- Gratuities
- Other: List

Tour of Medical Center and work area

Communications processes:
- Phone usage
- E-mail
- Internet (appropriate usage)
- Confidentiality
- Beeper system
- Invision System (training and sign-on)

**Job description/responsibilities**
Review job description, have an available copy at all times for employee

Relationship of employee job to the Medical Center and its staff

Annual merit and rating reviews

Performance/reappointment evaluation: review, available copy

**Hospital Policies**
Review of the following manuals:

- Hospital Policy and Procedure Manual
- Departmental Policy and Procedure Manual
- Safety Manual
- Infection Control Manual
- Administrative Directives
- Hospital Formulary

Other (list):
- No smoking
- Discipline Grievance
- Check out/Separation
<table>
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<tr>
<th>Qualified Observer Initials/Date</th>
<th>Departmental Policies</th>
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<tbody>
<tr>
<td></td>
<td>Departmental orientation skills checklist complete*(employee demonstrated ability to do core job functions, demonstrated ability to a preceptor)</td>
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<tr>
<td></td>
<td>Reviewed unit-based policy manual</td>
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<td>Dress code</td>
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<td>Use of ID badge</td>
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<td></td>
<td>Time and attendance, scheduling and overtime codes</td>
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<td>Call-in procedure</td>
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<td>Leave requests</td>
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<td>Break, lunch, dinner periods</td>
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<td></td>
<td>CPR, ACLS, other certifications appropriate for area. Procedure for responding to emergent, life-threatening events involving patients, visitors and employees.</td>
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<tr>
<td></td>
<td>Ongoing competency assessment (annual requirements): performance appraisal, mandatory hospital and departmental training, unit-based competency assessment (employee demonstrates to a qualified observer on an annual basis the changing skills required for job performance, <em>ex: new or changing or high-risk equipment, policies, procedures, etc.</em> ) and hospital and departmental requirements.</td>
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<td>Charting, documentation, billing, compliance issues</td>
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<td></td>
<td>Ethics</td>
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<td>Professional affiliations and payments</td>
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**Customer relations**

<table>
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<tr>
<th></th>
<th>Patient rights and responsibilities</th>
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<tr>
<td></td>
<td>Patient handbook</td>
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<td></td>
<td>Financial counseling</td>
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<td></td>
<td>Confidentiality: patient records, privacy, release of information</td>
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<tr>
<td></td>
<td>Abuse-Neglect criteria (Hospital Policy 5.5)</td>
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<tr>
<td></td>
<td>Customer Service: staff behavioral expectations to all persons who enter the Medical Center Complex and interactions with other departments</td>
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</table>

**Disaster/Emergency**

|                                | Emergency ID paging codes: Code Red, Code Yellow, Code Blue (Hospital Policy 5.12), Code Pink (Infant Abduction, Hospital Safety Manual 2.14), etc. |
|                                | Fire Safety: overall hospital and school plan, department specific plan, drills, employee role and responsibility |
|                                | Disaster Plan: Employee shall review the following policies located in the Safety Manual: Emergency Preparedness Plan (#2.14), Chemical Exposure/Decontamination (#2.15), Radiation Accidents, Emergency Procedures (#2.16), Biological Terrorism Plan (#2.17), and unit specific emergency preparedness plan as applicable |
|                                | Inclement Weather Plan: overall plan, departmental plan, employee responsibilities (Hospital Policy 2.8) |
|                                | Code response: in-house, off-site, 911 |

**Safety-Risk Management**

<p>|                                | Hazardous Material and Waste: Procedures and Precautions |
|                                | Materials Safety Data Sheet, location |
|                                | Safe Medical Device Act |</p>
<table>
<thead>
<tr>
<th>Qualified Observer Initials/date</th>
<th>Safety-Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Equipment maintenance and safety: department and hospital policy, employee’s role and responsibility, equipment reporting process, department routine maintenance procedures</td>
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<td></td>
<td>Film badges, other safety devices</td>
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<td></td>
<td>Hospital Safety Program: Department safety inspection, Job safety analysis, etc.</td>
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<tr>
<td></td>
<td>Employee safety responsibility: reporting hazardous spills, faulty equipment, unsafe acts, etc.</td>
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<tr>
<td></td>
<td>Occupational Health Clinic: services, Clinic hours, after hour services (EMS), exposure reporting, on-the-job injury reporting, annual TB assessment</td>
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<tr>
<td></td>
<td>Review of Departmental Specific Plan: fire, utility outages and security incidents</td>
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<td></td>
<td>☐ x56165 ☐ reporting procedure (variance report) ☐ electric ☐ water ☐ medical gas</td>
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<tr>
<td></td>
<td>☐ vacuum ☐ tube system ☐ call system</td>
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<td><strong>Other (list):</strong></td>
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</table>

I have completed a review of the above noted items with my Administrator/Supervisor/Manager.

___________________________    __________________________
Supervisor Signature Date    Employee Signature Date

______________________________________________________________________________

*Employee skills checklist completed and filed in employee file.*

<table>
<thead>
<tr>
<th>Qualified Observer Signature Date</th>
<th>Employee Signature Date</th>
</tr>
</thead>
</table>

Note: skills checklist shall list core job functions. Employee shall **demonstrate** the ability to perform core job functions to a qualified observer prior to performing them without assistance. It is recommended that the checklist be completed within three months of hire.
DOCUMENTATION OF RESPONSE TO LEARNING NEEDS:
DEPARTMENT INSERVICE AND UNIT-BASED COMPETENCY ASSESSMENT
EDUCATION RECORD

Purpose:

To facilitate advanced planning of in-service and unit-based competency assessment education programs in an organized manner and maintain education records in a systematic manner. Also, provide a mechanism that assists in tracking the hospital's assessment of staff development needs on a hospital-wide, departmental, and individual level.

Policy:

1. A Department Education Record (SN 1100) is to be initiated prior to the implementation of an inservice or unit-based competency assessment by the Program Coordinator.

2. The following information shall be recorded on the form as appropriate:

   a. Program Title
   b. Department
   c. Program Coordinator
   d. Speaker
   e. Date(s) and time(s) program is to be conducted
   f. Target audience
   g. Total attendance
   h. Need for program
   i. Teaching method used
   j. Verification method used
   k. Age specific concern
   l. Content Outline
   m. Age groups
   n. Resources used

3. Filing of in-service and unit-based competency assessment education records:

   a. Patient Care Services - after the record is completed it should be submitted to the Standards Office for computerized data entry. The
record will be returned to the department where it is to be kept on file for a period of not less than six years.

b. Other departments - after the record is completed, it is to be maintained in the department for a period of not less than six years.

4. Any verification documents (ex: written exams, checklists, case studies, etc.) shall be maintained in the individual employee files.

Approved by Clinical Board: 2/21/01, 4/20/04, 5/15/07
Written: 2/97
Reviewed: 1/98, 1/01, 3/04, 4/07
Revised: 1/01, 3/04, 4/07
Hospital Policy Number
Policy number: 3.1.1
Effective Date: 6/01/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

TREATMENT AND REHABILITATION OF IMPAIRED PHYSICIANS

Purpose:

To provide a mechanism for treatment and rehabilitation of physicians suffering from impairment that may interfere with optimal professional function and ensuring the protection of patients.

Policy:

1. Physicians shall receive ongoing education on impairment recognition, including signs and symptoms of controlled or mood altering substance impairment. Education shall address prevention of physical, psychiatric and emotional illness. (Hospital personnel shall receive education about illness and impairment recognition issues.)

2. Any impaired, or suspected impaired, physician, regardless of how identified (including self-referral), shall be seen by the Physician Director of the LSUHSC Occupational Health Clinic (OHC). The OHC physician shall evaluate, or cause to be evaluated, the referred physician for suspected impairment. The evaluation process shall be conducted in a confidential manner.

3. Should the OHC physician determine that drug testing is indicated, testing shall be in accordance with established Occupational Health clinic procedure; cost of all testing shall be born by the institution.

4. Upon completion of the evaluation, the OHC physician shall report his findings to the Associate Dean for Clinical Affairs. The Associate Dean shall notify the appropriate regulatory bodies, department chairman or others as deemed appropriate or mandated by law.

5. The Associate Dean, in consultation with other appropriate individuals, shall provide the impaired physician with options regarding treatment and assistance to aid the physician in retaining or regaining optimal professional function. Such treatment shall be done in a non-punitive manner, and shall be based upon the assurance that patient care is at no time compromised.
6. Should it be necessary to restrict the practice privilege of the impaired physician in order to insure the safety and best interest of patients, the Associate Dean for Clinical Affairs shall notify the Credentials Committee of the restrictions.

7. Monitoring of the affected physician shall be the responsibility of the Associate Dean or designee.

Reference: Administrative Directives 1.5.2, 6.6
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER –
SHREVEPORT

EMPLOYEE ACCESS TO CARE

Purpose:

To insure that all employees seeking healthcare at LSUHSC are
appropriately registered with complete and accurate demographic and
financial information.

Policy:

1. Employees of LSUHSC-Shreveport desiring to obtain healthcare
services from a LSUHSC-S physician or department must be
entered as a patient in the Hospital registration system. This
includes obtaining medication prescriptions, consults/referrals, work
or school excuses.

2. Employees being seen in the Occupational Health Clinic do not
have to register as patients.

3. Employees of the institution cannot obtain healthcare services for a
family member or acquaintance without adhering to established
registration guidelines, registering that individual as a patient.

4. All copays, deposits and out of state fees are applicable for
employees, family members and/or acquaintances.

Administrator

5/20/09

Written: 4/03
Clinical Board Approval: 5/20/03, 6/17/03, 3/21/06, 5/19/09
Reviewed: 6/03, 2/06, 4/09
Revised: 6/03, 2/06, 4/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

LEAVE AND HOLIDAY PAY FOR SHIFT EMPLOYEES

Purpose:

To provide for consistent recording of leave time and holiday pay for classified employees.

Policy:

I. Recommendations for appropriate recording are as follows:

A. If leave, annual or sick, has been approved prior to the posting of the schedule the employee will receive leave hours based on their regular work schedule.

Examples:

1. Employee ABC requests annual leave for a day. Annual leave is granted by her supervisor. The unit’s schedule will be posted with this date reflected as annual leave. Employee ABC shift schedule for this date is for a 12-hour shift. Employee ABC will receive 12-hours of annual leave.

2. Employee ABC requests annual leave for the entire bi-weekly schedule -- 84 hours. This request is made prior to the schedule being posted. Upon supervisory approval, employee ABC will receive 84 hours of annual leave.

3. Employee ABC requests sick leave for a physician’s appointment/procedure prior to the posting of the schedule. The supervisor acknowledges receipt/approval of the request. The unit’s schedule posts reflecting the date(s)/hours as a sick leave occurrence. Employee ABC receives sick leave payment up to 12-hours for the absence(s).

B. If annual leave or sick leave requests are received for date/time frame during the posted schedule the employee will only receive leave hours/payment up to 80 hours in a bi-weekly schedule.
Examples:
1. Employee XYZ requests annual leave for a day during
the posted schedule. Upon approval from the
supervisor, Employee XYZ will receive annual leave
payment up to 8-hours. Total hours for the bi-weekly
schedule will not exceed 80 hours, including the hours
paid as annual leave.

2. Employee XYZ requests sick leave during the posted
schedule. If all criteria are satisfied with regard to the
call-in policy, employee XYZ will receive sick leave
payment up to 8-hours. Total hours for the bi-weekly
schedule will not exceed 80 hours, including the hours
paid as sick leave.

II. Holiday pay should be based on the employee’s work schedule.

A. Holiday pay for those employees who worked on a
scheduled holiday should receive holiday payment based on
hours worked, not to exceed 12-hours.

1. Employee CBS worked 8 hours on designated
holiday, holiday pay should equal 8 hours.

2. Employee CBS worked 10 hours on designated
holiday, holiday pay should equal 10 hours.

3. Employee CBS worked 12 hours on designated
holiday, holiday pay should equal 12 hours.

B. Holiday pay for those employees, which are scheduled off on
a designated holiday, will receive 8 hours of holiday pay
unless it is required to bring the employee up to 80 hours in
the pay period.

C. Employees coded as LWOP both before and after the
designated holiday are not eligible to receive holiday
payment.

D. If an employee calls in requesting to be absent for a
scheduled holiday shift, leave hours/pay (annual or sick)
shall not be paid – only holiday pay. Holiday pay should not
exceed 8 hours, unless it is required to bring the employee
up to 80 hours in the pay period.
III. All other approved leave occurrences should not result in payment exceeding 8 hours in a shift schedule and/or 80 hours in a bi-weekly schedule. This includes leave payment for special leave, funeral leave, educational leave and civil leave.

A. Managers are not required to grant annual leave for employees who choose to leave a scheduled shift early in order to fulfill 80 hours in a bi-weekly schedule.

B. Employees, who have been approved to receive educational leave to attend college courses during regular scheduled work hours, should receive up to three hours per week of educational leave. Any additional absences may be coded as annual leave or leave without pay, upon supervisory approval.

C. If the employee is not required to complete the scheduled shift due to patient census, the employee may choose between utilizing annual leave or LWOP (authorized) for the absence. However, annual leave should not result in the employee being paid greater than 80 hours in a bi-weekly schedule.

IV. Recording time for Educational/Training Attendance. (Policy provided in the KRONOS Timekeeper Manual).

A. Classified employees could have job requirements that include hosting, teaching, or other forms of educational involvement. If these services are provided off campus, the time should be reported as hours worked.

B. Classified employees who are mandated to take certain educational courses in order to perform their work and/or upgrade their skills shall report those hours as hours worked. Prior approval from the employee’s supervisor shall be required. This shall also apply to annual programs mandated by JCAHO.

Example: A new program or piece of equipment is being implemented, and the required training can only be given off campus.

C. Both classified and unclassified employees who choose to take any educational offerings whether they are provided on campus or off campus may request special leave or annual
leave for those hours attended. Approval and determination of type of leave is at the discretion of the department head.

V. Employee Travel. (Policy provided in the KRONOS Timekeeper Manual)

A. Special One Day Trip: When an employee who normally works at one location is given a special one day assignment in another city, all the time spent traveling to and returning from the other city is considered work time. The only time that would be excluded is mealtime and the time spent that the employee would normally spend traveling between home and work.

B. Overnight Travel: When an employee is required to take a trip that keeps them away from home overnight all time spent traveling during the hours corresponding to the employee’s normal working hours must be counted as time worked. Travel hours on Saturdays, Sundays, and holidays that correspond to an employee’s normal working hours on other days of the week also must be counted as time worked. However, time spent traveling away from home outside of regular working hours, as a passenger on an airplane, train, boat or automobile, is not considered time worked.

Example: If an employee regularly works from 8am until 5pm on Monday through Friday, any time they spend traveling during those hours on Saturdays and Sundays as well as on weekdays is work time. However, time they spend traveling as a passenger on an airplane from 6am until 8am on Monday, for instance, is not work time.

[Signature]

Administrator

11/19/08

Date

Approved by Clinical Board: 8/16/05, 11/18/08
Written: 7/05
Reviewed: 9/08
Revised: 9/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

EMPLOYEE COUNSELING

Purpose:

To define the services provided by the Department of Family Medicine and Pastoral Care Services for employees of LSU Health Sciences Center – Shreveport.

Policy:

1. The Department of Family Medicine Employee Assistance Program has been established to provide emotional and psychological support to employees.

   a. Employees who need assistance can request an Employee Assistance Program appointment by:

      1). seeking help from their supervisor or

      2). by calling directly to the Chairman of Family Medicine’s office at 5-5640 for an appointment.

   b. The employee shares a brief description of problems and an appointment is made.

   c. Upon initial consult, a plan for care is outlined.

2. Pastoral Care Services provides support to LSU Health Sciences Center – Shreveport employees and staff during debriefing sessions and after severe crisis situations on units as requested.

   a. Pastoral Care Services are available 24 hours a day, 7 days a week.
b. To obtain assistance from Pastoral Care Services, contact the switchboard and ask for the Chaplain-On-Call to be paged. (Refer to HP 5.37)

Approved by Clinical Board: 11/21/06, 10/20/09
Written: 8/06
Revised: 10/09
Reviewed: 10/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

BEHAVIOR EXPECTATIONS AND STANDARDS OF CONDUCT

Purpose:

LSUHSC-S is committed to supporting a culture that values integrity, honesty and fair dealings with each other; and promoting a positive and safe environment for the hospital community that is reflective of the highest quality of care and professional conduct.

Patients, employees, management, professional staff, volunteers, students, contract workers and visitors all comprise the “hospital community”. As a part of the hospital community, these individuals are expected to uphold LSUHSC-S mission and values.

We believe that our mission of providing quality patient care, fostering a teaching environment for the education and training of healthcare providers and supporting medical and scientific research can best be accomplished within a culture of mutual trust, mutual respect and appropriate empowerment of patients, physicians and employees.

LSUHSC-S strives to maintain a workplace that is free from discrimination, harassment, and other inappropriate behavior. Such behavior will be investigated and reviewed in accordance with institutional procedure.

Policy:

1. It is the policy of LSUHSC-S to encourage and expect each person connected with the Health Sciences Center to, at all times, be aware of and concerned about how his or her attitude and actions affect the patient, fellow workers and visitors.

2. Appropriate behavior, as described by the institution, is required of all persons in order to establish and maintain a culture of safety and quality care throughout the facility.

3. All staff, at the time of employment, shall read and sign the TEAM pledge and Code of Conduct, acknowledging their understanding of the expectations of the institution in regards to appropriate conduct.

4. Disruptive or inappropriate conduct (as defined below) shall be reported at the time of occurrence through the hospital variance reporting system (HP #2.22).
5. Supervisory personnel, at the level necessary to address and correct the identified issues, shall investigate and take corrective actions regarding reported disruptive and inappropriate behavior. A summary of actions taken shall be reported through the variance system.

6. The responsible administrator(s) shall be copied on all behavior related variances filed and will be responsible for ensuring that corrective action was taken; in addition, the administrator shall utilize data from the variance reporting system to monitor for trends or potential trends of inappropriate behavior either by individuals or work area.

7. Human Resources shall be consulted as needed in order to manage and correct behavioral issues; interactions may include mediation of conflict resolution among staff, disciplinary action, and/or referral to professional counseling.

8. Allegations or reporting of sexual harassment in the work place shall be reported directly to the Director of Human Resources (or their designee).

9. Incidents of disruptive inappropriate behavior involving members of the medical staff shall be referred to the appropriate department chair and the Vice-Chancellor of Clinical Affairs for investigation and corrective action. Incidents involving House Officers shall be referred to the appropriate department program director as well as department chair. In both cases, corrective action shall be taken in accordance with the Medical Staff By-laws and the House Officer manual.

Definitions:

1. Appropriate behavior - an attitude or action displayed in interaction with others (patient, patient families, fellow employees, medical staff, and visitors) that includes:
   a. Courtesy and politeness
   b. Friendliness
   c. Concern for the well being of others
d. Sensitivity and prompt responsiveness to the customer's wants and needs

e. Cooperation with and helpfulness to the patient, members of the patient's family, visitors, and coworkers

f. Pride in self, job/profession, and the Health Sciences Center

g. Respect for the customer and coworkers

2. Disruptive and inappropriate behavior - any behavior that causes unrest, disorder or interrupts or impedes progress in the workplace; such behavior may include insubordinate conduct between a staff member and supervisor, peers, staff – patient or staff – family interactions; disruptive and intimidating behavior include verbal outburst and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions.

Responsibilities:

1. It is the responsibility of each employee to:

   a. Ensure that his or her attitude and actions are at all times consistent with the standards as outlined within this policy.

   b. Compliment a coworker when his or her actions comply with this policy.

   c. Remind a coworker when his or her attitude or actions are inconsistent with these standards.

   d. Call instances of excellence or noncompliance to the attention of the appropriate supervisor or department head.

   e. Report, via the Hospital variance system, occurrences of inappropriate or disruptive behavior that negatively impacts, or has the potential to negatively impact, the safety of patients, staff or visitors.

2. It is the responsibility of each department head and supervisor to:
a. Ensure that each employee under his or her jurisdiction upholds these standards.

b. Investigate reports of, document instances of, violation of these standards, and take appropriate corrective actions, especially when behavior is shown to repeatedly and willfully disregard the standards of behavior described above. Such appropriate action may include verbal or written counseling and guidance. If disciplinary action of a classified employee is warranted, it will be taken pursuant to and in conformity with Civil Service rules.

c. Commend an employee under his or her jurisdiction whose attitudes and actions consistently exceed these standards. Such commendation should include the issuance of a letter of commendation for placement in the employee's personnel file.

d. Evaluate an employee's compliance with these standards as part of conducting regularly scheduled performance appraisals and at other times as may be needed for the effective operation of the work unit.

e. Bring to the attention of the appropriate supervisor or department head instances of behavior contrary to or consistently in excess of these standards by an employee under the jurisdiction of another supervisor or department head.

_________________________
Administrator

________________________________

Approved by Clinical Board: 4/21/09
Written: 2/09
Reviewed:
Revised:
Related policies and documents which support, clarify and direct LSUHSCS position include:

Administrative Directive 2.1.4 Violence in the Workplace
Administrative Directive 2.1.3 Harassment
LSUHSCS Faculty Handbook
Administrative Directive 2.4.1 Counseling and Disciplinary Actions
LSUHSCS Employee Handbook 5.3 Customer Relation Policy
LSUHSCS Employee Handbook 5.6 Grievance Procedures
LSUHSCS Employee Handbook 5.2 Code of Ethics
LSUHSCS Compliance Program Code of Conduct
LSUHSCS CM-23 Conflict of Interest in Research
Patient Bill of Rights and Responsibilities
Presidential Memo 11 – outside employment
LSUHSCS Medical Staff Bylaws
LSUHSCS House Staff Manual
LSUHSCS Medical Staff Orientation for Residents
STAFF RIGHTS

Purpose:

To provide guidelines for department managers to address the rights of employees in regards to their involvement in any aspects of care perceived as conflicting with their personal beliefs.

Policy:

1. LSU Health Sciences Center - Shreveport recognizes that staff members may have cultural, religious, or personal conflicts concerning their involvement with specific components in the care or treatment of patients. LSU Health Sciences Center - Shreveport shall provide a mechanism for employees’ to submit their requests for review of work assignments by the department head, however the continuum of patient care services shall be maintained.

2. Staff Members will make their requests known to the department head, manager or supervisor in writing. Examples of procedures, which may conflict with some staff members' beliefs – include, blood administration, therapeutic abortion, circumcision and sterilization procedures.

3. The department head, manager or supervisor shall make every effort to accommodate the request and maintain the duties referenced in the employees' job description.

4. The department head, manager or supervisor shall reassign duties, if reasonable and possible, to accommodate the request and meet the needs of the patient.

5. Response to all requests for duty reassignment whether approved or denied will be provided in writing to the employee by the department head.
6. A record of all requests and actions taken shall be maintained in the employees’ departmental file and in Human Resources.

7. If the request of the staff member cannot be granted, the employee may appeal to the appointing authority to review the request. The determination made by Human Resources shall be final.

_______________________

Administrator

8/22/07

Date

Approved by Clinical Board: 10/16/01, 9/21/04, 8/21/07
Written: 9/94
Reviewed: 3/97, 11/98, 3/01, 8/01, 9/01, 10/01, 7/04, 7/07
Revised: 3/97, 11/98, 3/01, 8/01, 9/01, 10/01, 7/04
PREGNANT WORKERS IN RADIATION AREAS

Purpose:

To protect pregnant workers from over exposure to radiation, including radiation-producing machines or radioactive materials.

Policy:

1. If a worker becomes pregnant and is to be working around radiation-producing machines or radioactive materials, she is strongly encouraged to contact her supervisor immediately. The notification must be in writing and give the approximate date of conception. The supervisor must send a copy of the “Declaration of Pregnancy” to the Radiation Safety Office for use in assigning and monitoring film badges. The pregnancy must also be confirmed in writing by her physician.

2. Current Louisiana Radiation Regulations restrict the maximum dose of radiation to the fetus of 500 mRem during full term (50 mRem in any one month). Any pregnant worker who is likely to receive as much as 10 percent of the maximum must be monitored (50 mRem full term or 5 mRem per month). For those workers already wearing a dosimeter (film badge), no further determination need be made and a fetal monitoring dosimeter will be assigned upon receiving the written declaration of pregnancy. For those workers not currently wearing a dosimeter, yet may receive some radiation exposure during the pregnancy, the Radiation Safety Officer (RSO) will determine whether or not she is likely to received the 10 percent dose. If so, the worker will be assigned a fetal monitoring dosimeter. It is the responsibility of the pregnant employee to properly wear and submit the dosimeter.

3. The fetal monitoring dosimeter is to be worn on the abdomen. If protective gear is worn, such as a lead apron, the fetal monitor will be placed underneath the apron. The wearing of a lead apron may or may not be indicated depending upon the source of radiation. The RSO will make the determination in consultation with the pregnant worker in those few cases where the wearing of lead aprons may not be indicated. Each month the RSO will carefully monitor the fetal dose and take appropriate steps to maintain the
fetal dose within the allowable limits. Should exposure reach a precautionary level, the employee may be reassigned to a work area that would minimized any future exposure, based upon recommendations of the hospital RSO. The worker must notify her supervisor, in writing, upon termination of the pregnancy.

4. Should an overexposure occur, the Radiation Safety Officer will contact the employee, appoint a physicist to estimate the dose, and designate a physician to consult with the employee concerning fetal exposure and follow-up.

5. The supervisor must contact Karen Kafai in the Safety office by e-mail after the employee has delivered the baby so that the fetal monitoring badge can be deleted from the radiation exposure report.

Administrator

6/21/07

Date

Approved by Clinical Board: 5/15/01, 7/20/04, 6/19/07
Written: 3/95
Reviewed: 10/97, 5/98, 4/01, 7/04, 5/07
Revised: 10/97, 5/98, 4/01, 7/04, 5/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

STAFFING

Purpose:

To define the components that are necessary in a staffing plan to ensure adequate staffing levels of competent personnel in the Hospital.

Policy:

1. Departments that provide patient care services shall develop and utilize a staffing plan, which should include:
   a. Staff qualifications;
   b. Core coverage;
   c. Staffing guidelines;
   d. Scheduling limitations;
   e. Staffing assessment;
   f. Daily staffing adjustments;
   g. Staffing alternatives;
   h. Staffing performance Indicators, and
   i. Is based on applicable licensure, certification, laws, and regulations relative to the required staffing complement.

2. Staffing plans will be assessed on an ongoing basis in response to selected outcome measures. Examples of outcome measures may include performance improvement, patient satisfaction, variance reports and employee satisfaction. Specific staffing indicators may also include late assessments, missed treatments, missed medications, case backlogs, errors, patient and/or staff complaints, excessive or prolonged restraint/seclusion use and patient/family education not provided.

3. If selected outcome measures are unsatisfactory, an assessment shall be made and if necessary, staffing levels shall be adjusted to meet patient care needs.

4. Staffing plans shall include possible solutions to staffing problems. For example, if staffing levels are too low to meet patient care needs, staff may be floated to the department or contract agencies may be used to supplement staffing.
5. Staffing plans shall be accessible to staff that are making changes in staffing levels.

Reference: Department/Unit specific plans

Administrator

4/23/07
Date

Approved by Clinical Board: 2/01, 4/20/04, 4/17/07
Written: 2/95
Reviewed: 9/97, 2/00, 3/04, 3/07
Revised: 3/04, 3/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

COMPETENCY ASSESSMENT PROGRAM

Purpose:

To define the mechanism of establishing and maintaining qualifications and performance expectations of employees providing services and/or patient care at the University Hospital. To provide a mechanism at the department level for competency assessment of employees.

Definitions:

Competence is the potential ability to integrate the knowledge, skills, and attitudes required for performance in a designated role or setting.

Competency is the demonstrated ability to integrate the knowledge, skills, and attitudes required for such performance.

Employee –

- Individuals hired by LSUHSC-S,
- Individuals hired by the Medical School providing direct patient care in the University Hospital or in the Medical School, and
- Physical plant employees.

Exception–

Medical staff governed by Medical Staff By-laws will meet the requirements of the By-Laws to ensure competency and will not be required to meet the requirements of this policy.

A. Position description (HR.1)

1. Each department head or supervisor shall maintain a position description that specifies job duties, expectations, qualifications and special requirements commensurate with the position, i.e., ADA. All direct patient care position descriptions will address employee responsibility in caring for age-specific groups.

2. Positions will be reviewed any time there is a turnover in the positions and updated if there are any changes. Position
descriptions shall also be updated when the tasks, duties, and/or

3. Responsibilities of the position are changed or altered to significantly impact the performance of the job duties.

B. Performance appraisal (HR.3 and HR.5)

Each department head/supervisor shall develop and utilize a performance appraisal, specific to the job description, (Civil Service format for classified) for each employee that includes an evaluation of performance and competency.

C. Unit-based competency assessment

1. Direct patient care providers

   Shall participate in an ongoing unit-based competency assessment program that will include high priority performance specific competencies. The components of the assessment shall include an assessment of the employee knowledge (written or oral testing) and of the employee’s demonstrated ability to do the skill (demonstration in simulated or clinical situation, case study, etc).

Example:

   a. Employee successfully completed written test requirements and demonstrated the ability to perform the following skills: drawing of blood gases, application of restraints and appropriate age-specific skills for the pediatric patient.

   b. Employee verbalized understanding of procedure and demonstrated the ability to perform the following skills: cleaning of bed rails, sterilizing of equipment, and handling of contaminated trash.

   Shall be assessed for age-specific competency on an ongoing basis.

2. Non-patient care providers – the unit-based competency assessment shall be addressed as outlined above or shall be documented with a criteria-based performance appraisal.
If the criteria-based performance appraisal is used it shall be based on the job description and shall be objective and measurable.

Example:

a. Meets budgetary goals.
b. Takes off orders without errors.

3. The department head/supervisor shall be able to produce verification documents (ex: written tests, documentation of oral questions, case studies, observation checklists, etc.) that validate the employee’s competency for high priority unit-specific competencies.

D. All staff of LSUHSC-S shall participate in a continuous competency assessment program. The department head/supervisor is responsible for ensuring that employees meet the requirements of the program.

E. The program shall consist of the following components and compliance will be documented in the employee departmental file by the manager or department head.

1. All employees, on initial hire:
   a. Will receive a hospital orientation and departmental orientation (Hospital Policy 3.1) and
   b. Shall be seen in the Occupational Health Clinic.

2. All licensed employees providing direct patient care, including licensed contract services, on initial hire will meet above listed components and shall have licensure and certification verified.

3. All employees, on an on-going basis will:
   a. Be evaluated annually for performance,
   b. Participate in a unit-based competency assessment (refer to 3A),
   c. Complete all CED requirements
   d. Be seen in the OHC as required for their job duties
   e. Meet specific departmental requirements. (Example: Mandatory Education Day for Patient Care Services)
4. All licensed employees providing direct patient care, including licensed contract services providing patient care, on an on-going basis will meet above listed components and shall have licensure and certification verified prior to expiration.

5. The safety office will assume responsibility for providing and documenting mandatory requirements for contracted employees when interim life safety is imposed.

6. Practitioners, such as, CRNA’s, PA’s and NP’s will initially be credentialed by the clinical board. After initial credentialing, the independent practitioner will be responsible for meeting and submitting the above listed requirements (5C and 5D) on an annual basis to the medical staff office. The medical staff office, on an annual basis, will be responsible for reminding the practitioner in writing that documents are to be submitted to the medical staff office showing that the requirements have been met for the year. The medical staff office will assume responsibility for storing the documents and notifying the employee’s supervisor and/or Clinical Chief when documents are not submitted in a timely manner. The Assistant Hospital Administrator for Patient Care Services, will be notified by the Medical Staff Office of Nurse Practitioner and CRNA compliance to this policy.

7. Contract services, not providing direct patient care for LSUHSC-S on-site will:

   On an on-going basis will:

   a. Meet requirements of their contract, this includes meeting JCAHO and employee health care standards,
   b. Have their services evaluated annually as a group,
   c. Complete CED requirements and
   d. Meet specific departmental requirements.

8. All contracted services, professional and non-professional will meet the requirements listed in this policy. The department head that contracts for the services is responsible for evaluating services provided and documenting that the contracting agency is meeting above listed requirements; if requirements are not met, the contract will not be renewed.
9. All agencies that have affiliated agreements will meet JCHAO and health care requirements.

[Signature]
Administrator

5/20/09
Date

Approved by Clinical Board: 2/20/2001, 3/18/03, 3/21/06, 5/19/09
Written: 5/98
Reviewed: 9/99, 3/00, 1/01, 3/03, 3/06, 4/09
Revised: 9/99, 3/00, 1/01, 3/03, 3/06, 4/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PERSONAL RADIATION MONITORING DEVICES

Purpose:

The recording of radiation dose received by persons working with radioactive material and radiation-producing equipment is essential to minimizing exposure as well as maintaining compliance with state and federal regulations. LSUHSC utilizes personal dosimeter badges for monitoring radiation exposure. Badges are obtained through the Safety Office. In order to ensure the proper use of the dosimeter and subsequent protection of employees the guidelines contained in this policy must be followed at all times.

Monitoring Requirements:

Dosimeter badges must be worn by personnel meeting any of the following requirements:

1. Personnel likely to receive an annual radiation dose in excess of 10 percent of any of the following annual dose limits:
   a. Total effective dose equivalent of 5 rems
   b. Sum of the deep dose equivalent and the committed dose equivalent to an individual organ or tissue (other than the lens of the eye) being equal to 50 rems
   c. Eye dose equivalent of 15 rems
   d. Shallow dose equivalent of 50 rems to the skin or to an extremity

2. Radiation and imaging employees with a declared or planned pregnancy.

3. Personnel who enter a High Radiation Area (exposure to greater than 100 millirem in any one hour).


5. Personnel who meet special criteria as assessed by the Radiation Safety Officer or his/her delegated representative.

Procedures for Monitoring Devices:

1. The personal monitoring device (film badge) must be worn properly, stored properly and exchanged monthly at the due date.
2. Badges are to be worn at collar level and outside of radiation protection garments. Pregnant employees will wear a second badge at waist level and underneath radiation protection garments (refer to Hospital Policy 3.3).

3. All issued badges must be opened by the user regardless of whether the user will be working in a radiation area or not.

4. Each department/unit with staff required to wear a dosimeter badge must designate a badge coordinator.

5. The Safety Office is responsible for delivery of the badges at the end of each month to each department. The designated badge coordinator is responsible for distribution and collection of the badges. The badge coordinator is also responsible for the return of the badges to the Radiation Safety Office. Any change in staff, such as transfer, resignation, pregnancy, etc., must be forwarded to the Safety Office. A delivery date and deadline date for return is emailed by the Safety Office prior to end of month.

6. Badges are not to be worn away from the hospital, not taken home and not worn as a badge for another job. In the event that you work weekends or are unavailable due to leave, your badge should be here to exchange and meet the deadline. Racks are provided for placing your badge when you leave from work.

7. The coordinator has the responsibility of collection and return of the badges. They are not responsible for tracking down the badges. They should be on the rack and ready for pickup.

8. Dosimeter badge reports are prepared on a set schedule. Failure to turn in a badge will affect the accuracy of exposure data on the report.

9. The badge coordinator and department head will be notified when badges are being turned in late. A missing or invalid dosimeter reading creates a gap in your radiation dose record.

Compliance with Dosimeter Badge Procedure:

The Safety Office will provide a report to the Chair of the Radiation Safety Committee regarding each department’s compliance with the dosimetry badge guidelines. The Safety Office will assess:

1. Timeliness of turning in badges
2. Number of badges returned as compared to the number issued

3. Condition of badges such as a badge being returned still in the wrapper.

The Radiation Safety Committee Chair will review this report and take action as necessary to ensure that all departments adhere to the policy. The actions taken will be progressive based on repeat occurrences within a 12 month timeframe.

1. First Occurrence – Letter to the badge coordinator as a reminder.

2. Second Occurrence – Letter to the badge coordinator and Department Chairman.

3. Third Occurrence – Refer to the Vice Chancellor for review.

Individual departments are strongly encouraged to establish guidelines for staff accountability. An example is shown below:

Employees that fail to follow these guidelines are subject to disciplinary action. Violation of the policy will be recorded as an occurrence. Occurrences will be cumulative for a 12 month period.

a. First Occurrence – Verbal counseling

b. Second Occurrence – Written reprimand

c. Third Occurrence – Referred to Human Resources to review for disciplinary action.

Review and Maintenance of Dose Reports:

The Safety Office and Radiation Safety Officer (RSO) review occupational dose reports upon receipt. The Safety Office maintains occupational radiation exposure records. Investigations of exposures exceeding ALARA levels are conducted in accordance with hospital and state regulations.

Records are also reviewed to determine the necessity of dosimeter badges. In the event that an employee’s badge consistently demonstrates exposure that is under the requirement for monitoring, the Safety Office will notify that employee that a dosimetry badge will no longer be issued. If the employee does not agree with this action an appeal must be submitted within 10 days of receiving notice. The RSO will review the appeal and determine if a badge should be issued.
Requests for Occupational Exposure Records:

The Safety Office will receive and send requests for occupational exposure records. If an employee works outside LSUHSC in a capacity that requires personal dosimeter monitoring, that employee is required to notify their manager and the Safety Office so that the dose record from the outside facility can be obtained. Exposure records are confidential and a release form must be obtained from the requester and must be included in outgoing requests to the other institutions.

Administrator

2/19/09
Date

Approved by Clinical Board: 5/15/01, 7/20/04, 7/17/07, 2/17/09
Written: 6/95
Reviewed: 5/98, 5/01, 7/04, 6/07, 1/09
Revised: 1/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

EMPLOYEE TIME AND ATTENDANCE

Purpose:

To provide consistent guidelines for handling and monitoring employee time and attendance issues.

Definitions

Occurrence - Each continuous period of absence related to the same event shall be counted as one occurrence regardless of the number of consecutive workdays duration.

Tardy - Any incident in which the employee is not at their scheduled work station, ready for work at the beginning of the designated time/shift, shall be considered tardy.

Policy:

Each employee is accountable for his/her personal compliance with all aspects of the time and attendance policy. Deviations from this policy may result in disciplinary action up to and including termination.

A. Reporting to Work

1. Hourly/Classified Employee - Each employee shall be responsible for obtaining his or her scheduled work hours from his or her respective supervisor or department director. Each employee shall be expected to be at his or her workstation and ready for work at his or her assigned time. The assigned telephone shall be used to clock in and out. Employees should allow additional time for personal tasks, such as, changing uniforms, getting coffee, getting materials to take report, etc. Each employee is responsible for time clocked in or out, timely arrival at his or her workstation, and appropriate readiness for work.

2. Salaried/Non-Classified Employees - These staff members shall be expected to report to work as scheduled, adhere to all schedule requirements and demonstrate flexibility in the scheduling process.
B. Absence from Work

1. Any time planned by the employee to be away from their regularly scheduled time must be approved in advance by their supervisor or department director and must be done in compliance with any departmental policies regarding scheduled time off. This shall include vacation, holidays, educational days, planned surgical procedures, jury duty, funeral time, etc. All scheduled time shall comply with applicable time off policies.

2. Unscheduled Time Off - It is understood that an emergency may occasionally arise which prevents an employee’s prompt attendance at work. Such instances may include personal illness, illness of a minor dependent or a death in the family. For these instances, the employee shall be responsible for contacting their department head or supervisor as per departmental policy. The employee must speak with the designated individual responsible for receiving call-ins. Under no circumstances should a message be left with the switchboard operator or others regarding absence from work. A reason for the absence/tardiness must be given. A daily absence call is required unless a physician has specified an anticipated length of absence and this has been received in writing. After an absence for a personal illness of more than three consecutive days or at the request of the supervisor, a physician’s excuse may be required. Absence without notification for three consecutive days may constitute job abandonment.

C. Disciplinary Action

1. Disciplinary action may be taken when an employee:

   a. has an excessive number of occurrences of leave without pay
   b. has a significant number of tardies.

2. For purposes of disciplinary action, absences for the following reasons shall not be counted as an occurrence:

   a. jury or military duty
   b. authorized funeral leave
c. approved absences designated as family and medical leave

D. Disciplinary Action Steps

Step 1. Verbal counseling or written counseling may occur when an employee incurs three or more incidences of attendance issues. These incidences can be any combination of time off/absences or tardiness occurrences.

Step 2. Request for disciplinary action for continuous attendance issues, may be requested by the employee’s designated supervisor. Discipline should normally be progressive in nature, starting with a less severe action (i.e., suspension, reduction in pay) to move severe action (termination).

NOTE: If the employee performs with perfect attendance for a defined period and then reverts back to issues of tardiness or absenteeism, the disciplinary process shall begin again.

D. Unscheduled Absenteeism Non-Disciplinary Action
Refer to Administrative Directive 2.8.12 regarding non-disciplinary removal for employees’ absences from work.

[Signature]
Administrator

6/18/09
Date

Approved by Clinical Board: 5/15/01, 7/20/04, 4/18/06, 6/16/09
Written: 6/96
Revised: 11/98, 5/01, 6/04, 3/06, 5/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

EDUCATIONAL TIME

Policy:

To establish guidelines for both classified and unclassified personnel in regard to attendance at educational events.

Procedures:

1. Classified and unclassified employees whose job requirements include hosting, teaching and/or other forms of educational involvement shall report hours spent off campus providing these services as regular hours worked.

2. Classified and unclassified employees who are mandated to take certain educational courses in order to perform their work and/or up-grade their skills, shall report those hours as regular hours worked. Prior approval from their supervisor shall be required.

3. Both classified and unclassified employees who choose to take any educational offerings, whether they are provided on campus or off campus, may request special leave for those hours attended. These include classes or courses required for licensure or certification. Special leave is paid at base rate and is approved at the discretion of the supervisor.

_______________________
Administrator

7/19/07

Date

Approved by Clinical Board: 5/15/01, 7/20/04, 7/17/07
Written: 6/96
Reviewed: 11/98, 6/07
Revised: 5/01, 6/04
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PERSONNEL IDENTIFICATION AND BUILDING ACCESS BADGE

Purpose:
To establish a policy regarding issuing employee identification badges and granting building and clinic access.

Policy:
1. Every employee of the LSU Health Sciences Center will be furnished and required to wear an identification badge while on duty.
2. New employees will be furnished an identification badge during the orientation process by the UPD.
3. Employees who change names, position or department should immediately request a new identification badge.
4. Employees transferring between departments will be issued a new identification badge as well as revised building or clinic access upon receipt of an updated Request for Building Access and Photo ID card form.
5. Lost or damaged identification badges must be reported to the UPD for replacement. Replacement badges must be obtained by the next scheduled workday. Employees will be charged a $20.00 replacement fee for lost or employee caused damage to badges.
6. Identification badges remain the property of the LSU Health Sciences Center but are the responsibility of the employee.
7. The identification badge must be worn while on duty, displayed on the front portion of the outer garment, clearly visible and not obscured in any way. Exceptions may be made in sterile areas or where damage may occur.
8. Employees should carry their identification badge when visiting or conducting business at the hospital during off-duty hours.

9. Employees are required to present their identification badge upon request of any supervisor or university police officer.

10. Identification badges must be unaltered and free of any other material, i.e., pins, stickers, tape, etc.

11. The employee identification badge may not be used by any person, for any purpose, other than the individual to whom it was issued.

12. Employee misuse or alteration of the identification badge will be grounds for disciplinary action.

13. Employees must return their identification badge to the UPD upon termination of employment or a $20.00 fee will be assessed the employee or employee department.

BADGE COLOR DESIGNATION:

<table>
<thead>
<tr>
<th>Color</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Physician (faculty)</td>
</tr>
<tr>
<td></td>
<td>MD</td>
</tr>
<tr>
<td>Gold</td>
<td>RN</td>
</tr>
<tr>
<td>Gray</td>
<td>LPN</td>
</tr>
<tr>
<td>Green</td>
<td>House Staff</td>
</tr>
<tr>
<td></td>
<td>House Officers</td>
</tr>
<tr>
<td></td>
<td>Residents</td>
</tr>
<tr>
<td></td>
<td>Fellows</td>
</tr>
<tr>
<td>Orange</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td></td>
<td>CRNA</td>
</tr>
<tr>
<td></td>
<td>Physicians Assistant</td>
</tr>
<tr>
<td>Purple</td>
<td>Staff (All Employees/Faculty/Student Workers)</td>
</tr>
<tr>
<td>Dark Blue</td>
<td>LSUHSC-S Students (Medical Students, Graduate, Allied Health, visiting students with expiration date)</td>
</tr>
<tr>
<td>Brown</td>
<td>Observers/Participants (other schools) with expiration date</td>
</tr>
<tr>
<td>Pink</td>
<td>Volunteer (visiting Chaplains)</td>
</tr>
<tr>
<td>Black</td>
<td>Contractors (with expiration date)</td>
</tr>
<tr>
<td>White</td>
<td>Library Access only (landscape with expiration date)</td>
</tr>
</tbody>
</table>
NOTE: Students under facility contracts, i.e., Nursing programs, Radiology Technologist, etc., shall wear identification badges issued by their sponsoring institution while doing rotations at LSU Health Sciences Center.

Approved by Clinical Board: 9/18/01, 9/21/04, 4/19/05, 4/15/08
Written: 10/97
Revised: 8/01, 8/04, 3/05, 3/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

EMERGENCY PROCEDURES FOR DISLODGED OR LOST CESIUM IMPLANT

Purpose:
To provide a mechanism to safely handle dislodged or lost Cesium Implants (sources).

Policy:

A. Upon discovery of implanted radioactive source(s) out of applicator or applicator out of vagina:

1. Place source(s) or loaded applicators in transport cart using the following precautions.
   a. Handle sources using forceps with minimal pressure.
   b. Keep sources extended away from body at least 15 cm.

2. Place source(s) in transport cart in patient’s bathroom.

3. Record in the patient’s chart the time the sources or applicators were discovered out of place.

4. Call Therapeutic Physicist, extension 54656 or Beeper #0448.

5. Notify Therapeutic Radiology Physician 55334. Beeper #0416

6. After hours, contact Radiation Oncologist on Call and/or Therapist on call.

B. In case of lost source(s):

1. Call Therapeutic Physicist immediately, extension 54656 or Beeper #0448.
2. Notify Therapeutic Radiology Physician 55334 or Beeper #0416.

3. Leave patient in room with minimal attendance.

4. Do not allow any visitors to enter the patient’s room.

5. Do not remove any items from the patient’s room.

6. Do not move anything in the patient’s room.

7. Do not flush toilet.

8. After hours, contact Radiation Oncologist on Call and/or Therapist on call.

_______________________
Administrator

8/22/07
Date

Approved by Clinical Board: 5/15/01, 8/17/04, 8/21/07
Written: 1/86
Revised: 4/95, 5/01, 7/04
Reviewed: 5/98, 6/04, 6/07
Purpose:

To reduce worker and public exposure during radiopharmaceutical therapy.

Policy:

1. Patient’s room will be as far away from the nursing station and heavy traffic hallways as possible, while ensuring appropriate level of care is maintained. Patients will only be admitted to private rooms with private sanitary facilities.

2. Nuclear Medicine will notify Environmental Services to pick up the supplies from the Safety Office in order to prepare the room for the procedure as follows:
   
a. Use leak-proof absorbent paper to cover large surfaces (bed, pillow, chairs, night stand, bed-side table, and entire floor of the room and restroom) that are likely to be contaminated. Small items (telephone, door knobs, bed remote control, television control, and nurse call cord) may be covered with absorbent paper or plastic bags. Plastic protector sheets will be placed under the absorbent paper beside the bed and around the toilet in the bathroom.
   
b. Prepare (2) separate yellow plastic bags. One to be used for disposable contaminated items and the other to be used for non-disposable contaminated items.
   
c. Stock additional gloves, shoe covers, absorbent paper, and radioactive waste labels in the room for use as necessary by nursing, nuclear medicine, and radiation safety personnel. Gloves and shoe covers are used when entering the room.

3. Nursing will order disposable table service for the duration of the patient’s stay. Inform Environmental Services that their personnel should stay out of the room until otherwise notified.

4. Safety Office will supply nursing personnel with film badges.
5. Prior to the administration of I-131 nursing personnel will be briefed on radiation safety precautions. Use Form: I-131-no.7, “Nursing Instructions for Patients Treated with I-131” and Form: I-131-no.2, “Radiation Safety Checklist for Iodine Therapy over 30 Millicuries” as an outline.

6. A written copy of the radiation safety precautions will be left at the nurse’s station. Training Director for Radiation Safety will ensure training is current for nursing personnel. Document training on Form I-131-no.3 and retain.

7. Administering personnel will educate the patient on radiation safety procedures for the dosage administration, visitor control, radioactive waste, and other items as applicable.

8. Only those persons needed for medical, safety, or training purposes should be present during the administration.

9. Following administration of the dosage, Nuclear Medicine staff will measure and record the exposure rate in millirem per hour at bedside, at 1 meter from the patient and in adjacent rooms. Establish a safe distance line at 2 mrem/hour and mark with yellow tape on the floor. Post the bed with Form: I-131 Rx3; post the door to the room with Form I-131 Rx9; and post the chart with Form: I-131 Rx4 and Form: I-131 Rx5.

10. The physicist will calculate nursing time at bedside and record this and exposure rates on Form: I-131-no.1, “Room Survey Instructions for Patients Treated with Iodine and P-32”. Post Form: I-131-no.1 on door to patient’s room.

11. Thyroid burden of all nuclear medicine technologists is calculated monthly. Records of bio-assays are kept on file in nuclear medicine.

12. As the therapy proceeds, the Safety Office will pick up waste daily for transfer to a decay-in-storage area.

13. Patients undergoing radiopharmaceutical therapy shall not be transported to other areas of the hospital for treatment or testing without the approval of the medical director of Nuclear Medicine or their designee.

14. The patient will not be released until either the exposure rate from the patient is less than -7 (seven) millirem per hour at 1 meter or the retained radioactivity is less than 30 millicuries. If the exposure
rate standard is used as the release criterion, then measure at a distance of 1 meter from the umbilicus while the patient is standing or, if the patient is not ambulatory, 1 meter from the bedside with the patient supine.

15. Before using the room for general occupancy, it must be decontaminated and released. Complete the steps outlined below:

a. Nuclear Medicine staff will remove all absorbent paper, place it in the appropriate container; the Safety Officer will transfer all containers to a decay-in-storage or decontamination area.

b. Nuclear Medicine Staff will use a radiation detection survey meter to check for room contamination. Clean contaminated areas until removable contamination is less than 200 dpm/100 cm². When decontamination process is complete, the Nuclear Medicine staff will notify the hospital physicist that the room is ready for release. Should decontamination be unsuccessful, Nuclear Medicine will notify the Safety Office and Hospital Administration.

c. Nuclear Medicine staff and the Safety Officer will certify the room for release when decontamination is completed (removable contamination below 200dpm); complete Form: I-131 Rx6, signed and dated to release the room for general occupancy and notify Nursing that the room has been released.

d. Nursing will remove radioactive labels and notify Environmental Services to clean the room.

_____________________
Administrator

3/27/07

Date

Approved by Clinical Board: 1/12/01, 2/17/04, 3/20/07
Written: 8/28/97
Revised: 10/97, 12/03, 12/06
Reviewed: 2/00, 9/00, 1/01, 12/03, 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PLANNING AND PROVIDING CARE

Purpose:

To delineate policy for the planning and providing of patient specific care, medication use, nutrition care, care during operative and other invasive procedures, rehabilitation care, and care during special procedures including restraint or seclusion.

Policy:

1. The planning and provision of care will be based on individual patient assessment and focuses on the patient's response to actual or potential alterations to health.

2. The planning of care provides for communication of pertinent problems/needs, delineation of age-appropriate interventions to meet these needs, and documentation of the effectiveness of the intervention in the medical record. Care is planned by qualified staff.

3. When care is not planned to meet all identified needs this is documented in the medical record.

4. Integration of the plan will be accomplished through collaboration with various disciplines/departments, and is communicated through assessments, physician's orders, 24-Hour Patient Progress Report/Plan of Care, consults, progress notes, discharge plans and interdisciplinary meetings. The most recent patient orders will be utilized.

5. The planning and provision of care is driven by consideration of the rights of patients to make informed decisions regarding their care, including the right to accept or refuse care.

6. Patient progress is periodically evaluated against care goals and he plan of care and when indicated the plan or goals are revised.
7. Goals for the patient are based on assessment, needs, and diagnosis and are evident in the planning and provision of care as defined by the various disciplines involved in the care.

8. Provision of care will be accomplished by competent staff who are permitted by job descriptions, legal parameters, and hospital policy to perform the task/function.

9. The setting for care is determined by the patient's problems/needs, diagnosis, and care requirements for that particular patient. Admission and discharge criteria for intensive care standards of care and patient acuity system will serve as guides to the care given in planning and providing care. At no time will a patient be placed on a closed unit unless approved by the Administrator on call.

10. Follow up care is coordinated to ensure the patient’s needs are met or referred through the appropriate department or service.

Administrator

4/22/09

Date

Approved by Clinical Board: 1/12/01, 7/15/03, 11/21/06, 10/16/07, 4/21/09
Written: 1/95
Reviewed: 10/97, 1/01, 10/06, 9/07, 2/09
Revised: 4/01, 5/03, 11/06, 9/07, 2/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

HOSPITAL PATIENT/FAMILY EDUCATION POLICY

Purpose:

To promptly identify patient/family* educational needs in order to facilitate understanding of the patient’s health status, and care options, increase their potential to follow a therapeutic health care plan, and promote a healthy patient lifestyle.

Policy:

1. All patients shall be assessed for identification of educational/learning needs.

2. Patient assessment shall include identification of literacy problems, learning abilities, readiness to learn, financial implications of care choices, cultural and religious practices, emotional barriers, motivation to learn, physical and/or cognitive limitations and language barriers.

3. Once educational needs are identified, the health care worker shall determine what departments/disciplines will be required to meet those needs. Individuals or Departments involved may include:

   Physicians       Respiratory Care Services
   Inpatient/Outpatient Nursing Service       Clinical Lab
   Specialized Nursing Educators       Radiology Services
   Nutritional Services       Social Services
   Pharmacy       Case Management

4. Specialized instructions regarding medications, treatments, diet, activities, exercise, and other pertinent educational needs shall be documented in the medical record. The patient/family level of understanding should also be noted, as well as any referrals and actions taken to assist the patient in meeting educational needs.

5. Patient/family members shall receive education regarding illness or injury, medications, food-drug interactions, and use of medical equipment from qualified personnel. Education shall include information about future appointments, community resources, and discharge instructions. Specific education may be given by specialized instructors in various hospital departments. All
education shall be documented in the medical record preferably with the Interdisciplinary Patient Education Record (S/N 1102). Discharge instructions shall be noted on the Medication Assessment History and Discharge Instructions (S/N 7266). A copy of the Assessment History/Discharge Instructions shall be given to the patient/family, and may be sent to the primary care provider. A copy of the instructions shall also be retained on the patient’s medical record.

6. All specific educational forms that are to become a permanent part of the medical record must have the following approvals:

   a. Department Head

   b. Other Department, if impacted

   c. Administrator

   d. Medical Records Committee

   A copy of all the Education forms shall be given to the patient/family member and a copy placed in the medical record.

* Family refers to the person(s) who play a significant role in patient’s life. Individual(s) may or may not be legally related to the patient.

____________________________________________________________________________________

Administrator

5/20/09

Date

Approved by Clinical Board: 9/19/00, 3/18/03, 3/21/06, 5/19/09
Written: 2/95
Reviewed: 4/09
Revised: 1/97, 2/98, 8/00, 3/03, 3/06, 4/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

PATIENT EDUCATION REGARDING POTENTIAL FOOD/DRUG INTERACTIONS

Purpose:

To identify and educate patients and families on possible food/drug interactions so that optimal benefits from both medication and food can be obtained, and harmful interactions avoided.

To improve patient outcome.

To report actions to the Pharmacy and Therapeutics Committee.

Policy:

1. Hospitalized patients and families may receive education on potential food/drug interactions during hospitalization and/or upon discharge.

2. The patient and family will be assessed for readiness to learn and teaching will occur as appropriate.

3. Supplemental written information on food-drug interactions will be provided in the patient handbook. The objectives covered in the patient handbook will include:
   a. Educate patients on medicines commonly implicated in food-drug interactions
   b. Provide information on specific examples of food-drug interactions
   c. Inform patients of practices used to prevent food-drug interactions
d. Refer patients to healthcare professionals for additional food-drug interaction information.

Administrator

1/19/07

Date

Approved by Clinical Board 6/20/00, 6/17/03, 6/20/06, 1/16/07
Written: 3/16/95
Reviewed: 11/06
Revised: 11/97, 4/00, 5/03, 5/06, 11/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

TUTORIAL SERVICES
(PUBLIC SCHOOL SYSTEM)

Purpose:

To delineate guidelines for obtaining hospital based tutorial services for school aged patients who are hospitalized for 3 weeks or longer or for those school aged patients who will not be able to return to public school for an extended period of time post discharge.

Policy:

1. Information regarding tutorial services will be given to those school aged patients (and their families), who are hospitalized for three weeks or longer and/or those who will not be able to return to school for extended period post discharge.

2. The Case Manager will consult with treating physician to determine course/length of hospitalization for all school age patients in order to assess the appropriateness of a referral.

3. Once a determination has been made as to the length of hospitalization and the needs post discharge, the Case Manager will instruct patient/parent verbally on Hospital/Homebound Services.

4. A Hospital/Homebound Referral Form will be placed on the patient’s chart for completion by the physician.

5. After the physician has completed Special Educational Services Hospital/Homebound Referral Form, the Case Manager will mail or fax completed form to the parish school board (special education department) where patient attends school. In addition, a copy is given to the parent.

6. Referral form must be updated every 12 weeks.

7. Only those patients who are residents of Caddo-Bossier Parish Public Schools are eligible for hospital based tutoring.
8. Patients who reside out of Caddo-Bossier must have anticipated homebound needs for a minimum of 3 weeks after hospital discharge to qualify for services through their local school board. Those select patients who live out-of-parish, and have an expected lengthy hospital stay, may opt to transfer from their school of origin to a designated Caddo Parish school and receive homebound services through Caddo Parish while in-patient. The parents would then transfer back to their school of origin at hospital discharge.

9. Private schools do not have homebound services. When a private school student will have an extended absence from school due to illness, the case manager will work with the family to obtain the necessary school work and excuses for the student.

Approved by Clinical Board: 8/19/03, 9/19/06, 10/20/09
Written: 4/97
Reviewed: 11/97, 9/06, 9/09
Revised: 2/00, 7/03, 9/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

IMMUNIZATION EDUCATION & DOCUMENTATION

Purpose:

To provide immunization education and documentation guidelines which comply with the National Childhood Vaccination Injury Act.

Policy:

1. As required under the National Childhood Vaccine Injury Act (42 U.S.C. 300 aa-26), all healthcare providers in the United States who administer any vaccine containing diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, hepatitis B, Haemophilus influenzae type B (Hib), pneumococcal conjugate or Varicella (chickenpox) Vaccine shall, prior to administration of each dose of the vaccine, provide a copy of the relevant vaccine information materials that have been produced by the Centers for Disease Control and Prevention (CDC):

   a. to the parent or legal representative of any child to whom the provider intends to administer such vaccine, and

   b. to any adult to whom the provider intends to administer such vaccine.

2. The following Centers for Disease Control Vaccine Information Statements (VIS) are available from LSUHSC’s print shop or the website (http://www.cdc.gov/nip). By law, asterisked (*) items must be reviewed with the responsible party. In addition, all vaccine information sheets listed below must be used when giving vaccines purchased through a CDC contract.
### Vaccine Information Statements

<table>
<thead>
<tr>
<th>Vaccine Information Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diptheria-Tetanus-Pertussis *</td>
</tr>
<tr>
<td>Tetanus &amp; Diphtheria *</td>
</tr>
<tr>
<td>Measles-Mumps-Rubella *</td>
</tr>
<tr>
<td>Polio *</td>
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<tr>
<td>Hepatitis B *</td>
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<tr>
<td>Haemophilus Influenza type B *</td>
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<tr>
<td>Varicella *</td>
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<tr>
<td>Hepatitis A</td>
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<tr>
<td>Inactivated Influenza *</td>
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<tr>
<td>Pneumococcal Polysaccharide</td>
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<tr>
<td>Pneumococcal Conjuage *</td>
</tr>
<tr>
<td>Anthrax</td>
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<tr>
<td>Live, intranasal influenza</td>
</tr>
<tr>
<td>Meningococcal</td>
</tr>
<tr>
<td>Rabies</td>
</tr>
<tr>
<td>Yellow Fever</td>
</tr>
<tr>
<td>Small Pox (smallpox vaccine information statements should be used in conjunction with CDC’s smallpox information packet which includes 5 supplements)</td>
</tr>
</tbody>
</table>

3. A copy of the relevant Center's for Disease Control (CDC) vaccine information statement (VIS) shall be provided to the adult patient or, in the case of a minor, to the parent or legal representative prior to each dose of vaccine. The materials shall be supplemented with visual presentations or oral explanations, in appropriate cases. When a combination vaccine is administered, the VIS sheet for each of the components shall be provided.

4. Healthcare providers shall document the following information at the time a Vaccine Information Statement is provided:
a. Adults (over 18 years of age)

**Document the following in the LINKS system:**

1) Vaccine information statement used.
2) Date printed on the Vaccine Information Statement.
3) Date the vaccine Information Statement is given/discussed with the vaccine recipient, or the parent or legal representative.
4) Vaccine type, date, & route of administration.
5) Manufacturer lot number and expiration date of the vaccine.
6) Name and title of the healthcare provider administering the vaccine.
7) Address where the permanent medical record is maintained.
8) Patient’s name, medical record number, and date of birth.

**Document the following in the medical record:**

1) Vaccine type, date, & route of administration.
2) Name and title of the healthcare provider administering the vaccine.

b. Children (under 18 years of age)

**Document the following in the LINKS system:**

1) Vaccine information statement used.
2) Date printed on the Vaccine Information Statement.
3) Date the vaccine Information Statement is given/discussed with the vaccine recipient, or the parent or legal representative.
4) Vaccine type, date, & route of administration.
5) Manufacturer lot number and expiration date of the vaccine.
6) Name and title of the healthcare provider administering the vaccine.
7) Address where the permanent medical record is maintained.
8) Patient’s name, medical record number, and date of birth.

**Document the following in the medical record:**

1) Vaccine type, date, & route of administration.
2) Name and title of the healthcare provider administering the vaccine.
Document the following on the Compliance Website for all vaccines that are put into LINKS: Document requested patient information, choose immunizations in the quick complete disclosures section, click on guess the values and all information will be automatically displayed of what is being disclosed.

5. The LINKS (Louisiana Immunization Network for Kids Statewide) must be used to document vaccine administration for all patients. The use of the LINKS system is mandated for those of all ages because it prevents duplication of vaccination and resources.

6. LSUHSC is a participant in the LINKS program. The Louisiana Department of Health and Hospitals is considered a public health authority as defined in 164.501 of the HIPAA privacy rule, and is authorized under Louisiana Revised Code 40:31.11-16 to collect this information and re-disclose information to authorized users without consent.

Under this program, patients less than 18 years of age are able to obtain eligible vaccines at no cost in our hospital and clinics. Providers at LSUHSC who administer vaccinations must enter the required VIS/vaccination information into the LINKS system.

Nursing managers will be responsible for obtaining passwords, training each new vaccinator on the use of the LINKS system, and completing the competency assessment form. Clerks and medical records personnel may be given passwords, which enable them to enter and access data as a part of their normal work duties.

Vaccinators will be assigned passwords from the local health unit office, after a signed user agreement has been submitted. Each vaccinator prior to signing the agreement should read a copy of the LINKS confidentiality policy. The nursing manager for each area is responsible for obtaining passwords from the health unit, and notifying them to delete access when vaccinators are no longer working at LSUHSC.

Each unit shall post a notice that the hospital is a participant in the LINKS system. The patient or parent can refuse to let their child’s information be shared with other providers by completing a request form, which should be faxed to the LINKS program office in New Orleans.

On each day an immunization is entered into the LINKS system, an entry should also be entered into the LSUHSC disclosure log as described in Hospital Policy 6.3.
7. The American Academy of Pediatric Vaccine Administration Record (HE0116) may be used to document vaccine administration. It may be special ordered through the American Academy of Pediatrics at:

141 Northwest Point Blvd.
P.O. Box 747
Elm Grove Village, IL 60009-0747
Fax # 847-228-1281
Phone # 1-800-433-9016

References

Vaccine Information Statements: http://www.cdc.gov/nip/publications/VIS/

__________________________
Administrator

__________________________
1/19/07
Date

Clinical Board Approved: 11/21/00, 5/18/04, 1/16/07
Written: 4/99
Reviewed: 2/04, 10/06
Revised: 3/04, 10/06
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 house officers 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/Psych Crisis Center** - 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.

[Signature]

Administrator

9/17/08

Date

Approved by Clinical Board:  1/12/01, 3/16/04, 7/19/05, 9/16/08
Written:  11/86
Reviewed: 6/95, 2/96, 8/97, 5/00, 1/01, 2/04, 6/05, 8/08
Revised: 6/95, 2/96, 8/97, 5/00, 1/01, 2/04, 6/05, 8/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

PATIENT IDENTIFICATION

Purpose:

To provide an identification system to insure that all hospital patients are properly identified prior to any care, treatment or services provided.

Exception: Patients unable to provide identifying information, who experience conditions requiring emergency care, will receive treatment prior to identification if such care and treatment is necessary to stabilize the patient’s condition.

Policy:

1. Identifying procedures:

   a. A tamper-proof, non-transferable identification band shall be prepared and affixed to the patient. Personnel responsible for preparing the ID bands are as follows:

      1) Emergency Department – Patient Registration
      2) Inpatient Admissions and Observation Admits – Admitting Department.
      3) Labor and Delivery – Labor and Delivery Unit
      4) Outpatient Surgery – Outpatient Surgery Unit Staff
      5) Ambulatory Care Clinics/FWCC – Registration Staff
      6) Chronic Renal Unit/Interventional Suite – Renal Unit

      Identification bands are sent with admission paperwork to the patient location and affixed at the point by the receiving personnel.

   b. If an admission through the Emergency Room, the Admitting Office will prepare identification band, deliver to the Emergency Room and place it on the patient.

      Exception: A “stat pak” registration packet is initiated by ER Nursing for patients who are taken directly to the OR.

   c. The identification band shall show the Medical Record number, patient’s name, date of birth, sex.
d. Color codes for bands are as follows:

1) Inpatient – blue
2) Outpatient for 24 hour observation – yellow
3) ER – red
4) Outpatient Surgery – orange
5) Ambulatory Care Clinics/FWCC – No designated color
6) Chronic Renal Unit/Interventional Suite – No designated color

2. Initially, the identification band shall be checked by the appropriate hospital staff to ensure that it is legible and contains the correct information when the patient is registered.

3. Prior to the administration of tests, treatments, medications, or procedures the healthcare professional providing the care is responsible for verifying the patient’s identity by utilizing two identifiers: patient name and patient medical record number or DOB. Staff shall verbally assess the patient to assure proper identification, the patient’s name and DOB, and match the verbal confirmation to the written information on the identification.

4. If the identification band is illegible, missing, or contains incorrect information, the test, treatment, medication, or procedures will not be done until the patient is properly identified.

5. Nursing is responsible for obtaining a new band in the event that an identification band is illegible, missing, or contains incorrect information, obtaining a new band is from Patient Registration and Admissions. Labor and Delivery and Outpatient Surgery shall generate a new band if needed for their patients.

6. The patient can remove the identification band after discharge. In the event of death, the identification band shall remain on the patient’s body.

_______________________
Administrator

___________
Date

2/22/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PATIENT CALLBACK

Purpose:
To provide protocol for notifying patients of the need to return to LSUHSC for further examination or treatment as a result of missed appointments for high-risk diagnosis and/or abnormal test results.

Policy:

1. Patients shall be contacted for further examination, instructions or treatment when diagnostic test results are significantly abnormal compared to the patient’s norm and/or when their condition/diagnosis indicates a need for further treatment.

2. Documentation of missed appointments and abnormal test results are to be made according to unit-specific policy.

3. Physicians or other designated staff are responsible for determining the need to recall the patient.

4. Patients who have missed an appointment will be contacted for a return visit when they have a high-risk diagnosis. Each outpatient care area maintains a list of medical conditions, which may require the patient to be contacted for a return visit.

5. Method of contact will be based on the urgency of the occurrence. Methods of contacting the patient include: phone, regular mail and certified mail. If the timeliness of recall is critical, the local law enforcement agency or other public agency, such as the Public Health Unit, may be requested to make contact if other methods are unsuccessful.

Hospital Administrator
10/23/09

Date

Approved by Clinical Board: 3/20/01, 4/20/04, 1/16/07, 10/20/09
Written: 4/95
Reviewed: 4/98, 2/01, 3/04, 12/06, 9/09
Revised: 3/04, 12/06
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. For all non-arrest intubations, appropriate ancillary support shall be available to floor staff (i.e. at least cardiopulmonary and ICU nursing staff). The adult and pediatric code teams are designed to manage airway issues.

4. 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).
5. The switchboard operator, following notification of a Code, beeps the Code Team, Administrative House Manager 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.

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

7. 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.


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.

Approved by Clinical Board: 8/15/00, 7/15/03, 6/21/05, 6/17/08, 5/19/09
Written: 11/85
Reviewed: 2/95, 1/98, 5/03, 5/08, 4/09
Revised: 1/98, 7/00, 5/03, 5/05, 5/08, 4/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

CRASH CARTS

Purpose:

To insure availability of all drugs, equipment, and supplies necessary to initiate advanced life-support measures and insure uniformity of emergency carts throughout the medical center.

Policy:

1. Crash carts shall be provided on an “exchange basis” by Central Medical Supply (CMS) to all patient care areas to initiate emergency life-support measures.

2. Designated licensed personnel in the patient care area shall be responsible for:
   
a. Notifying CMS after crash cart has been used or lock has been broken.

b. Verifying contents of new crash cart with CMS personnel.

c. Co-signing central medical supply crash cart log.

d. Checking external contents of cart.

3. Central Medical Supply shall be responsible for:

   a. Delivering a restocked crash cart to the patient care area immediately upon notification of need.

   b. Verifying contents of cart with licensed personnel in-patient care area.

   c. Co-signing central medical supply crash cart log noting number and expiration date.
d. Placing numbered lock on cart and writing earliest expiration date on lock.

e. Verifying the presence and expiration date of all items on carts at least every three (3) months.

f. Returning medication drawer and its contents to the pharmacy if expiration date is exceeded or seal is broken.

4. Pharmacy shall be responsible for maintaining the red drug drawer on all crash carts. The earliest expiration date of any medication shall be documented on the front lid of the drawer.

5. The fourth drawer of each adult crash cart (BLUE) shall only contain supplies and equipment to initiate pediatric life-support measures. Upon initiation of pediatric life-support measures, Central Medical Supply shall be notified to deliver a pediatric crash cart (RED) to the patient care area.

6. All crash carts will be checked as per the following:

a. The defibrillator and cardiac monitor shall be checked and appropriately documented for performance on both battery and electrical current once every 24 hours except when the unit is closed.

b. The defibrillator will remain plugged into an electrical outlet at all times, except during battery testing.

c. The Biomedical Department will be contacted immediately when a defibrillator problem is detected. A loaner defibrillator shall be obtained from Biomedical Engineering.

d. All external contents of cart shall be checked and verification documented once every 24 hours except when the unit is closed. Document when unit/department is closed on the crash cart log.

7. Crash carts shall be kept locked at all times when not in use. A Variance Report shall be completed after any unauthorized entry into the cart or when routine supplies are missing from the cart.
Central Medial Supply shall be notified so that the cart may be exchanged.

8. Request for change in crash cart contents, shall be reviewed by the Special Care Committee.

_______________________
Administrator

6/18/08
Date

Clinical Board Approved: 11/21/00, 3/19/02, 7/15/03, 6/21/05, 6/17/08
Written: 4/84
Revised: 9/96, 2/99, 2/02, 5/03, 5/05
Reviewed: 5/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

CARDIOPULMONARY RESUSCITATION FORM

Purpose:

To facilitate accurate and complete documentation of code occurrences and action taken.

To provide a record for review and evaluation of CPR & Advanced Life Support measures.

Policy:

1. The Cardiopulmonary Resuscitation form (SN 1036) shall be kept on the Crash Cart for ready use and completed by a registered nurse, or their designee, during each code. Additional forms may be kept on the unit.

2. All drugs administered during a code shall be read back and documented, by the recorder, in the spaces provided at the time of administration.

3. All other resuscitative measures shall be read back and documented as they occur in the spaces provided at the time of occurrence. Sections of the code sheet that do not apply shall be marked N/A.

4. The completed Cardiopulmonary Resuscitation form with rhythm strips attached shall be stamped with the patient’s addressograph card and the white (top) copy placed with the chart as a permanent part of the patient’s medical record. Signatures of the recorder and the physician in charge are required for completion of the form. Physician’s signature affirms that all documented interventions were ordered.

5. Resuscitative measures shall be immediately critiqued by the attending MD or RN with appropriate documentation recorded in the space provided on the back of the hard copy. NOTE: Separate the hard copy from the original (chart copy) before completing critique.

6. The Code Team RN shall review and sign code documentation, code critique, and follow up as needed to ensure documentation is complete.
7. Staff shall complete a Variance Report for problematic codes (equipment not available, personnel not responding, etc.). Refer to Hospital Policy #2.2 Variance Reporting/Sentinel Events for further information.

8. The hard copy of the **Cardiopulmonary Resuscitation** (SN 1036) form shall be sent to Hospital Quality Management for collection of Performance Improvement data. Hospital Quality Management:

   A. Refers to issues identified via the CPR Form to the appropriate Supervisor/Administrator/PEER Review for corrective action, and

   B. Reports code findings to Hospital Quality Management quarterly via Nursing Performance Improvement.

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Administrator

6/18/08

Date

Approved by Clinical Board: 8/15/00, 7/15/03, 6/21/05, 6/17/08
Written: 1/93
Reviewed: 5/96, 2/99, 5/03, 5/08
Revised: 7/00, 5/03, 5/05
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER
SHREVEPORT

LATEX ALLERGY

Purpose:

To identify patients who have latex allergies or who are at high risk for latex allergies.

To provide a safe environment for individuals with known latex allergies.

Policy:

A. Conduct an assessment of all patients for the presence of known or suspected latex allergies.

B. If a patient is identified as latex allergic, the following latex precautions shall be implemented:

1. A non-latex cart shall be requested from Central Medical Supply to manage the latex allergic patients. Notify Central Medical Supply to restock non-latex cart.

2. When possible, the non-latex cart shall be placed at patient’s bedside.

3. The latex-free cart shall be moved with the patient if they are transferred to another unit.

4. Latex allergy shall be documented in the medical record.

5. A pink armband shall be placed on the patient. **

6. A pink latex allergy sticker shall be placed on the outside of the patient’s chart. **

7. Signage indicating latex allergy shall be placed on both the outside of the patient’s door and over the patient’s bed. **

8. Latex allergic patients shall be placed in a private room, if possible, with the door shut as latex antigens can become airborne in the powder from latex gloves or other latex products. If a private room is not available, the patient with whom the allergic patient is housed must also use latex free products.
9. Pharmacy must be notified of latex sensitive patient. Physician order sheet shall be marked "Latex Sensitive Patient" by nursing personnel prior to sending the order to the Pharmacy.

10. Before a latex allergic patient is transported to another area, the area will be notified of the patient’s allergy.

11. When possible, a latex allergic patient who is scheduled for surgery shall be the first case of the day.

C. When no latex-free substitution is available for required product/equipment, the following measures will be implemented to protect the patient from latex allergens.

1. Protect the patient’s arm with rolled cotton or Kerlix if no latex free BP cuff is available. Cover stethoscope with stockenette.

2. Remove rubber stopper from medicine vials before withdrawing medications. Use decapper.
   a. Use latex free syringes to mix and/or administer medications.
   b. Use IV tubing with latex ports covered to prevent injection.

D. Patients at high risk for development of latex allergies shall be monitored closely and, if allergic symptoms develop, the patient should be placed on latex precautions and immediately assessed for latex allergy.

E. Patients who are at high risk for development of latex allergy:

1. Spina bifida patients

2. Patients with congenital urologic anomalies

3. Patients who have the following food allergies:
   a. Bananas
   b. Avocados
   c. Kiwi
   d. Nuts
** Stocked in latex-free cart

Administrator

7/19/07
Date

Approved by Clinical Board: 5/15/01, 7/20/04, 7/17/07
Written: 4/01
Reviewed: 6/07
Revised: 6/04
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PATIENT COMMUNICATION NEEDS

Purpose:

To establish a mechanism to provide resources available for patients with special communication needs.

Policy:

LSUHSC shall establish mechanisms by which communications between staff and patients may be effectively achieved. Patient needs for communication services shall be addressed concerning interpretive services for the hearing impaired, translator services for non-English speaking patients, guide assistance modalities for sight impaired patients, and educational aides.

1. **Fire Alarm System Capabilities For the Hearing and Visually Impaired:** The hospital shall provide audible and visual alarm notification for the hospital's fire alarm system.

2. **Interpretive Services For the Hearing Impaired:** The Hospital shall provide sign language interpreters for patients and staff to facilitate effective communications for the hearing impaired. The services shall be provided through the use of contracted professional agencies. These services shall be made available upon request by contacting the Social Services Department during regular office hours or by contacting the Administrative House Manager after hours.

3. **Telecommunications Services for the Hearing Impaired Patient:** The Hospital shall provide a Telecommunication Device for the Deaf (TDD) for hearing impaired inpatients in their room upon request. Outpatients in need of a TDD for communication purposes may utilize the TDD in the Social Services Department upon request. Hearing impaired patients needing to communicate with the Hospital from outside the facility may access the TDD machine by contacting the Switchboard. Patients with hearing difficulties may request an amplified telephone handset. These devices/services shall be made available upon request by contacting the Social Services Department during regular office hours or by contacting the Administrative House Manager after hours.
4. **Translation/Interpreting Services For Non-English Speaking Patients:** The Hospital shall provide services through the use of contracted professional resources that have been identified as able to provide multi-lingual translation/interpreting services. These services shall be made available upon request by contacting the Social Services Department during regular office hours, or by contacting the House Manager or Switchboard after hours.

5. **Guide Assistance for the Impaired:** The Hospital shall allow access to the facility for individuals utilizing guide assistance animals. In the event such patients require overnight hospitalization, the patient shall be provided a private room accommodation (if available) in which the guide assistance animal may accompany the patient. The nursing unit shall contact the Infection Control Department for specific infection control guidelines regarding guide assistance animals.

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Approved by Clinical Board: 4/17/01, 5/18/04, 1/16/07
Written: 10/94
Reviewed: 1/97, 2/99, 3/04, 10/06
Revised: 3/97, 4/01, 4/04, 10/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

RESTRAINTS

Purpose:

To provide guidelines regarding appropriate restraint use for the medical
well-being of nonviolent medical-surgical patients and unanticipated
severely aggressive or destructive behavior that places the patient(s) or
others in imminent danger.

Policy:

A. Restraint Philosophy

1. Louisiana State University Health Sciences Center –
    Shreveport strives to be a restraint-free environment. All
    patients have a right to considerate, respectful care at all
    times, with recognition of their personal safety, dignity, rights
    and well being.

2. Restraint use within the hospital is limited to those situations
   with adequate, appropriate clinical justification. Orders for
   restraint intervention are appropriate only after non-physical
   alternative measures have failed unless safety issues
   demand an immediate physical response. Behavioral health
   care reasons for the use of restraint are primarily to protect
   the patient against injury to self or others because of an
   emotional or behavioral disorder. Alternative measures may
   include, but are limited to: behavioral intervention,
   distraction, verbal de-escalation, communication using non-
   threatening body language/tone of voice, more frequent
   observation, environmental change (quiet surroundings),
   room change, comfort measures, obtaining family/sitter
   support, orientation to his/her surroundings, treatment
   change, night light, verbal calming techniques, obtaining a
   psychiatric consult, etc. Each episode of use is recorded
   along with the following:

   a. Events of the situation and start time;

   b. Alternative measures tried, and

   c. Patient’s response to the alternative measures
3. Emergency, pediatric and/or cognitively or physically impaired patients are closely assessed to determine if their presenting behavior is usually manifested in this manner, and/or if their behavior may harm themselves or others. If the patient’s presenting behavior is usual for the patient and they are not threatening themselves or others, then restraints shall not be utilized. If restraints are used in these situations, the physician and/or RN may determine that more frequent reassessment is indicated. (Referring to use of restraints in cognitively impaired, pediatric, physically impaired or emergency use.)

4. The use of restraint is not based on an individual’s restraint history or solely on a history of dangerous behavior. Restraints should only be used for as long as necessary to help a patient regain control of his behavior.

5. Staffing levels and assignments shall be set to minimize circumstances that give rise to restraint use and to maximize safety when restraint is used.

B. Policy Application

1. Restraint use to promote medical-surgical healing applies to patients of any age receiving pediatric, obstetrical and rehabilitative care. This includes those who are:

   a. hospitalized in an acute care hospital in order to receive medical or surgical services,
   b. in the emergency department for the purpose of assessment, stabilization or treatment for other than behavioral health reasons,
   c. in medical observation beds,
   d. undergoing rehabilitation as an outpatient or inpatient,
   e. undergoing same-day surgical or other ambulatory healthcare procedures, and/or
   f. receiving subacute services.

2. Restraint use associated with unanticipated, severely aggressive or destructive behavior applies to:
a. patients with a behavioral health disorder in the emergency department for the purpose of assessment, stabilization, or treatment, even if awaiting transfer to a psychiatric hospital/unit,

b. patients with a behavioral health disorder awaiting transfer from a non-psychiatric bed to a psychiatric bed/unit after receiving medical or surgical care,

c. patients with a behavioral health disorder who are hospitalized in other than a psychiatric unit in order to receive medical-surgical services, and/or

d. medical-surgical patients with severely aggressive or destructive behavior.

C. The following devices/situations are specifically excluded from requirements as set forth by this policy:

1. Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic or surgical procedures and the related post-procedure care processes. Such standard practices may or may not be described in procedure or practice descriptions. Examples may include, but are not limited to surgical positioning, radiotherapy, protection of surgical and treatment sites in pediatric patients, etc.

2. Devices utilized for forensic and correction restrictions for security purposes (i.e. prisoner shackles such as leg-irons, handcuffs, etc). Restraint use, related to the clinical care of a person under forensic or corrective restrictions does apply (i.e. prisoner patient requiring restraints related to clinical care (pulling lines, etc.) or who exhibits unanticipated severely aggressive or destructive behavior that places the patient(s) or others in imminent danger.

3. A voluntary mechanical support based on assessed patient need used to achieve proper body position, balance or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support.

4. Protective equipment such as helmets.
5. Restraint/seclusion for behavioral health purposes in patients hospitalized on the psychiatric unit.

6. Cribs with side rails raised in pediatric patients who are unaware of restrictions on their movement; and/or

7. Raised side rails in comatose, unresponsive patients.

D. Definitions

1. **Physical Restraint** is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient’s body that he or she cannot easily remove that restricts freedom of movement or normal access to one’s body. This is a functional definition and is not based on the device used. This definition does not apply to:

   a. interactions with patients that are brief and focus on redirection or assistance in activities of daily living; such as hygiene, and

   b. the use of any psychoactive medication that is not a usual or customary part of a medical diagnostic or treatment procedure, and that is used to restrict a patient’s freedom of movement. (Psychoactive medication used in this manner should be reported as a variance.

E. Guidelines for Restraints in Emergency Situation

1. An emergency is defined as an instance in which there is an imminent risk of a patient harming himself/herself or others, including staff; when nonphysical interventions are not viable, safety issues require an immediate physical response, and a physician is not readily available to conduct an assessment and write restraint orders.

2. If the MD is not available to order restraints in an emergency, an RN or other qualified licensed personnel (as cited in section G) based upon an appropriate assessment of the patient may initiate restraint use. The RN or licensed staff shall write documentation of the assessment findings and justification in the medical record. A verbal physician’s order shall be obtained as soon as possible.
3. If initiation of restraint is based on a significant change in patient condition, the RN shall immediately notify the MD.

F. Least Restrictive Restraint Devices

1. The least restrictive restraint device shall be utilized. Manufacturer's instructions for restraint application shall be followed. Generally, restraint devices are listed in order from least restrictive to most restrictive. However, restraint interventions should be tailored to the individual patient based on an assessment. Restraint devices may include, but are not limited to, the following:
   a. Pediatric L-Bow, etc
   b. mittens without straps
   c. mittens with straps
   d. soft wrist restraints
   e. Posey vests
   f. Non-locking restraints
   g. locking restraints

2. Generally, a one-point restraint is less restrictive than two points; two-points are less restrictive than three; three-points are less restrictive than four; and four-points are less restrictive than five. One-point restraint generally refers to one extremity restrained; two-points refers to two extremities, etc. Five-points generally means a vest and four extremities are restrained.

G. Staff Education

1. Training for ALL STAFF who have DIRECT patient contact (RN, LPN, NA, Psyche Aide, PT/OT, Cardiopulmonary, UPD, Radiology Tech, etc.)

All staff that has direct patient contact shall receive ongoing education and training in the proper and safe use of restraints before they participate in restraint use. Those who apply mechanical restraints must have competency
assessed and documented in their file. This education also covers alternative methods for managing behavior, symptoms and situations that have traditionally been treated through the use of restraints.

2. Additional training requirements for staff that manage restraint use in the patient with unanticipated severely aggressive or destructive behavior:
   a. Staff who are authorized to perform the 15-minute assessments (RN, LPN) also receive ongoing training and demonstrate competence in:
      1). Assisting individuals in meeting behavior criteria for the discontinuation of restraint or seclusion;
      2). recognizing readiness for the discontinuation of restraint or seclusion; and
      3). recognizing when to contact a physician/code team/EMS to evaluate and/or treat the patient’s physical status.
   b. In addition to the above criteria, RN and other licensed staff who, in the absence of an MD, are authorized to initiate restraint or seclusion, and/or perform evaluations/reevaluations of individuals who are in restraint or seclusion in order to assess their readiness for discontinuation or to establish the need to secure a new order, receive training and demonstrate competencies for the specific task.

3. Training in first aid, CPR and EMS:
   a. An appropriate number of staff are available at all times who are competent to initiate first aid and CPR.
   b. The code team and University Police are accessible at all times.

H. Patient/Family Education
As appropriate, staff shall make every effort to discuss the issue of restraint with the patient and/or family/significant at around the time of restraint initiation.

I. Reporting Adverse Events

1. Staff shall complete a variance report for any injury or death that occurs while a patient is restrained, or where it is reasonable to assume that a patient’s injury/death is a result of restraint. Staff shall immediately notify the Administrator/Administrator On Call of any death that occurs while a patient is restrained or where it is reasonable to assume that a patient’s death is a result of a restraint. Refer to Hospital Policy #2.2 Variance Reporting/Sentinel Events for additional information.

2. The hospital shall report to the HCFA Regional Office any death that occurs while a patient is restrained for the management of unanticipated severely aggressive behavior. This report shall be made by the next business day following the patient’s death. Staff shall document in the patient’s medical record the date and time the death was reported to CMS.

3. Patients who receive psychoactive medications that are not a usual or customary part of a medical diagnostic or treatment procedure, and that is used to restrict a patient’s freedom of movement are reported through q variance report.

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Administrator

8/22/07

Date

Approved by Clinical Board 6/20/00, 1/12/01, 8/19/03, 7/18/06, 8/21/07
Written: 4/85
Revised: 6/97, 2/98, 5/99, 4/00, 6/00, 12/00, 7/03, 6/03, 6/06, 7/07
Reviewed: 6/06, 7/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER -
SHREVEPORT

RESTRAINT OF THE BEHAVIORAL HEALTH DISORDER – UNANTICIPATED
SEVERELY AGGRESSIVE PATIENT

Purpose:

To provide guidelines regarding appropriate use of restraints for patients
displaying unanticipated severely aggressive or destructive behavior that
places the patient(s) or others in imminent danger. Refer to Policy 5.15
for general restraint information.

Policy:

A. PHYSICIAN Orders

1. A physician’s order shall be obtained prior to application of
restraints except in emergency situations as defined by
Hospital Policy 5.15. Section “E”. No restraints shall be
ordered unless the physician, after personally observing and
examining the patient, is clinically satisfied that the use of
restraints is justified.

2. The order for restraint/seclusion shall be documented on the
Physician’s Orders (SN 1138) by use of a restraint label
(SN1283), stamp, or by handwriting. Restraints shall not be
ordered PRN or as standing orders. The physician who
orders the restraints and/or the RN that obtains a
verbal/telephone order in an emergency shall document the
following:

   a. date and time of order
   b. type of restraint
   c. clinical reason for restraint
   d. restraint time frame (Refer to section 3 for time frame
guidelines)
   e. behavioral guidelines for early release of restraints if
different from that listed in policy
f. monitoring requirements, if more restrictive than hospital policy

g. signature of ordering physician

h. For a verbal order in compliance with Verbal Order Policy 6.13, the name of the individual who gave the order and who accepted it. The verbal order shall be read back to the physician.

3. Maximum Time frames

a. Each order for restraint used for the management of violent or self destructive behavior, may only be renewed in accordance with the following limits for up to a total of 24 hours:

1) four (4) hours for adults 18 or older
2) two (2) hours for 9-17 year olds
3) one (1) hour for patients less than 9 years of age
4) The physician may order for the RN to reassess the patient to determine if restraint is still necessary. If this is ordered, refer to section “3b” below.

b. If the physician orders restraints, the RN or other qualified licensed staff may renew the original order in the same time increments listed in section “3a” above. This means when the original order is about to expire, the qualified licensed staff member shall telephone the physician, report the results of his/her most recent assessment, and request that the original order be renewed for another time period not to exceed the time frames listed in section “3a”. The RN would enter this as a verbal order in the medical record, ensuring all components of section “A2” are met. The physician shall sign the verbal orders when he/she conducts the face-to-face reassessment. Reevaluation by the physician, RN, or other licensed staff determines the need for continued restraint use.

c. The physician must conduct a face-to-face reassessment of the continued need for restraint after 24 hours from the original order.
4. Guidelines for Emergency Situations:

a. Refer to Hospital Policy 5.15 Section “E” for additional guidelines.

b. In emergency application situations, the order (a verbal order is acceptable) must be obtained either during the emergency application, or immediately (within a few minutes) after the restraint has been applied.

c. In an emergency, the physician must personally examine the patient, supply staff with guidance in identifying ways to help the patient regain control in order for restraint to be discontinued, evaluate the need for restraint, and sign the restraint order within one (1) hour after restraint initiation.

d. If the patient is no longer in restraint when an original verbal order expires, the physician still must conduct an in-person evaluation of the individual within one (1) hour of the initiation of restraint, and sign the restraint order.

B. The patient’s treating physician shall be notified as soon as possible if another physician orders restraints. Consultation with the “treating” physician must follow each order as soon as possible. The “treating” physician is the physician who is primarily responsible for the management and care of the patient (i.e. physician from the patient’s primary medical team).

C. When the patient with a behavioral health disorder is awaiting transfer to a psychiatric bed/unit, the transfer is accomplished as rapidly as possible. If the patient is in restraint, emergency department staff or medical/surgical services staff, collaborate with psychiatric staff, to ensure appropriate evaluation of the patient until transfer occurs. The physician shall review with the staff the physical & psychological status of the patient, determine whether restraint should be continued, supply staff with guidance in identifying ways to help the patient regain control in order for restraints to be discontinued, and supply staff with a restraint order.

D. Assessment/Reassessment
1. The RN shall modify the Plan of Care to reflect monitoring/care required for patients in restraints.

2. The patient requires continuous in-person observation by a trained and competent staff member as well as every 15 minutes reassessments/documentation.
   
a. If the patient is in a physical hold, a second staff person is assigned to observe the patient.
   
b. The patient is assessed and assisted at the initiation of restraint and every 15 minutes thereafter. The RN/LPN performs and documents this assessment which includes, as appropriate to the type of restraint employed:
   
   1) signs of any injury associated with the application of restraint,
   2) nutrition/hydration,
   3) circulation and range of motion in the extremities,
   4) hygiene and elimination,
   5) physical and psychological status and comfort
   6) readiness for discontinuation of restraint, 
   7) vital signs as appropriate to the diagnosis, treatment and health status, and,
   8) qualified RN’s provide assistance to patients in meeting behavior criteria for the discontinuation of restraints.

   c. An RN, physician, or other qualified licensed staff member performs reevaluation every 4 hours for adults, every 2 hours for patients 9-17 years and every 1 hour for children under 9 years. The purpose of this reevaluation is to determine the efficacy of the patient’s treatment plan and to work with the patient to identify ways to help him/her to regain control of behavior. Reevaluation of the patient determines if the behavior that precipitated the use of restraints is still present or if the restraints can be discontinued.

E. Protocols for Restrained Patients Leaving the Unit/Floor

1. If a patient in restraints needs to leave the floor/unit for a test/procedure, they leave the unit as close to the time of the
procedure/test as possible and are accompanied by appropriately trained staff.

2. A minimum of a RN/LPN shall remain with the violent/severely aggressive patients who are restrained while they are off the unit.

Exception: Based on a patient assessment, an RN may allow a qualified psychiatric aide accompanied by University Police to transport the patient to the psychiatric unit.

F. Restraint Termination

1. Restriction of patient movement or activity by restraints shall be terminated at the earliest possible time. This shall be based on observation and assessment that determines that the patient no longer needs the restraint to protect self or others or behavioral guidelines ordered by the physician have been met and documented.

2. The physician or RN or other qualified licensed personnel makes the decision to terminate restraint use.

3. When restraint/seclusion is terminated prior to the expiration of the order, a new order must be obtained prior to reapplying the restraints.

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Administrator

____8/20/09
Date

Approved by Clinical Board: 2/17/04, 7/18/06, 8/18/09
Written: 5/03
Revised: 7/03, 6/06, 7/09
Reviewed: 6/06, 7/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

RERAINT OF THE NONVIOLENT PATIENT

Purpose:

To provide guidelines regarding appropriate use of restraints on nonviolent patients.

Policy:

A. Physician Orders

1. A physician’s order shall be obtained prior to application of restraints except in emergency situations as defined by Policy 5.15. No restraints shall be ordered unless the physician, after personally observing and examining the patient, is clinically satisfied that the use of restraints is justified to prevent the patient from removing tubes, lines/dressing or to protect the patient (i.e. support medical healing).

2. The order for restraint/seclusion shall be documented on the Physician’s Orders (SN1138) by use of a restraint label (SN1221, SN 1283), stamp, or by handwriting. Restraints shall not be ordered PRN or as standing orders. The physician who orders the restraints and/or the registered nurse that obtains a verbal/telephone order in an emergency shall document the following in the space provided:

   a. Date and time of order
   b. Type of restraint
   c. Clinical reason for restraint
   d. Restraint time frame refer to section “3” for time frame guidelines
   e. Behavioral guidelines for early release of restraints if different from that listed in policy
f. Monitoring requirements, if more restrictive than hospital policy, and


g. Signature of ordering physician

h. In the case of a verbal, the name of the individual who gave the order and who accepted it. The verbal order shall be read back to the physician.

3. Maximum Time frames for Physician orders

a. The INITIAL restraint order is limited to 24 hours

b. RENEWAL restraint orders are valid for no longer than one calendar day (example: A renewal restraint order written today for one calendar day will expire at midnight tomorrow).

c. The physician must conduct a face-to-face reassessment to determine the continued need for restraint before writing a new restraint order.

d. The maximum time frame to obtain verbal order from physician – 12 hours after restraint initiation.

e. In an emergency, the physician must personally examine the patient, evaluate the need for restraint, and sign the restraint order within 24 hours of restraint initiation.

4. Assessment/Reassessment

a. The RN shall modify the Plan of Care to reflect monitoring/care required for patients in restraints.

b. The patient’s diagnosis, treatment, and health status dictates whether continual assessment, monitoring, and reevaluation is required while restrained or if the patient can be monitored and reassessed at regular intervals not to exceed every two hours for nonviolent medical-surgical patients. This determination is made based on the clinical judgment of the RN/physician.

c. Monitoring is accomplished by an RN/LPN via observation, interaction with the patient, or by direct
patient examination. Monitoring shall include evaluation of the continued need for restraints and a skin and circulatory assessment of the affected extremity. Assessments and interventions shall also be performed and documented at this time as appropriate to the type of restraint employed and may include:

1) Alternatives/less restrictive restraint interventions attempted and outcome/readiness for restraint discontinuation;

2) Whether the restraint has been appropriately applied, removed or reapplied, and signs of injury;

3) Assistance with ADL’s (bathroom, food/fluids as permitted by the patient’s medical regime);

4) Repositioning for comfort as possible;

5) Physical well-being, hygiene, dignity/rights maintained.

6) Level of distress/agitation;

7) Vital signs taken based on the patient’s diagnosis, treatment, and health status, and/or

8) Changes in the patient’s behavior or clinical condition needed to initiate the removal of restraints.

d. The LPN notifies the RN/physician if the patient is ready for restraint discontinuation. The RN/physician makes the decision to discontinue restraints based on criteria listed in section “C” below.

B. Protocols for restrained patients leaving the unit/floor

1. If a patient in restraints needs to leave the floor/unit for a test/procedure, they leave the unit as close to the time of the test/procedure as possible and are accompanied by appropriately trained staff.
2. A minimum of a nursing assistant must remain with a restrained, nonviolent medical-surgical patient at all times while they are off the unit.

C. Restraint Termination

1. Restriction of patient movement or activity by restraints shall be terminated at the earliest possible time. This shall be based on observation and assessment that determines that the patient no longer needs the restraint to protect self or others, tubes/lines, or dressings have been discontinued, or behavioral guidelines ordered by the physician have been met and documented. The physician or RN or other licensed personnel makes the decision to terminate restraint use.

2. When restraint/seclusion is terminated prior to the expiration of the order, a new order must be obtained prior to reapplying the restraints.

____________________
Administrator

____________________
Date
8/20/09

Approved by Clinical Board: 8/19/03, 7/18/06, 8/18/09
Written: 5/03
Revised: 7/03, 6/06, 8/09
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, radiation
therapy and dialysis, 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”.


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.
2) The judicially appointed tutor or curator of the patient, if one has been appointed.

3) An agent acting pursuant to a valid mandate, specifically authorizing the agent to make health care decisions.

4) The patient’s spouse not judicially separated.

5) An adult child of the patient.

6) Any parent, whether adult or minor, for his child.

7) The patient’s sibling.

8) The patient’s other ascendants or descendants.

9) Any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his care and any guardian for his ward.

10) A person chosen by the interdisciplinary team, as defined in R.S. 28:451.2, to make recommendations on behalf of an individual with a developmental disability, as defined in R.S. 28:451.2. The interdisciplinary team shall exercise discretion in choosing, by majority vote, the family member, friend, or other person most familiar with the individual or most capable of making the decision at issue.

11) A person chosen by an ad hoc team assembled by any interested person for the purpose of addressing the medical decision at issue for an individual with a developmental disability.

a) This team shall consist of at least three persons familiar with the circumstances and needs of the individual, and shall contain representatives from at least two different services, educational or advocacy agencies serving individuals with developmental disabilities.
b) The team shall make decisions by majority vote, and no one agency shall provide a majority of the members.

c) The team shall exercise discretion in choosing the family member, friend, or other person most familiar with the individual or most capable of making the decision at issue.

k. If there is more than one person within the above named class in Paragraphs 4j 1) through 9), the consent for surgical or medical treatment shall be given by a majority of those members of the class available for consultation.

l. For an individual with a developmental disability, competency to act for the purpose of this Section shall be determined in accordance with principles set forth in R.S. 28:454.3, including capacity to consent and legally adequate consent.

m. Consent to surgical or medical treatment for an individual with a developmental disability will be implied where an emergency, as defined in R.S. 40:1299.54, exists.

n. 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 patient 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.
k. 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)

l. When the person, other than the patient, authorized to grant permission is not present; witnessed telephone consent may be obtained. Such consent is obtained by the attending staff physician or house officer 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.

5. HIV Testing

a. Consent for HIV testing shall be incorporated into the general informed consent for medical care on the same basis as are other screening or diagnostic test; a separate consent form for HIV testing is not required. (House Bill No. 512)

b. Prior to ordering an HIV test, the ordering physician must inform the patient that the test is medically indicated and provide information including an explanation of HIV infection and the meanings of positive and negative test results, and the patient shall be offered the opportunity to ask questions:
1). if the HIV testing is declined, this must be noted in the medical record by the physician.

2). the ordering physician must document in the medical record that the patient was informed that an HIV test was being ordered, information provided to the patient and the patient gave verbal consent for the test to be performed.

c. Anonymous Testing: Persons requesting an HIV related test but wish to remain anonymous will be referred at no charge to, Viral Disease Clinic or to a local site, which provides anonymous HIV testing. (Parish Health Unit, Louisiana AIDS hotline at 1-800-99AIDS).

d. 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 healthcare provider reasonably believes such test to be necessary in order to properly diagnose or treat the child's medical condition, including all newborns whose mothers refused HIV testing at delivery 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 healthcare worker becomes contaminated by a patient’s body fluid.


_____________________  
Administrator

4/21/08  
Date

Approved by Clinical Board 3/17/98, 5/16/00, 10/17/00, 2/20/01, 3/19/02, 4/19/05, 11/20/07, 4/15/08
Written: 2/83
Revised: 5/95, 4/98, 6/99, 7/00, 3/05, 10/07, 3/08
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-l)
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, transarectal 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)
Dialysis Initial Treatment and annually thereafter
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)
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
   Bronchography
   Cholangiography (transhepatic)
   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)
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PATIENT RIGHTS AND RESPONSIBILITIES

Purpose:

To assure that the basic rights of human beings for independence of expression, decision and action, concern for personal dignity and human relationships are preserved for all patients, and to define the responsibilities of patients seen at LSUHSC-Shreveport.

Policy:

It is the policy of LSUHSC-Shreveport to respect the individual rights of all persons that come to this facility for care. Patient rights include the right to make decisions regarding medical care, the right to accept or refuse treatment, and the right to formulate advance directives (written instructions, such as a living will or durable power of attorney for health care as recognized under Louisiana state law, relating to the provision of such, when an individual is incapacitated). Patient responsibilities include those actions on the part of patients that are needed so that healthcare providers can provide appropriate care, make accurate and responsible care decisions, address patients’ needs, and maintain a sound and viable health care facility.

A. Access to Care

Individuals shall be afforded impartial access to treatment that is available and medically indicated, regard-less of race, creed, sex, national origin, religion, sexual orientation or source of payment. (See Policy 2.11 - “Access to Care”)

B. Respect and Dignity

The patient has the right to considerate, respectful care at all times, under all circumstances, with recognition of his personal dignity and worth.

C. Privacy and Confidentiality

The patient has the right, within the law, to personal privacy and information privacy, as manifested by the right to:
1. Refuse to talk with or see anyone not officially connected with the hospital, including visitors, persons officially connected with the hospital but who are not directly involved in his care.

2. Wear appropriate personal clothing and religious or other symbolic items, as long as they do not jeopardize safety or interfere with diagnostic procedures or treatment.

3. To be interviewed and examined in surroundings designed to assure reasonable audiovisual privacy. This includes the right to have a person of one's own gender present during certain parts of a physical examination, treatment, or procedure performed by a health professional of the opposite sex; and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.

4. Expect that any discussion or consultation involving his/her case will be conducted discreetly and that individuals, not involved in direct care, will not be present without permission of the patient.

5. Have his/her medical record read only by individuals directly involved in treatment or monitoring of quality, and by other individuals only on written authorization by the patient or that of his/her legally authorized representative.

6. Expect that all communications and other records pertaining to his care, including the source of payment for treatment, be treated as confidential.

7. Expect that information given to concerned family members or significant other legally qualified person, be delivered in privacy and with due consideration of confidentiality.

8. Request transfer to another available room if another patient or visitors in that room are unreasonably disturbing to said patient.

9. Be placed in protective privacy and/or be assigned an alias name when considered necessary for personal safety.

D. Personal Safety and Security
The patient has the right to expect reasonable safety in so far as the hospital practices and environment are concerned. To address the needs of patient, visitor and staff regarding safety and security, the Health Sciences Center’s University Police patrol 24 hours per day and are present in the Emergency Room around the clock. Other safety and security measures include limited access to the facility through the use of electronic access cards and readers on exterior entrances, video monitoring in numerous areas of the campus, and the use of employee identification badges that are to be conspicuously displayed.

E. Identity

The patient has the right to know the identity and professional status of individuals providing service to him, and to know which physician or other practitioner is primarily responsible for his care. This includes the patient's right to know of the existence of any professional relationship among individuals who are treating him/her, as well as the relationship to any healthcare or educational institutions involved in his care. Participation by patients in research programs, or in the gathering of data for research purposes, shall be voluntary with a signed informed consent.

F. Information

1. The patient has the right to obtain from the practitioner responsible for coordinating his care, complete and current information concerning his diagnosis (to the degree known), treatment, pain management, and any known prognosis. This information should be communicated in terms the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information shall be made available to a legally authorized individual.

2. The patient has the right to formally access his/her medical records. The patient shall complete the Authorization to Disclose Protected Health Information (form #1148) which is then sent to Health Information Management for processing. The Manager/Charge Nurse is to be notified when such requests are made.

3. The patient may access, request an amendment to, and/or receive an accounting of disclosures of their own protected health information as permitted under applicable law.
G. Communication

1. The patient has the right of access to people outside the hospital by means of visitors, and by oral and written communication. The patient may request not to be included in the patient directory. Inclusion in the patient directory means that the patient’s name; room number and a general condition report may be given to people who ask about the patient by name.

2. The prisoner patient has the right to visitors only as approved by the warden of the prison or jail where the prisoner patient is incarcerated.

3. When the patient does not speak or understand the predominant language of the community, or is hearing impaired, he/she shall have access to an interpreter if at all possible. This is particularly true where language barriers are a continuing problem.

H. Consent

1. The patient has the right to reasonably informed participation in decisions involving his/her health care. To the degree possible, this shall be based on a clear, concise explanation of his/her condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. The patient shall not be subjected to any procedure without his/her voluntary, competent, and informed consent, or that of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

2. The patient has the right to know who is responsible for authorizing and performing the procedures or treatment.

3. The patient shall be informed if the clinician proposes to engage in or perform human experimentation or other research/educational projects affecting his/her care or treatment, and the patient shall sign an informed consent if participation is desired and maintains the right to refuse to participate or withdraw from any such activity at any time.
4. The patient may refuse treatment to the extent permitted by law. When refusal of treatment by the patient or his/her legally authorized representative prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the patient may be terminated upon reasonable notice.

5. If a patient is unconscious or is determined to be mentally incompetent and no consent can be obtained from an appropriate family member, legal action may be taken to obtain a court order for diagnostic and therapeutic procedures. In life-threatening emergencies, where the patient is incompetent or unconscious, appropriate treatment may be administered without consent.

I. Consultation

The patient, at his/her own request and expense, has the right to consult with a specialist.

J. Transfer and Continuity of Care

1. A patient may not be transferred to another facility unless he/she has received a complete explanation of the need for the transfer and the alternatives to such a transfer, and unless the transfer is acceptable to the other facility. The patient has the right to be informed by the responsible practitioner or his/her delegate of any continuing healthcare requirements following discharge from the hospital.

2. Regardless of the source of payment for his/her care, the patient has the right to request and receive an itemized and detailed explanation of his/her total finalized bill for services rendered in the hospital. The patient shall be informed of eligibility for reimbursement by any third-party coverage during the admission or pre-admission financial investigation.

K. Hospital Rules and Regulations

The patient shall be informed of the hospital rules and regulations applicable to his/her conduct as a patient. The hospital’s Notice of Privacy Practices is available from the Admitting Department or can be found on the hospital website.
L. Complaint Process

The patient has the right to file a complaint regarding services and is entitled to information regarding the hospital's mechanism for the initiation, review and resolution of such complaints.

M. Patient Responsibilities

Patients have the responsibility for:

1. Providing accurate and complete information about medical complaints, past illnesses, hospitalizations, medications, pain, and other matters relating to their health;

2. Following the treatment plan recommended by those responsible for their care;

3. Their actions if they refuse treatment or do not follow the health care team’s instructions;

4. Seeing that their bills are paid as promptly as possible; following hospital rules and regulations;

5. Being considerate of the rights of other patients and hospital personnel;

6. Seeking information, and in the event they have questions, asking them.

Administrator

1/19/07 Date

Approved by Clinical Board: 9/19/00, 5/15/01, 8/17/04, 1/16/07
Written: 1/83
Revised: 12/97, 3/01, 7/04, 12/06
Reviewed: 8/00, 6/04, 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER-SHREVEPORT

PAIN MANAGEMENT via CONTINUOUS IV INFUSION

Purpose:

To provide physical, psychological, and pharmacological relief for patients with pain due to end-stage illness, acute, chronic, or intractable pain. Guidelines assist professional staff in alleviating patient suffering and improving quality of life.

Scope:

The most critical component in managing pain is assessment. If a patient is experiencing pain, their pain is further assessed for pain intensity using the appropriate pain scale, pain location, quality, etc. This policy applies to all patients—adult and pediatric. Assessment of pain in young children may rely on observation and physiological indicators of pain. Refer to the Hospital Pain Policy # 5.34 for additional assessment information.

Policy:

1. Patient controlled analgesia (PCA) is the recommended route for narcotic analgesic administration. Refer to Nursing PCA Policy P15 for additional information.

2. Pain management requires a variety of approaches to achieve relief. Consistent use of the pain assessment tools will facilitate the choice of treatment options by the physician.

3. The attending faculty physician shall be responsible for documenting in the progress notes:
   a. the justification for intravenous narcotic analgesic,
   b. the nature of the illness or terminal disease, and
   c. the potential risk factors and/or side effects were discussed with the patient or a responsible family member.

4. A written physician's order for continuous narcotic analgesic therapy shall include the type of analgesic, dosage, loading/bolus
doses, and rate of administration. A separate, specific order shall be written by the physician for titration every 72 hours.

5. The medication shall be signed out following guidelines for controlled substances. (See Hospital Policy 8.13 Medication Control for additional information). Tampering with the PCA cartridge for the purpose of diverting narcotics is prohibited and shall result in disciplinary actions up to and including termination.

6. Morphine waste shall follow the Controlled Substance Policy. In addition, when the cartridge is changed, the remainder of the narcotic analgesic IV solution shall be wasted in the presence of a witness. The disposal must render the product unrecoverable. User and witness must document waste on the PCA Nursing Pain Flow sheet record (SN 1101) and in the medication-dispensing machine.

7. The Registered Nurse who initiates the narcotic analgesic IV infusion shall verify the medication dose and setting with a second RN or LPN prior to initiation, change in settings or when the patient is received upon transfer. The second RN or LPN shall initial/sign behind the initiating RN on the PCA Nursing Pain Flow sheet (SN1101) and/or MAR. The RN or LPN may monitor the patient’s vital signs and pain assessment.

8. Recording LOC, Vital Signs, and Pain Assessment - Blood pressure (BP), pulse, respiratory rate, level of consciousness (LOC), and pain assessment shall be assessed and recorded on the Medical Record as follows:
### Initiation of Therapy

<table>
<thead>
<tr>
<th>Within One Hour of Initiation or Change in Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance (After therapy has been established)</td>
</tr>
<tr>
<td>Transfer</td>
</tr>
</tbody>
</table>

- **Record Respiratory Rate, Level of Consciousness, Blood Pressure, Pulse, and Pain Assessment (score, quality, site, and duration) prior to initiating narcotic analgesic therapy.**
- **Record Respiratory Rate, LOC, Blood Pressure, Pulse, and Pain Assessment (score, quality, site, and duration) within one hour of initiation of therapy or change in settings; then maintenance parameters shall be utilized.**
- **After therapy has been established:**
  - **Every 2 hours:** Record Respiratory Rate, Cumulative Total, and LOC
  - **Every 4 hours:** Record Blood Pressure, Pulse and Pain Assessment (score, quality, site, and duration)
- **When a patient is transferred, two nurses on the receiving unit will verify the settings, medication, and dosage and record. Also record the Respiratory Rate, LOC, Blood Pressure, Pulse, and Pain Assessment (score, quality, site, and duration).**

### Note: The Physician shall be notified of the following so that orders may be obtained for continuing, slowing or stopping the infusion when one or more of the following exists:

a. **Diastolic Blood Pressure drops of more than 20% from baseline**

b. **Respiratory rate of less than 10/minute**

c. **Significantly altered mental status**

d. **Pain Score of 5 or greater and/or pain score that is not decreasing.**

10. **Documentation of Continuous infusion medication administered and clearing of the Pump.**

   a. **At 0600 the nurse shall obtain from the PCA and document on the medical record:**
1) the medication amount mg/cc self-administered by the patient
2) any bolus doses given by the nurse
3) and total mg/cc infused

b. The PCA shall then be cleared.

11. Changing Narcotic Cartridges/Admixture and tubing.

The PCA cartridges and tubing shall be changed at least every 72 hours using aseptic technique. Refer to Nursing PCA Policy P15 for additional information.

12. IV Site Assessment

The IV site shall be assessed every eight hours with appropriate documentation recorded on the chart regarding site condition, patency, and IV administration.

13. The Pain Management Service may be consulted as needed.

Reference:

Hospital Administrator

4/23/07

Date

Approved by Clinical Board: 1/12/01, 4/20/04, 4/17/07
Written: 6/95
Revised: 5/95, 12/97, 11/00, 1/01, 2/04, 3/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

DO NOT RESUSCITATE (DNR)

Purpose:

1. To establish a mechanism for reaching decisions about withholding resuscitation services from individuals.

2. To define a means for resolving conflicts which may arise with respect to "no code" decisions.

3. To clarify the roles of physicians, hospital staff, family members and the patient in the decision to withhold resuscitation services.

4. To prescribe the appropriate orders, documentation, and physicians' notes which shall be written in the patient's records when a "no code" decision has been reached.

DEFINITION:

"Do Not Resuscitate" (DNR) means that a patient who suffers sudden cardiac or respiratory arrest will not receive Cardiopulmonary Resuscitation (CPR). DNR is also referred to as a "No Code".

Policy:

1. The physician primarily responsible for a patient's care is responsible for determining when CPR is no longer an appropriate medical response. That decision should be reached when it is the physician's judgment that death is imminent and the cause is irreversible and, therefore, resuscitation will only delay the moment of death. NOTE: The primary MD may either be attending/faculty or house officer/resident.

2. Decisions to withhold CPR must be supported by clinical evidence of irreversible illness, which is reasonably expected to result in the patient's death. Such evidence shall be reviewed by at least two physicians, one of whom must be a faculty member. When agreement that CPR is not an appropriate therapy has been reached in a specific case, a notation of that fact with a summary of the reasons for it shall be made on the physician's progress notes and signed by all physicians involved. In those cases where the patient initiates the action or a person lawfully empowered to act for the patient, the hospital protocol for a "Living Will" shall be followed.
3. "DNR" decisions shall never be made solely on the basis of age. A DNR decision shall only be made after a complete evaluation of the patient's condition.

4. When the physicians have firmly established that CPR should not be the medical response to cardiopulmonary collapse, the physician who is the principal caregiver shall review the plan of treatment and the expected outcome with the patient (or in the case of an incompetent patient, with the person(s) legally empowered to act for the patient). If agreement on the intent to withhold CPR is reached, and the patient or family has been informed and no disagreement remains, the record shall reflect these facts. Then and only then, shall a "Do Not Resuscitate" order be written by the primary physician, if the primary physician is not an attending or faculty, the order must be countersigned by an attending or faculty. The DNR order does not go into effect until the order has been signed by an attending or faculty physician.

5. In a case where the patient or responsible family member does not agree with the treatment plan after a full explanation has been given, the attending physician shall consult a member of the Ethics Committee. A medical staff-attending member of the committee will work with the treatment team and the patient/family to seek a resolution. When agreement has been reached, the DNR order may then be entered.

6. Where no such resolution is possible, and the CPR is deemed by the medical staff to be an inappropriate treatment, the patient or family will be advised by the attending physician that they have the option of transferring the patient to another attending physician who will accept the care of the patient, or to another healthcare facility. Every assistance shall be rendered to effect acceptance of the patient by another physician outside LSUHSC and every effort will be made to arrange a transfer at the earliest practical time. Prior to transfer, however, CPR will be initiated if the patient suffers cardiopulmonary collapse.

7. All codes shall be maximum resuscitation efforts until the physician running the code directs that it end.

8. When a valid DNR order is entered in the patients' chart, the unit nursing staff, residents, and faculty shall follow it. A code shall not be called if and when the patient suffers cardiac or respiratory arrest, and CPR will not be administered.
9. When a patient undergoes operative or invasive procedures, any DNR order shall be revoked from the time the patient arrives in the Operating Room and shall remain revoked until the patient is discharged from the Recovery Room. If the DNR order is still indicated after the patient’s discharge from the Recovery Room, then the physician shall order it reinstated.

10. In the event a patient recovers from an episode of illness and is discharged from the hospital, any existing "DNR" orders are canceled. Subsequent admissions will require an evaluation of the patient's condition, prognosis, and physical state to determine whether or not a "DNR" order is appropriate.

11. If a patient or a relative legally empowered to act for a patient has agreed to a "Do Not Resuscitate" order then changes his mind and withdraws his/her agreement at any time, the order will be immediately canceled. The right to decide rests with the patient, or in the case of an incompetent patient, with his/her legal next of kin. That right may never be compromised by a physician or anyone else, no matter how well intentioned they may be.

Administrator

2/17/09

Date

Approved by Clinical Board: 2/20/01, 5/18/04, 5/15/07, 2/17/09
Written: 9/89
Revised: 5/95, 12/97, 1/01, 2/04, 1/09
Reviewed: 2/04, 4/07, 1/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

POINT OF CARE TESTING

Purpose:

To insure that laboratory testing at Louisiana State University Health Sciences Center performed outside the main Clinical Laboratory or designated Special Function Laboratory is accomplished utilizing methodologies to insure valid, reliable test results and that all such testing is done in compliance with all state and federal regulations.

Definitions:

Point-of-care testing (POCT): refers to those analytical patient testing activities provided within the institution, but performed outside the physical facilities of the clinical laboratories. The central criterion of POCT is that it does not require permanent dedicated space. Examples include kits and instruments that are hand-carried or otherwise transported to the vicinity of the patient for immediate testing at that site or analytic instruments that are temporarily brought to a patient care location. POCT does NOT include limited service satellite laboratories with fixed, dedicated testing space.

Waived test: Those tests identified by the Clinical Laboratory Improvement Amendments 1988 (CLIA 88) that are simple laboratory examinations and procedures, which employ methodologies that are simple and accurate, minimizing the likelihood of erroneous results or which pose no reasonable risk of harm to the patient if the test is performed incorrectly. Test are reassessed and may be recategorized on a regular basis by CLIA. Some examples of waived tests include but is not limited to:

- non automated urinalysis, dipstick or tablet
- fecal occult blood
- urine pregnancy test
- urine HCG by visual color comparison test
- blood glucose monitoring devices cleared by the FDA for home-use
- spun microhematocrit
Moderate Complexity: A category of tests identified by the Clinical Laboratory Improvement Amendments 1988 (CLIA88) that are either automated procedures with no operator intervention during the analytical process or manual procedures with limited steps and limited reagent preparation. Test are reassessed and may be recategorized on a regular basis by CLIA. Some examples of moderately complex tests include but is not limited to:

- electrolytes
- urine microscopics
- activated clotting times
- modified waived test procedures

Policy:

1. Laboratory test data which will be utilized for the diagnosis, management or treatment of a patient must be produced in an environment which insures that the testing procedure is accurate and reliable on a consistent basis. All areas performing point-of-care testing must have an established written procedure which addresses:

   a. Competency of personnel performing the test.
   b. Quality control activities.
   c. Reporting, utilization, and maintenance of test results.

2. Laboratory tests performed at the point-of-care, both waived and moderate complexity, are required to meet all applicable standards for their designated accrediting body. Louisiana State University Health Sciences Center accreditation will be through the College of American Pathologists (CAP).

3. Testing methods classified as waived testing under federal law and regulation are required to meet all applicable standards (PA.6.4) in the Point-of-Care Testing in the Commission on Laboratory Accreditation Inspection Checklist (CAP).

4. Monitoring and review of all POCT procedures is the responsibility of the Clinical Laboratory, including quality control standards, competency of individuals performing the test and management of data.

5. A multidisciplinary committee, shall oversee the utilization of POCT within Louisiana State University Health Sciences Center. Responsibilities include:
a. The review and approval of requests for implementation of POCT within specific areas, based on the impact on patient care and cost / benefit analysis.

b. Review and revise hospital policy related to POCT as needed, but not less than annually.

** "Compiled List of Clinical Laboratory Test Systems, Assays, and Examinations Categorized by Complexity" (LAB-93-20.1) published Monday, July 26, 1993 Federal Register (FR) Vol. 58, No 139

[Signature]
Administrator
6/18/09
Date

Approved by Clinical Board: 5/16/2000, 5/20/03, 4/18/06, 6/16/09
Written: 12/94
Revised: 10/97, 4/03, 4/06
Reviewed: 2/00, 4/03, 3/06, 5/09
Request for Approval of Point of Care Testing

1. Service / section / area where testing is to be done: ____________________________

2. Test being requested? ______________________________________________________
   Instrument/Kit Needed (if known) ____________________________________________

3. Categories of individuals who will be authorized to perform test.
   (check all that apply): MD ____ RN ____
   Other ____ LPN ____
   (Specify) ____ Nursing Assistants ____

4. Requested test will be used for:
   Screening _______ Definitive diagnosis _______

5. Briefly provide a clinical justification for this request (ie., why performing this test at
   the point-of-care will result in improved patient care; convenience of the clinician is not
   in itself sufficient justification) ____________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

6. Provide a cost analysis for the requested test performed on a per test basis; this cost
   must include equipment, supply and quality control cost. Include anticipated volume of
   tests / year. If multiple panels are available, calculate separately.

<table>
<thead>
<tr>
<th>Test/Panel:</th>
<th>Cost:</th>
<th>Volume:</th>
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</table>

7. Will utilization of requested test reduce / eliminate testing currently done in the
   Clinical Lab? Indicate degree of impact (% reduction) on test volume sent to Clinical
   Laboratory.

| Reduce -          | Yes _____ Percentage ______% |
|-------------------|______________________________|
| Identify which test(s) __________________________ |
| No __________     |                             |
| Eliminate-        | Yes _____ Percentage ______%|
| Identify which test(s). __________________________|
| No effect -       | N/A _______                  |
8. Individual submitting request:

Name: ________________________________ (please print)

Credentials: ____________________________

Dept. & phone #: __________________________

I have read and understand the Louisiana State University Health Sciences Center policy on point of care testing; I also understand that this testing cannot commence until approval from the POCT Oversight Committee has been received.

Authorization for request

________________________________________
Medical Director

________________________________________
Nursing Director

________________________________________
Hospital Administration

Submit completed form to Director of Clinical Lab or designee, Clinical Lab, extension 55719

DO NOT WRITE BELOW THIS LINE, FOR COMMITTEE USE ONLY.

Request Approved: __________ Date: ________________

Request Rejected: __________ Date: ________________

Reason Rejected:

________________________________________________________________________

________________________________________________________________________

Authorizing Signature: ________________________________
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

TRANSPORT OF LABORATORY SPECIMENS VIA THE PNEUMATIC TUBE SYSTEM

Purpose:

To set forth guidelines for the appropriate transport of laboratory specimens via the pneumatic tube system.

Policy:

A. The Clinical Laboratory will accept a specimen via the pneumatic tube system (PTS) only if:

1. it is in an approved container (see below)
2. the container is enclosed in a zip-lock bag
3. the container is not leaking
4. the container is sent in an undamaged carrier lined with a blood tube foam liner
5. it is not a non-allowable specimen (see below)
6. all applicable requirements for the labeling of the specimen have been met.

B. Specimen Containers

The types of specimen containers which can presently be sent via the PTS are:

1. vacutainer tubes and
2. plastic screw-cap 16 mm test tubes in which urine specimens may be submitted. **Be certain that these containers are tightly capped before sending via the PTS.**

C. Non-allowable Specimens

1. Any tissue specimen
2. Feces
3. Spinal fluid or any other fluid difficult to recollect or that can’t be replaced. **Note:** This may include blood on certain patients.
4. Any specimen requiring special and/or rapid transport to the laboratory; examples include blood for lactic acid and ammonia (both of which must be taken to the laboratory immediately on ice) and blood for cold agglutins and cryoglobulins (both of which must be taken to the laboratory immediately at body temperature).

5. Specimens in blood culture bottles, respiratory collection containers, and any other containers that do not fit the specially padded pneumatic tub carriers, must be hand carried to the Laboratory office (E2-6).

D. If leakage has occurred and is contained within the zip-lock bag, nursing service will be notified by the laboratory staff to recollect the specimen. If the specimen is deemed irreplaceable, upon laboratory receipt of an approved waiver, the specimen will be processed.

E. If the inside of the PTS carrier is contaminated by blood or body fluids it must be cleaned and disinfected prior to return to use in the PTS. Refer to the Infection Control BIT for cleaning of blood/body fluid spills.

F. If the outside of the PTS carrier is contaminated by blood or body fluids, contact Bio-Medical Engineering for assessment and possible decontamination of the PTS.

NOTE: Biohazard labels are not used for any patient specimen. Standard precautions for infection control mandate the handling of all blood and body fluids with the same appropriate infection control measures.

\[signature\]

Administrator

3/27/07

Date

Approved by Clinical Board: 1/12/01, 2/17/04, 3/20/07
Written: 12/85
Revised: 5/94; 5/98, 1/01, 12/03, 12/06
Reviewed: 12/03, 12/06
INFECTION CONTROL GUIDELINES FOR ALL
POINT-OF-CARE-TESTING AREAS

1. Point of Care Tests

   Bedside Glucose  Urine Uristix  Urine Albustix
   Urine Pregnancy Test  Urine Hemastix  Urine Ketostix
   Hemoccult  Urine Ketodiastix  Urine Multistix
   Strep A Screen  Clinitest (urine)  Activated Clotting Times
   Electrolyte Panel *  Gastric Occult  pH-Gastric
   * (includes Bun & Hematocrit)
   Hemoglobin by Hemocue

2. General Guidelines

   a. A thorough routine hand washing is done according to hospital policy.

   b. Standard Precautions are practiced with all patients. Caution is used when handling specimens.

   c. Mouth pipetting is not done. Automatic devices are used for pipetting when applicable.

   d. Eating, drinking, smoking, application of cosmetics and manipulation of contact lenses in testing area is prohibited.

   e. Employees receive ongoing in-service program on infection control given by either the Supervisor or the Infection Control Nurse.

   f. Recapping, purposeful bending, breaking, removal from disposable syringes, or other manipulation of needles is prohibited. Exception: Procedures requiring multiple usages of the same needle and syringe, recapping using one hand technique will be permitted.

   g. Personal protective equipment (PPE) (gloves, gowns, mask) is available and shall be used, when needed, according to the Hospital Isolation Guidelines.

   h. Patients in isolation for resistant organisms should have dedicated instruments and equipment (exception MRSA). For assistance in obtaining dedicated instruments and equipment, contact either the


Infection Control Department or the Clinical Laboratory POC personnel.

i. Reagents that are biological in nature, i.e. controls for Hemocue hemoglobin or urine testing, must not be stored in the same refrigerator with food and/or medicine.

3. Waste Disposal

a. All waste is disposed of in compliance with the institutional waste disposal policy.

b. Urine specimens may be poured into a designated sink drain. (Always avoid splashing.) Sinks should be flushed with running water. Decontamination should be done using hospital approved disinfectant at the end of each shift.

4. Occupational Health

a. Exposure to blood or body fluids are reported to the supervisor and the Occupational Health Office immediately for follow-up according to the Hospital Bloodborne Exposure Plan.

5. Processing of Items

a. Disposable items are not reused.

b. Reusable items are sent to CMS for cleaning and disinfecting after each use.

c. Instruments and non-disposable equipment (not cleaned by CMS) are cleaned thoroughly at least monthly or when contaminated using appropriate personal protection equipment (PPE) as follows:

1. Using a 3x3 gauge square dampened with 10% bleach or alcohol prep pad.

2. Thoroughly wipe instrument/equipment being careful not to wet areas sensitive to moisture. Should areas sensitive to moisture become contaminated, notify POC personnel or assistance.

3. Allow to air dry.
d. All testing work surfaces are wiped daily or when soiled with hospital disinfectant. Any accidental leaks or spills of specimens are cleaned up immediately wearing appropriate PPE.

e. Centrifuges and other specialized equipment are cleaned as spills occur and on a monthly basis with hospital disinfectant. Appropriate PPE is worn.

f. Procedures, which create aerosols, should be avoided.

g. Instruments should be cleaned as outlined above when soiled and prior to leaving testing area.

6. Shipping Specimens

a. Any laboratory specimens collected by the patient and mailed back to the institution (i.e. Hemoccult) will be packaged according to state and federal regulations. Questions regarding this can be forwarded to the POC office.
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PROVIDER PERFORMED TESTING (PPT) PROCEDURE GUIDELINES

Purpose:

To provide guidelines that insures valid, reliable tests results when laboratory testing is performed outside the main Clinical Laboratory or designated Special Function Laboratory at the University Hospital.

Definitions:

Provider Performed Testing (PPT) Procedure:

Any laboratory type test performed outside the physical facilities of the laboratory that is not classified as a Point-of-Care Test. These tests are performed by physicians, physicians assistants and nurse practitioners to confirm a diagnosis and to monitor treatment.

Test Approved As Provider Practice:

- Urine Multistix
- Urine Ketostix
- Urine Ketodiastix
- Urine Albustix
- Fecal Occult Blood
- Gastric Occult Blood
- Qualitative Semen Analysis

- Gram Stain
- Gastric pH
- Urine Microscope
- Urine Hemastix
- Wet Prep
- Fern Test

Test Requiring Point-of-Care Approval – (Contact the Point-Of-Care Coordinator in the Clinical Laboratory for additional information).

- Strep A Screen
- Urine Pregnancy Test
- Clinitest (Fecal or Urine)
- Heliobacter Pylori
- I Stat
- Gastric Occult Blood

- Activated Clotting Time
- Bedside Glucose Testing
- Fecal Occult Blood
- Urine Dipsticks
- Gastric pH
Policy:

1. The Medical Director of the area shall be responsible for determining the PPT that will be performed. Medical Staff must request and have approved privileges to perform PPT testing through the medical staff credentialing/privileging process. This privilege will be designated as PPT on the E-Priv listing. Any additional training requirements will be at the discretion of the Medical Director(s) or their designee.

2. Testing will be performed using the procedures established by the Clinical Laboratory. All tests will be recorded in a log and will include the following items:
   a. Patient Name
   b. Patient medical record number
   c. Quality control (when applicable)
   d. Test result
   e. Name or initials of person performing test
   f. Date test performed

   All records will be maintained in the clinic where the tests are performed.

3. Although testing supplies are available in some areas of the institution for physician practice, nursing personnel shall not perform testing with these supplies, but may be required to maintain inventory.

4. Nursing personnel may be required to assist the physician with sample collection but shall not perform testing without approval from the Point-Of-Care area of the Clinical Laboratory.

5. Medical students must adhere to the department’s accepted physician practices, procedures and policies.

   [Signature]

   Administrator

   6/18/08

   Date

Approved by Clinical Board: 5/98, 3/20/01, 2/17/04, 3/20/07, 1/15/08, 6/17/08
Written: 4/98
Revised: 2/01, 12/03, 12/07, 5/08
Reviewed: 1/07, 11/07, 5/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

DEATH BY NEUROLOGIC CRITERIA

PURPOSE:

The Louisiana Revised Statutes 9:111 Definition of Death states:

A person will be considered dead if in the announced opinion of a physician, duly licensed in the state of Louisiana based on ordinary standards of approved medical practice, the person has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, duly licensed in the state of Louisiana based upon ordinary standards of approved medical practice, the person has experienced an irreversible total cessation of brain function. Death will have occurred at the time when the relevant functions ceased. In any case when organs are to be used in a transplant, then an additional physician, duly licensed in the state of Louisiana not a member of the transplant team, must make the pronouncement of death.

Added by Acts l976, No. 233 & 1.

POLICY:

1. The following criteria are set forth for making the diagnosis of brain death:

   A. Diagnostic tests for confirmation of brain death.

      All brainstem reflexes are absent.

      1). The pupils are fixed in diameter and do not respond to direct bright light.
      2). The corneal reflex is absent.
      3). The vestibulo-ocular reflexes are absent.
      4). The oculocephalic reflex is absent.
      5). Primitive spinal reflexes may be present but motor responses from cranial motor reflexes (jaw jerk, snout) and brainstem reflex responses must be absent.
      6). There is no gag reflex or reflex response to bronchial stimulation by a suction catheter passed down the trachea.
7). There is absence of spontaneous breathing when the patient is disconnected from the mechanical ventilator. Hypocapnia should be excluded and oxygen should be administered by airway when the ventilator is disconnected.

B. Qualifying statements:

The interval between tests must depend upon the primary pathology and the clinical course of the disease.

Body temperature should not be less than 35 degrees C (95 degrees F) when the diagnostic tests are carried out. Depressant drugs, neuromuscular blockers, hypothermia and metabolic disturbances should be excluded as being responsible for the comatose state. A diagnosis of brain death may be made by the primary attending physician or an upper level physician (PGY-4 or higher, duly licensed by the State of Louisiana) after consultation with a medical staff member. Brain Death declaration shall be recorded in the progress notes of the medical record.

2. Declaration of brain death of a minor.

If a minor has been certified (as per clinical criteria) as a qualified patient the following individuals may voluntarily make a declaration to document the decision relative to withholding or withdrawal of medical treatment or life-sustaining procedures on a minor’s behalf:

A. the spouse if he has reached the age of majority; or

B. if there is no spouse, or if the spouse is not available, or is a minor, or is otherwise unable to act, then either the parent or guardian of the minor

An individual listed above may not make a declaration:

A. if he has actual notice of contrary indications by the minor who is terminally ill; or

B. if as a parent or guardian, he has actual notice of opposition by either another parent, or guardian, or a spouse who has attained the age of majority.

Form SN 1290 shall be completed upon the decision to withhold or withdraw life sustaining procedures by a qualified individual. The attending physician shall be responsible for ensuring the form is
completed, witnessed and made a part of the patient’s medical record.

References:


Wijdicks, EFM. Brain Death Worldwide; Accepted fact but no good global consensus in Diagnostic Criteria. Neurology 2002;58:20-25.

_____________________________________
Administrator

10/23/09
Date

Approved by Clinical Board: 7/20/99, 8/19/03, 9/19/06, 10/20/09
Written: 6/85
Reviewed: 10/97, 12/97, 3/98, 9/06, 9/09
Revised: 5/95, 9/99, 3/02, 7/03, 9/06, 9/09
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.

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
ADVANCE DIRECTIVES POLICY

Purpose:

To define the rights of patients to establish decisions concerning their medical and psychiatric care, including the right to formulate Advance Directives.

Policy:

1. **Definition** - Advance Directives are defined as living wills, healthcare power of attorney, or other instructions of a patient about their medical and psychiatric care.

2. For all adult inpatients, Admitting personnel ascertain whether patients' have designated a medical decision maker. This information is documented on the admit form (SN 1175). A patient handbook containing advance directive information is provided to the patient upon admission. Exception: Outpatient surgery staff complete this information with their patients.

3. Inquiry is made of all adult patients as to whether they possess or wish to execute an Advance Directive. This information is obtained and documented on admission by the registered nurse who completes the Patient History/Assessment and Discharge Record or other approved unit specific admission form. This information is obtained and documented on the ambulatory care record by the nurse during the initial clinic visit.

4. If the patient has an Advance Directive, the inpatient registered nurse or ambulatory care nurse will notify the patient's primary physician that the patient has an Advance Directive and ask the patient and/or family to bring the Advance Directive as soon as possible for placement on the medical record.

5. If the patient requests further information on executing or revising an Advance Directive, the nurse may consult case management to assist with additional information and/or execution of the directive. If case manager is not available, the inpatient registered nurse or
ambulatory care nurse shall review the Advance Directive contents of the Patient Handbook with the patient and/or family; if more information is requested, the patient/family will be given a copy of “Five Wishes” brochure.

6. If an Advance Directive is executed by the patient, the Case Manager/Nurse shall place it in the patient’s medical record and contact the unit registered nurse or clinic nurse. The nurse shall then contact the patient’s primary physician so that appropriate planning of care may be accomplished.

7. Refer to Hospital Policies 5.21 “Withholding or Withdrawal of Life Sustaining Treatment” or 5.19 “Do Not Resuscitate” for additional information.

Administrator

1/21/09

Date

Approved by Clinical Board: 10/16/01, 6/18/02, 7/19/05, 1/20/09
Written: 6/92
Revised: 8/92, 6/95, 5/00, 1/01, 9/01, 10/01, 5/02, 5/05, 11/08
CONTINUUM OF CARE

Purpose:

To assure the patient’s needs are met with the appropriate level and type of medical, health, or social services.

Policy:

1. Goals and objectives include, but are not limited to the following:
   - Ensure continuity of care
   - Reduce the rate of re-admissions
   - Ensure appropriate utilization of hospital resources
   - Avoid inappropriate levels of care
   - Reduce hospital length of stay

2. The leadership of LSUHSC plans and provides the necessary resources for the care of patients entering into the system. The development of patient programs and strategic planning is an ongoing process driven by community and regional needs and available resources. Access to the facility, admission, and patient transfer are defined by hospital policy.

3. Patient entry into the system begins with the assessment of the patient by both physician and nursing personnel. Based on this assessment, a patient plan of care is developed. The Medical plan of care includes the decision regarding the dispensation of the patient, which may include one or a combination of the following:
   a. admission to an inpatient unit
   b. treatment and discharge with follow-up care scheduled in an appropriate outpatient clinic(s)
   c. consultation to a medical service
   d. referral to another agency to provide services
   e. consultation to hospital based service, i.e., Rehabilitation, Social Services/Case Management
   f. treatment and discharge with no further action needed
4. If LSUHSC has the necessary resources available and is deemed the appropriate setting for meeting the needs of the patient, services are provided. Patients requiring care not available through LSUHSC are appropriately transferred by the medical staff in collaboration with the Case Management department.

5. In order to ensure patient safety, accurate information about the patients' care, treatment and services, current condition and any recent or anticipated changes must be provided at the time of a patient hand off.

Patient hand offs include, but are not limited to, nursing shift changes, physician transferring complete responsibility for a patient (including on call responsibility), responsibility for staff leaving the unit for a short time, the transfer of the patient from one area of care to another; example: ER to inpatient unit.

6. Department specific policies and procedures for effective hand off communications include the following components:

a. Interactive communications allowing opportunity for questioning between the giver and receiver of patient information.

b. Include up to date information regarding the patient's care, treatment and services, condition and any recent or anticipated changes.

c. Interruptions during hand offs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

d. Verification of the received information, including repeat-back or read-back, as appropriate.

e. Receiver of the hand off information has an opportunity to review relevant patient historical data, which may include previous care, treatment and services.

7. Prior to discharge the patients' nurse, Case Manager and physician collaborate to ensure an appropriate plan is developed and implemented to provide for continuity of the patient’s care.

8. To facilitate the continuum of care the following policies and procedures have been developed and implemented:
a. LSUHSC Hospital Policy

Transfer of Patients 2.9
Access to Care 2.11
Patient Assessment 5.9
Admission 5.10
Patient Recall 5.11
Patient Handoff 5.43
Medical Record Content 6.5
Specialty Clinics 5.8
Utilization Review 2.5

b. Nursing Policy and Procedure

Case Management/Coordinated Care D45
Discharge Planning (Nurses’ Role) D47
Emergency Medical Services (EMS) E21
Patient History/Assessment/and Discharge A20
Transfer Summary - Inpatient T40
Memorandum of Transfer

c. Department specific policies and procedures as appropriate in meeting patient care needs.

Administrator

4/22/09
Date

Approved by Clinical Board: 9/19/00, 11/18/03, 1/17/06, 4/21/09
Written: 10/94
Reviewed: 11/03, 3/09
Revised: 1/95, 4/98, 7/00, 11/03, 12/05, 3/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

DISCHARGE POLICY

Purpose:

To provide guidelines for the discharge of in-patients from LSUHSC.

Policy:

1. Discharge procedures must be followed to ensure patients are discharged effectively and efficiently, allowing for optimal utilization of available resources.

2. An authorized hospital discharge shall be made by a physician’s written order. However, a patient may discharge himself/herself against medical advice (AMA). If a patient desires to leave against medical advice, the physician shall be notified, and the patient shall sign an AMA form. The form shall be attached to the medical record and the medical record sent for processing per usual route.

3. Early discharges, prior to 12 noon, are encouraged.

4. The physician shall document discharge instructions in the patient’s medical record prior to the anticipated discharge.

5. Anticipated discharge orders shall be written twenty-four hours prior to the anticipated discharge when possible, in order to ensure timely processing of all orders.

_____________________
Administrator

5/21/07

Date

Approved by Clinical Board: 3/20/01, 4/20/04, 5/15/07
Written: 3/96
Reviewed: 5/98, 2/01, 3/04, 4/07
Revised: 3/04, 4/07
MINIMUM AND MODERATE SEDATION

Purpose:

To outline the management before, during, and immediately following a procedure utilizing procedural sedation.

Definitions:

Sedation- For the purpose of this policy and procedure, sedation refers to administration of a medication to provide anxiety reduction, amnesia, or analgesia during a procedure. This policy and procedure does not refer to:
(1) muscle relaxants given to paralyze a patient in the intensive care units,  
(2) medications administered to alleviate pain following a procedure or resulting from a disease process, and/or  
(3) sedation given to make a patient rest comfortably.

Minimal Sedation – (Anxiolysis) a drug induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. In this stage, the following should be present:

1. Normal respirations;  
2. Normal response to verbal stimulation;  
3. Cardiovascular function unaffected; and  
4. Intact protective reflexes. Amnesia may or may not be present. The patient is technically awake, but under the influence of the drug administered; and  
5. The determination of patient monitoring and staffing requirements by the responsible physician should be based on the patient's acuity and the potential risk of complication. Staffing during minimal sedation should include one registered nurse or qualified practitioner to observe the patient's response to medication(s).

Moderate Sedation - (moderate sedation/analgesia) a drug induced depression of consciousness which:

1. Protective reflexes are maintained,
2. Patient's ability to maintain a patent airway independently and continuously,

3. Permits purposeful response by the patient to verbal commands, either alone or accompanied by light tactile stimulation (reflex withdrawal from a painful stimulus is not considered a purposeful response), and

4. Cardiovascular function is usually maintained.

**Deep Sedation** – see Policy 5.9.2

**Location:**

Procedural sedation is administered in various departments within the organization, for example, endoscopy, cardiac cath, special procedures, surgery clinic, inpatient units, etc.

**Policy:**

1. The physician shall order the pharmacological agent to be administered for sedation. An anesthesiologist is available 24 hours a day for consultation if needed.

2. **Staffing**

   Sufficient numbers of qualified personnel (in addition to the physician performing the procedure) are present during procedures using moderate sedation to:

   - Appropriately evaluate the patient prior to beginning moderate sedation,
   - Provide the moderate sedation,
   - Help with the procedure (CAMH, Update 3, August 2004, PC42)
   - Perform the procedure,
   - Monitor the patient, and
   - Recover and discharge the patient from either the post-sedation recovery area or from LSUHSC-S.

3. **Equipment and Monitoring:**

   a. Appropriate equipment for care and resuscitation is available for monitoring vital signs including heart and respiratory rates and oxygenation using pulse oximetry equipment.
b. Heart rate and oxygenation are continuously monitored by pulse oximetry and plethymographic display.

c. Respiratory frequency and adequacy of pulmonary ventilation are continually monitored via E+CO₂.

d. Blood pressure is measured at regular intervals (minimum of every 5 minutes during procedures).

e. EKG is monitored in patients with significant cardiovascular disease or when dysrhythmias are anticipated or detected.

f. Reversible agents shall be readily available.

4. Competency Requirements:

a. Qualified individuals are trained in professional standards and techniques:

1) To administer pharmacologic agents to predictably achieve desired levels of sedation, and

2) To administer pharmacologic agents to reverse the level of sedation, and

3) To monitor patients carefully in order to maintain them at the desired level of sedation.

4) RN’s (non CRNA’s) must have documented initial and annual competency assessment.

b. RN's administering procedural sedation agents shall not exceed the maximum dose listed in Hospital Formulary or Nursing Policy I:50-IV Therapy – Conscious Sedation.

For dosage of sedation agents and antagonists staff may refer to:

1) Hospital Formulary

2) Nursing Policy I:50 -IV Therapy – Conscious Sedation

3) Drug Inserts

c. Individuals administering procedural sedation are qualified and have the appropriate credentials to manage patients at whatever level of sedation is achieved, either intentionally or unintentionally.
d. Included in the qualifications of individuals providing procedural sedation are competency-based education, training and experience in:

1) Evaluating patients prior to performing procedural sedation.

2) Practitioners intending to induce procedural sedation are competent to manage a compromised airway and to provide adequate oxygenation and ventilation. Completion of an ACLS/PALS course or the equivalent based on patient’s age is required. RN’s must follow the requirements as written in Nursing Policy I-51, IV Therapy- Conscious Sedation Guidelines.

3) Performing the procedural sedation to include methods and techniques required to rescue those patients who unavoidably unintentionally slip into a deeper-than-desired level of sedation or analgesia (i.e., Practitioners who have appropriate credentials and are permitted to administer procedural sedation are qualified to rescue patients from deep sedation).

5. The RN managing the care of the patient receiving procedural sedation shall not leave the patient unattended or otherwise compromise continuous monitoring and shall have no other responsibilities.

6. Prior to pharmacologic agent administration:

a. Explain/reinforce, with the patient:
   - Sedation purpose

b. Confirm IV access and immediate availability of antagonists, emergency medication/equipment, crash cart, equipment for monitoring vital signs (heart & respiratory rate) and oxygenation using pulse oximeter, blood pressure machine, suction, oxygen, and airway/intubation equipment. IV access is required for all patients receiving procedural sedation regardless of sedation route.

c. The physician pre-procedure assessment shall be documented in the medical record. It shall include a history of family/personal problems with anesthesia/sedation, auscultation of the heart and lungs, airway evaluation, pertinent physical exam, review of abnormal laboratory results, ASA classification and evaluation of blood/blood component requirements (if applicable). Additionally, the physician shall obtain informed consent; form a pre-procedure
diagnosis and plan, and a sedation plan. The physician shall review the history and physical, patient's allergies, current medications, and NPO status prior to the procedure. Immediately before beginning moderate procedural sedation, the patient is reevaluated by a physician, who makes the determination that the patient is a suitable candidate to undergo the planned sedation. The RN (non-CRNA) shall not monitor:

1) An adult patient with an ASA classification higher than Class III, and/or

2) A pediatric patient with an ASA classification higher than Class II.

d. If history/physical has been completed within the last 30 days and a copy is available on the chart, staff shall document significant changes in patient status.

e. The RN shall assess NPO status (exception: emergency procedures), current medications, allergies/adverse reactions, tobacco/alcohol/drug use, pregnancy, and level of activity, psychological status, level of consciousness, skin, pain level, and the musculoskeletal system prior to the procedure. The RN shall document a plan of care prior to the procedure. The RN shall document pre-procedure, intra-procedure, and post-procedure assessments/interventions in the medical record.

f. The post-procedure plan shall be completed by either the MD or RN.

g. The RN shall notify the Physician and document:

1) Prior to beginning procedural sedation; NPO not maintained for 6 hours for solids/2 hours for clear liquids prior to beginning procedural sedation, history or symptoms of acute or chronic respiratory illness, unexplained fever, or other signs of an acute illness.

2) Post sedation Modified PADSS/Modified Aldrete scores not meeting discharge criteria (see Attachment B).

7. Patient Care

a. Document medication dosage/times and patient response, type and amount of fluids, blood/blood products administered, pertinent interventions results, and any other events of importance.
b. Monitors heart rate and oxygenation continually by pulse oximetry. Monitors respiratory rate and adequacy of ventilations, level of consciousness (modified Ramsey Score, etc), response to verbal commands, pain intensity, and blood pressure (except when blood pressure monitoring will interfere with ability to maintain sedation). Documents as noted below:

1) Obtain and document baseline findings prior to the procedure.

2) Monitor all parameters continuously during the procedure, documenting at least every 5 minutes and more often as indicated. Attach monitor strip to patient record if able to obtain a monitor strip.

3) Monitor and document a minimum of every 15 minutes x 2 following the procedure. If a reversal agent has been used, monitor and document at least q 15 minutes x 4 following the procedure. Ensure the patient meets the following discharge criteria:

   a) Stable vital signs and oxygen saturation,

   b) Returns to pre-sedation level of consciousness and/or until patient is completely arousable and responsive and/or responding appropriately for age, and

   c) Able to ambulate with minimal assistance if tolerated by physical status and surgical procedure. The pediatric patient’s activity/mobility level is appropriate for their age.

   d) The Modified Post Anesthesia Discharge Scoring System or the Modified Aldrete must be ≥8, shall be used for those patients discharged home. Patients must have a score of greater than or equal to 9 for discharge home or be reassessed and discharged by a physician. Refer to Attachment A.

   e) If discharge criteria are not met, the physician shall be notified. The physician must reassess the patient and determine appropriate action.

c. Continuously monitor the patient during the procedure and until protocol is discontinued for the following complications. Staff shall
initiate emergency protocols, notify the physician, document complications and complete a variance report for the following:

1.) Signs and symptoms suggesting respiratory distress or airway impairment

2.) Signs and symptoms suggesting pharmacologic overdose, and

3.) Signs and symptoms suggesting unexpected drug effect.

8. Discharge instructions will be given and documented. Outpatients will be discharged to a responsible adult who will accompany them from the hospital. If there is no responsible adult available, the patient may be admitted to the 23-hour observation unit, etc.

9. Outpatients will be escorted by hospital personnel to appropriate exit or waiting room.

10. Outcomes of patients undergoing sedation are collected and analyzed in the aggregate to identify opportunities to improve patient care.

Administrator

6/18/08
Date

Approved by Clinical Board: 11/21/00, 1/20/04, 5/17/05, 6/17/08
Written: 7/96
Revised: 8/96, 5/98, 10/00, 12/03, 4/05, 5/08
Attachment A

Table 4. Modified Post-Anesthesia Discharge Scoring System (Modified PADSS)

**Vital Signs**
2 = within 20% of preoperative value  
1 = 20% to 40% of preoperative value  
0 = 40% of preoperative value

**Ambulation**
2 = steady gait/no dizziness  
1 = with assistance  
0 = none/dizziness

**Nausea and vomiting**
2 = minimal  
1 = moderate  
0 = severe

**Pain**
2 = minimal  
1 = moderate  
0 = severe

**Surgical bleeding**
2 = minimal  
1 = moderate  
0 = severe

**Note:** Maximum total score is 10; patients scoring 9 or 10 are considered fit for discharge home.
Attachment B

Modified Aldrete Recovery Score

Respiration:
2 = able to deep breathe and cough freely
1 = dyspnea
0 = apnea

Activity (age appropriate, surgery):
2 = able to move 4 extremities voluntarily or on command
1 = able to move 2 extremities voluntarily or on command
0 = unable to move any extremities

LOC:
2 = awake
1 = responding to stimuli
0 = nonresponsive

Circulation:
2 = systolic blood pressure within 10% of preanesthetic values
1 = systolic blood pressure within 11-20% above preanesthetic values
0 = systolic blood pressure > 20% above preanesthetic values

Temperature (axillary or equivalent site):
2 = axillary temperature 36.6°C-37.5°C
1 = axillary temperature 35°C-35.5°C
0 = axillary temperature <35°C or >37.5°C

Adequate recovery is achieved if modified Aldrete score is ≥ 8.
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER-SHREVEPORT

MANAGEMENT OF VIOLENT AND/OR COMMITTED PATIENTS

Purpose:

To provide guidelines for the management of violent and/or committed patients who present to LSUHSC-S with an Order of Protective Custody, an Emergency Commitment, a judicial commitment, and/or those patients who are violent.

Policy:

1. When violent and/or committed patients are brought to the ECC or Children's Health Clinic, responsibility for examination, psychiatric evaluation and appropriate disposition of the patient is placed directly upon the Medical Center. Louisiana Public Law regarding Emergency Commitment (PEC) and Order of Protective Custody (OPC) relieves the police of any responsibility for the patient when the patient is delivered to a medical treatment facility. Therefore, if the patient is injured, leaves the hospital prior to evaluation, or injures someone else because we failed to meet obligations imposed upon the Medical Center by statute, LSUHSC-S may be individually and jointly liable for any injury or damage, which occurs.

2. These patients may enter the system in the following ways:

A. Written order of the parish coroner or judge (commitment paper or emergency certificate) OPC;

B. Request for protective custody by an official law officer/healthcare provider (RPC); or

C. Referred by physician emergency certificate (PEC);

"An official law officer may take a person into protective custody and transport him for medical evaluation when he has reasonable grounds to believe...that the person is acting in a manner dangerous to himself or others" (R.S. 28:53). A request for protective custody (RPC) must be completed with date, time, and signature of presenting officer.

The patient with an order of protective custody (OPC) must be presented to the healthcare facility within 12 hours for evaluation. The medical staff must then complete the patient's evaluation within 8 hours after arrival. The patient will either be admitted or discharged during this time.
3. If the patient is in custody, the law enforcement officers shall remain with the patient at all times.

4. The University Police Department (UPD) shall be notified and shall screen the patient for weapons. The Nursing and Medical Staff persons at the scene are responsible for subduing a violent or combative patient. If they are unable to do so, the UPD may be called to assist. Responsibility for medical management of a patient, including restraint when required, always rests with the clinic/emergency personnel. The role of UPD Officers is assistance.

5. If psychiatry is open and an adult patient has a PEC (physician’s emergency commitment) OPC (order of protective custody), CEC (coroner’s emergency commitment) or judicial commitment, the triage nurse completes a triage screening of the patient with vital signs. If vital signs are abnormal or there is trauma, the appropriate physician will assess the patient to determine the care needed. The patient is then transferred to the psychiatry unit after report as outlined in statement 8.

6. If the psychiatry unit is full, immediately upon arrival to Triage/ECC, the patient shall be placed in appropriate treatment room and Patient Processing notified to register the patient. If the patient has an RPC, the physician shall, as quickly as possible, examine the patient to rule out a physical illness or injury, which would require immediate treatment.

7. LSUHSC-S does not provide psychiatric services for persons under 18 years of age: For a child, after the Children's Health Physician has determined that physical treatment is not required, the Psychiatry Physician on call evaluates the patient in Children's Health Clinic to determine if placement is needed. The Children's Health Clinic notifies the psychiatrist on call and/or Case Manager/Administrative House Manager to facilitate transfer to a juvenile facility if appropriate.

8. Psychiatry (10th floor nursing station) shall be notified of the patient with a PEC, OPC, CEC or judicial commitment and/or violent patient in the ECC and are advised to be prepared to receive the patient.

9. A patient that is transported from any area to the Psychiatry Unit must be accompanied by at least one or more Nursing Staff members (RN, LPN, or Aide) and UPD. However, responsibility for the patient’s care during transport remains with the clinical/technical medical person(s).

10. Patients who must be restrained prior to transport shall be placed in appropriate restraints, which are safely secured to the frame of a stretcher or wheelchair.
11. A psychiatric staff member shall remain with the patient while he/she is awaiting evaluation on the psychiatric unit.

12. The Psychiatrist shall evaluate the patient in appropriate surroundings. If the patient does not require hospitalization, personnel employed by the psychiatric unit will escort him to the front of the hospital. If the patient needs to be held in custody for pick-up by Shreveport Police, the patient will be held in the security cell until Shreveport Police picks up the patient. If the patient who is discharged requires follow-up for a medical condition, an appointment shall be given for the appropriate clinic.

13. Upon decision to admit the patient by emergency certificate for inpatient treatment, the physician/nurse shall notify the Caddo Parish Coroner and provide the following information:

   A. the person's name and address
   B. date of birth
   C. name of certifying physician
   D. date and time of admission
   E. the name and address of the treatment facility
   F. date and time emergency commitment signed

[Signature]

Administrator

_1/19/07_______________
Date

Approved by Clinical Board: 2/20/01, 2/17/04, 1/16/07
Written: 8/94
Revised: 11/96, 4/98, 11/00, 2/01, 12/06
Reviewed: 2/04, 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

AUDIOLOGY SERVICES

Purpose:

To define the role of Audiology Services in the administration of hearing, balance assessment, and aural rehabilitation to the patients of LSU Health Sciences Center.

Policy:

1. Audiology services shall provide hearing testing on an outpatient basis in the ENT Clinic of LSUHSC, as deemed necessary by ENT residents and staff during clinic hours. A standard audiological battery includes:

   A. An audiogram
   B. Speech reception threshold
   C. Speech discrimination score
   D. Tympanogram

2. Audiology Services shall provide hearing testing on an inpatient and outpatient basis. A written consult or physician’s prescription must be submitted to Audiology Services in the ENT Clinic prior to the administration of the hearing evaluation. Reasons for consult include:

   A. Decreased hearing
   B. Decreased speech understanding
   C. Failed hearing screening
   D. Tinnitus

3. Audiology Services shall provide the following special tests upon the recommendation of a physician:

   A. Stapedial Reflex Measures
   B. Eustachian Tube Function Test
   C. Auditory Brainstem Response (ABR) Testing
   D. Auditory Steady State Response (ASSR) Testing
   E. Videonystagmography (VNG) Testing
   F. Otoacoustic Emissions (OAE) Testing
   G. Cochlear Implant Assessments and Subsequent Mappings
4. Audiology Services will determine hearing aid candidacy based on the audiological test results and make the appropriate recommendations for amplification and/or aural rehabilitation. Periodic monitoring of hearing aid benefit is provided for children fit with hearing aids through Children’s Special Health Services or Medicaid assistance.

5. Audiology Services will provide newborn hearing screening in the 4J nursery and NICU in accordance with the Universal Newborn Hearing Screening Law (ACT 653) of Louisiana, as well as the protocols provided by the Joint Committee on Infant Hearing 2000 Position Statement.

6. Inpatient audiology assessments are completed within 48 hours of consult if deemed necessary by the on-call ENT physician. Consult the on-call ENT physician to manage emergency consults after clinic hours, on weekends, and holidays. Outpatients are assessed as scheduled.

[Signature]
Administrator

7/27/09
Date

Approved by Clinical Board: 3/20/01, 7/15/03, 9/19/06
Written: 3/97
Reviewed: 2/99, 5/03, 8/06, 7/09
Revised: 1/01, 6/03, 8/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

SUBSTANCE ABUSE/ADDICTIONS

Purpose:

To provide medical staff personnel guidance in referring patients with suspected substance abuse for treatment.

Policy:

1. LSU Health Sciences Center - Shreveport has no identified treatment program for Substance Abuse. Admission of such patients is based only on associated medical or psychiatric needs.

2. During the course of inpatient or outpatient treatment, medical staff may identify the need for substance abuse treatment. They will consult Social Services (57076) to inform patient of local agencies and treatment programs serving people with substance abuse problems. Social Services will assist patients in contacting agencies if they so desire. A partial list of agencies follows:
   
   A. Northwest Regional Center for Addictive Disorders (318-632-2040)
   B. Narcotics Anonymous (318-677-8862)
   C. Alcohol Abuse Drug Addiction Treatment Information (1-800-234-0420)
   D. Alcoholics Anonymous (318-865-2172)
   E. Council on Alcoholism & Drugs (318-222-8511)
   F. Gamblers Help Line (1-877-770-STOP)
   G. S.T.E.P.S (318-222-1289)

3. Documentation of the referral will be noted on the patient’s medical record by the person making the referral.

Administrator

Date

Approved by Clinical Board: 4/16/02, 6/17/03, 6/20/06, 6/16/09
Written: 11/96
Revised: 5/97, 2/99, 3/02, 6/03, 6/06, 5/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

NUTRITIONAL CARE

Purpose:

A. To ensure the provision of appropriate medical nutrition therapy to all patients, including nutritional education for the promotion of health and prevention of disease.

B. To identify patients at nutritional risk and establish the need for further assessment by a registered dietitian.

C. To provide timely nutritional intervention for patients identified at nutritional risk by a clinical dietitian.

D. To document data pertinent to the nutritional care of the patient and develop a nutritional care plan for the individual patient throughout the continuum of care.

POLICY:

A. LSUHSC Nutritional Services and the contracted vendor are committed to providing a comprehensive nutrition care program including medical nutrition therapy in a timely, effective, and efficient manner. The program incorporates individual, ethnic, and religious food preferences. The nutrition care program is integrated with physicians, nursing, pharmacy, and other appropriate disciplines as needed.

B. All inpatients will be screened for possible nutritional risk within eight (8) hours of admission by nursing staff and a nutrition consult initiated via Net Access within twenty-four (24) hours of patient admission, as indicated. Physician or nursing initiated nutrition consults shall be completed within forty-eight (48) hours of notification by a registered dietitian or designee. Patients at nutrition risk according to the following screening criteria will also be assessed within forty-eight (48) hours of notification: initiation on parenteral nutrition support, initiation on enteral nutrition support, NPO/Clear liquid diet order > four (4) days, prealbumin <15. Ongoing monitoring of patients at nutritional risk occurs routinely.

C. All outpatients will be screened for possible nutritional risk upon each clinic visit by nursing staff and a nutrition consult initiated as indicated.
by designated screening criteria. A physician or nurse may refer outpatients to a dietitian via a consult.

Procedure:

Interdisciplinary Roles:

A. Inpatient Nursing:

1. Completes Nutritional Screening on the Patient History/Assessment and Discharge Record within eight (8) hours of patient admission. Nutrition consults may be initiated by nursing staff within twenty-four (24) hours of patient admission and/or physicians via the Net Access patient information system when the potential for nutritional risk or need of nutritional education is identified.

2. A consult should be ordered for adult patients with nutritional risk criteria including the following:

   a. Unintentional weight loss of greater than 10 pounds/month
   b. DKA/new onset Diabetes Mellitus/Gestational Diabetes Mellitus
   c. Acute or Chronic Renal Failure
   d. Hepatic Encephalopathy
   e. HIV/AIDS
   f. Malnutrition or cachexia
   g. Tube feeding
   h. Multiple trauma
   i. Burn >10%
   j. Diarrhea and/or vomiting > 4 days
   k. Pressure ulcers
   l. Dysphagia

3. Pediatric nutritional risk criteria includes the following:

   a. Unintentional weight loss in past month
   b. Multi trauma
   c. Burn >10%
   d. Malnutrition or FTT
   e. Inborn errors of metabolism
   f. DKA/new onset diabetes
   g. Obesity
   h. NICU grad<6 months old
   i. Tube feeding
4. Nursing Staff will document intake and weight on Graphic Chart/I&O (Form S/N 1191). Nursing will assist in documentation of intake for Calorie Count at bedside.

B. Outpatient Nursing:

1. Completes Nutritional Screening upon patient visit to outpatient clinic and initiates a nutrition consult with physician permission.

2. Outpatient screening criteria includes, but is not limited to, the following:
   a. End Stage/Chronic Renal Disease
   b. Uncontrolled Diabetes
   c. Elevated lipids
   d. Malnutrition

C. Inpatient Dietitian:

1. A nutrition assessment is completed on inpatients identified at moderate or severe nutritional risk. A follow up assessment by the dietitian will be completed weekly and twice weekly, respectively, following the initial nutrition assessment or consult. Follow up assessments will include review of the same components as the initial assessment and evaluation.

2. The Nutrition Assessment and Plan of Care will include a chart review of laboratory data, diagnosis, height, weight Body Mass Index, weight history, pertinent medications, diet order, nutritional needs, appropriateness of diet order, assessment of nutritional status, and recommendations/nutrition goals, as appropriate.

3. A dietitian or physician may initiate a Calorie Count. Calorie Counts will be conducted for three (3) days unless otherwise ordered by physician. Calorie Counts are documented at the bedside by the patient, patient’s family, or nursing staff and results recorded in progress notes upon completion.

D. Outpatient Dietitian:

1. The dietitian schedules appointments for all consults received from outpatient clinics in a timely manner. Appointments may be scheduled Monday through Friday between the hours of 8-
4:30. Dietitians are available to see “walk-ins” as their schedule allows.

2. The dietitian mails an appointment notification to the patient stating the date and time of appointment. Classes may be scheduled if there are numerous consults for the same type of counseling- these patients will be notified in the same manner.

3. Patients who need or desire nutritional follow-up after hospital consultation may be referred to the outpatient dietitian for scheduling.

Clinical Board Approved: 6/00, 10/17/00, 5/15/01, 10/21/03, 9/19/06, 1/16/07, 5/19/09
Written: 5/95
Revised: 3/95, 10/97, 4/00, 9/00, 3/01, 4/01, 6/03, 9/03, 9/06, 12/06, 4/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER –
SHREVEPORT

REPORTING CRITICAL TESTS RESULTS

Purpose:

To provide a protocol for notification of critical patient test results. Each department is responsible for ongoing assessments and to identify and implement a process, as needed, for the reporting of critical values.

Definitions:

Normal: A test result that is within the normal variation and does not require follow-up.

Non-Critical: A test result that is beyond the normal variation and that:

1. is not what is expected due to the patient’s current medication and/or disease state,
2. may require follow-up to ensure stability, resolution, or further evaluation and/or
3. may change the medical management of that patient.

Critical: A test result beyond the normal variation with a high probability of a significant increase in morbidity and/or mortality in the foreseeable future and requires rapid communication of results for determination of intervention.

Read Back: The individual accepting the critical test result must record and then read back the critical test result, in its entirety, to the reporter at the time the result is given.

** NOTE: Only licensed healthcare providers may accept test results (excludes medical, nursing, other allied health students)

Communication Tools:

Electronic: including Laboratory Information System (LIS), Radiology Information System (RIS), Pictorial Archival Computer (PAC) System, Hospital Information System (HIS)-Invision, NetAccess (view only version of the HIS) Witt, and Cardiology Information System (Muse), facsimile machine.
Manual: including the manual processing and delivery via pneumatic tube system, hand delivery or pick up to/by the testing area, patient care area or physician.

Verbal: including verbal report in person or by telephone, contacted through beeper system or overhead page.

Order of Notification:

1. Ordering Physician or their designee, Attending Physician or their designee:
   - Inpatient-the RN
   - ACD (Ambulatory Care Department) or Therapeutic Radiology-the RN or LPN, and after operating hours, MD on call for the ordering service.
   - Operating Room-RN or Perfusionist (CCP)

2. MD on call for the service which ordered the test, beginning with “first call” proceeding up through the attending staff physician.

3. Chief of Service

4. Administrative House Manager

5. Administrator on call

Receipt of Notification: Refer to Nursing Policy N-43 and ACD-Ambulatory Care Division Policy C 80.1

Policy:

Each department reporting critical values must have in place a defined process which documents the reporting of pre-approved critical values.

Process Examples:

Examples of the process include, but are not limited to, Cardiopulmonary Services, Echo, Clinical Laboratory and Radiology/Breast Imaging.

Normal/Non Critical Test Results Reporting and Documentation

Cardiopulmonary Services
Results are sent to HIS/Misys via Radiance
Echo
The assigned Cardiology Fellow/Attending completes the Echo Report Form which is saved in the departmental filing system with a copy being sent to the patient record. The images are saved in the Witt (archival viewing system).

Clinical Laboratory
Results are reported in HIS via LIS

Radiology/Breast Imaging
Results are reported in the HIS via RIS or can be viewed at the PAC station. Both the image(s) and report are archived, when applicable, in the PAC system.

Critical Test Results Reporting and Documentation

Cardiopulmonary Services
1. When a critical result is identified, the Cardiopulmonary staff member performing the test will contact the ordering physician or their designee within fifteen (15) minutes of test readiness. The name and credentials of the person the value was reported to will be entered into the ABL 800 series blood gas analyzer and sent to the LIS via Radiance. Documentation includes: the person who received the report along with their credentials, and acknowledgement of a “read back”.

2. If the ordering physician or their designee does not respond within fifteen (15) minutes of test readiness, the Cardiopulmonary shift supervisor is notified. The shift supervisor will follow the order of notification.

3. If the lab result is normalizing the MD may wish to write an order to accept normalizing value and give set range for notification.

Echo
1. When a significant abnormality is identified, the Cardiac Sonographer contacts the assigned Cardiology Fellow or Attending within fifteen (15) minutes via phone, beeper, or overhead page system.

2. If the assigned fellow/attending does not respond within fifteen (15) minutes of the initial notification attempt, the ordering physician or their designee is contacted via the phone, beeper, or overhead page system within fifteen (15) minutes.

3. If the ordering physician or their designee does not respond within fifteen (15) minutes, the Cardiac Sonographer will follow the order of notification.
4. The ECHO report form is completed by the Cardiology Fellow or Attending which is saved in the departmental filing system with a copy being sent to the patient record. Included in the report is the person receiving the report and the date/time it was received. The images are saved in the Witt archival viewing system.

Clinical Laboratory
1. When a critical result is identified, the Laboratory Technologist contacts the ordering physician or their designee within fifteen (15) minutes of test readiness via a phone call, beeper, or overhead page system. The result can be accessed in the HIS. Included in this report is the name of the notifying technologists, the person receiving the report along with their credentials, the time of reporting and acknowledgement of a “read back”.

2. For the patient who is no longer in the hospital or clinic, the Laboratory Technologist contacts the ordering physician within fifteen (15) minutes of test readiness. If the ordering physician is not reached within fifteen (15) minutes of test readiness, the Laboratory Technologist will follow the order of notification.

Radiology/Breast Imaging
1. When the radiologist identifies a critical test result, a verbal report is given to the ordering physician immediately in person or by phone.

2. If the ordering physician is not available, the radiologist immediately contacts their designee and a verbal report is given in person or by phone.

3. If their designee could not be reached, the radiologist will immediately follow the order of notification.

4. The result is reported in the HIS via RIS and includes the name and credential of the receiver of the critical test result. The image(s) and the report are archived, when applicable, in the PAC system.

System Failures:

Cardiopulmonary
With any applicable communication system failure, the Cardiopulmonary staff member will give an in person verbal report of the critical test to the ordering physician or their designee. Documentation will continue in the log book as previously described.

Echo
With any applicable communication system failure, the Cardiac Sonographer will give an in person verbal report of the significant abnormalities to first: Cardiac Fellow or Attending; second: ordering physician or their designee. The Cardiac Sonographer will document the name and credentials of the person receiving the report with the method of reporting and time of delivery.

Clinical Laboratory
With any applicable communication system failure a hard copy of the critical result will be delivered to the ordering physician or their designee. The Laboratory Technologist will document the name and credentials of the person receiving the report with the time of delivery in LIS.

Radiology/Breast Imaging
1. With any applicable communication system failure, the radiologist will give an in person verbal report to the ordering physician or their designee including this information in the final report.

2. In the event that the PAC system fails, the Radiology Department will revert to films, recording the critical result on the film and delivering the marked film to the ordering physician or their designee and include this information in the final report.

Approved by Clinical Board: 5/20/03, 1/20/04, 6/15/04, 11/21/06, 3/17/09, 5/19/09
Written: 6/95
Revised: 9/96, 12/97, 11/98, 2/00, 5/00, 2/01, 5/03, 12/03, 5/04, 10/06, 2/09, 4/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PRE-OPERATIVE VERIFICATION PROCESS

Purpose:

To make sure that all relevant documents and related information or equipment are:

- Available prior to the start of the procedure.
- Correctly identified, labeled, and matched to the patient’s identifiers.
- Reviewed and are consistent with the patient’s expectations and with the team’s understanding of the intended patient, procedure, and site.

Policy:

A. Scheduling Verification

1. Verification of the correct person, procedure and site should occur (as applicable)
   a. at the time the surgery/procedure is scheduled
   b. at the time of admission or entry into the facility
   c. anytime the responsibility for care of the patient is transferred to another caregiver

2. The following information is required when scheduling an invasive/surgical procedure:
   a. The correct spelling of the patient’s full name;
   b. Medical Record number (Date of birth is used when a medical record number is unavailable)
   c. Procedure to be performed.

3. Scheduled procedures that involve anatomical sites that have laterality, the word(s) right, left, or bilateral will be written out fully on the procedure/operating room schedule and all relevant documentation (e.g., consents).

B. Pre-procedure/Preoperative Verification

1. The healthcare professional will verify patient’s identity by asking the patient to state his or her full name, date of birth and procedure/surgery to be performed.
2. The patient will be involved in the process to the extent possible with verbal and visual responses (e.g., stating name and pointing to correct site location). If the patient is a minor, incompetent or sedated, has a language barrier; or is a trauma/emergency victim, impeding communication, the patients’ family, healthcare proxy agent, interpreter, or legal guardian should complete the identifiers and verify site mark.

3. A pre-procedure verification checklist shall be utilized to ensure that all relevant documents, including the procedure consent form, are available and have been reviewed for accuracy and completeness. This includes ensuring blood products, implants and special equipment are available prior to the start of the procedure and accurately matched to the patient.

4. If any of the above guidelines cannot be followed, the attending physician must write a detailed explanation of the extenuating circumstances in the medical record.

Approved by Clinical Board:  1/20/09
Written: 10/08
Revised:
Reviewed:

Administrator

1/21/09
Date
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

SITE MARKING

Purpose:
To clearly identify without ambiguity the intended site for the procedure.

Policy:

1. Surgical markings shall be completed before the patient enters procedure/operating room; a site mark is required for all patients having an invasive/surgical procedure, including bedside invasive procedures.

2. Procedures for Site Marking:
   a. Site marking shall be performed by the licensed independent practitioner (LIP) or other provider who is privileged or permitted by the hospital to perform the intended surgical or invasive procedure. The provider must be involved directly in the procedure and will be present during the procedure. The site mark is completed before the patient enters the procedure/operating room.
   b. Marking must take place with the patient involved, awake and aware, if possible. If the patient is a minor or unable to verify the information for his or herself, the verification process must, as possible, take place with parent, legal guardian, etc. as per informed consent policy. The LIP performing the site marking shall ask the patient to state the procedure(s), the site(s)/side(s) of surgery as well as point to the site(s).

3. The LIP performing the procedure will mark the procedure site which addresses the following:
   a. made at or near the procedure site on the incision site
   b. Includes the LIP's initials, with or without a line representing the proposed incision.
   c. Is made using a marker that is sufficiently permanent to remain visible after completion of the skin prep and sterile draping. Adhesive site markers are not to be used as the sole means of marking the site.
   d. Is positioned to be visible after sterile draping is complete.
4. For spinal procedures, preoperatively the skin is marked in the general spinal region and special radiographic techniques are used for marking the exact vertebral level.

5. If the procedure involves multiple sites/sides during the same operation, each side and site must be marked.

6. The skin mark shall not be placed on an open wound or lesion.

7. In the case of multiple lesions and when only some lesions are to be treated, the sites should be identified prior to the procedure itself.

C. Special Site Marking Requirements/Exceptions:

1. An alternative process for site marking shall be used in the following circumstances:
   
   a. Patient refuses marking – a temporary, unique wristband shall be placed on the side of the procedure containing the patient’s name; a second identifier shall be used for the intended procedure and site.

   b. For minimal access procedures that intend to treat a lateralized internal organ, whether percutaneous or through a natural orifice – intended site is indicated by a mark at or near the insertion site and remains visible after completion of skin prep and sterile draping.

2. Exceptions for Site Marking

   a. For interventional procedure cases for which the catheter/instrument insertion site is not predetermined.

   b. Cases in which it is technically or anatomically impossible or impractical to mark the site (mucosal surfaces, perineum, premature infants).

   c. For teeth, the operative tooth name(s) and number shall be indicated on documentation of the operative tooth (teeth) is marked on the dental radiographs or dental diagram. The documentation, images, and/or diagrams are available in the procedure room before the start of the procedure.
d. For premature infants, for whom the mark may cause a permanent tattoo.

3. Emergency Procedure

Site marking may be waived in critical emergencies at the discretion of the operating physician, but a “time out” should be conducted unless there is more risk than benefit to the patient.

4. Procedures exempt from Site Marking:

a. Gastroenterology endoscopic cases
b. Tonsillectomy
c. Hemorroidectomy
d. Single organ cases (c-section, cardiac surgery)

Approved by Clinical Board: 1/20/09
Written: 10/08
Revised:
Reviewed:
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

TIME OUT PROCESSING POLICY

Purpose:

To promote patient safety by providing guidelines for verification of correct site, correct procedure, and correct patient for invasive/surgical procedure(s). This policy applies to all invasive/surgical procedures including bedside invasive procedures performed at the facility. Certain routine “minor” procedures such as venipuncture, peripheral IV placement, insertion of nasogastric tube or insertion of a foley catheter are not within the scope of the protocol.

Policy:

1. The “Time Out” process shall be completed and documented prior to starting the procedure and ideally, prior to the introduction of the anesthesia process unless contraindicated. The process involves the interactive verbal communication between all immediate members of the procedure team.

2. The process includes “Time Out” confirmation requirements, documentation, and exceptions.

   a. Confirmation of the correct side and/or site must be completed by appropriate health care personnel:

      1). The physician performing the procedure/surgery is responsible for reading and interpreting the radiographic images to be used during the procedure.

      2). Non-OR cases, confirmation shall be completed by the health care professional involved in the procedure.

      3). For OR cases, confirmation shall be completed by the entire procedure/surgical team and documented in the medical record by the RN.

   b. The “Time Out” requires confirmation and documentation of all of the following:

      1). Correct patient (verification using two patient identifiers)

      2). Correct side/site (site marking must be visible at the “Time Out”)

      3). Correct and accurate procedure consent form

      4). Correct patient position
5). Correct radiographs
6). Correct implants and/or equipment needed are present
7). Personnel present at the “Time Out”

3. All activity will cease during the “Time Out” process; If a discrepancy is identified during the process the procedure will not resume until the issue is resolved.

4. When two or more procedures are being performed on the same patient, a time-out is performed to confirm each subsequent procedure before it is initiated.

5. The time out procedure will not be conducted in emergency situations where delay in providing care may result in patient harm.

_____________________________
Administrator

1/21/09
Date

Approved by Clinical Board: 7/17/07, 11/20/07, 1/05/08, 1/20/09
Written: 6/07
Revised: 12/07, 11/08
Reviewed: 12/07, 11/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PAIN MANAGEMENT

Policy:

The LSUHSC-S healthcare professional:

- Recognizes the right of individuals to appropriate assessment and management of pain.
- Plans, supports, and coordinates activities and resources to ensure that the pain of all individuals is recognized and addressed appropriately.
- Provides individualized care in settings responsive to specific needs.
- Provides education on pain management as part of the patient’s treatment considering the patient’s personal, cultural, spiritual, and/or ethnic beliefs.
- Works with the patient to set, develop and implement a plan to reach a goal for pain relief.
- Develops plan in conjunction with the patient, if on discharge the patient has pain, to address management at home.
- Monitors the performance of the pain management program.

A. Patient Rights

1. Patient Rights will be communicated to the patients. A patient at LSUHSC-S can expect:
   a. Information about pain and pain relief measures,
   b. A concerned staff committed to pain prevention and management,
   c. Health professionals who respond quickly to reports of pain,
   d. That reports of pain will be believed,
   e. State-of-the-art pain management, and
   f. Dedicated pain relief specialists.

2. Patient Responsibilities will be communicated to the patients. LSUHSC-S can expect a patient to:
a. Ask the doctor or nurse what to expect regarding pain and pain management,
b. Discuss pain relief options with the doctors and nurses,
c. Work with the doctor and nurse to develop a pain management plan,
d. Ask for pain relief when pain first begins,
e. Help the doctor and nurse assess the pain,
f. Tell the doctor or nurse if the pain is not relieved, and
g. Tell the doctor or nurse about any worries regarding taking pain medication.

B. Assessment

1. A patient’s report of pain will be accepted and respected as they key indicator of the amount of pain he/she is experiencing. Medical/nursing staff will assign the rating only if the patient is unable to report their pain.

2. The presence of pain is assessed on admission to the hospital, at the initial clinic visit, post invasive procedure and when the patient complains of pain. The assessment is performed by: a physician, RN, LPN, Physician’s Assistant, Nurse Practitioner, or other licensed healthcare staff and documented in the medical record.

3. The frequency of pain reassessment shall be dictated by the intensity of the patient’s pain and the effectiveness of pain relief strategies. However, when pain is present, a pain reassessment is generally performed at least every 4 hours and more often as needed by a licensed healthcare provider. The physician is notified of the patient’s pain when treatment fails to reduce the pain to a level acceptable to the patient, as ordered by the physician, or pain score $\geq 5$ using the approved Pain Scales (exception: those patients not assessed by the physician, i.e. triage, for patient safety and the prevention of abandonment from the hospital or clinic). If no pain is present, the licensed healthcare provider will reassess for pain as warranted by patient condition, when the patient complains of pain and post invasive procedure.

4. Pain Scales

a. The Numeric Pain Intensity Scale (NPIS) will be used universally to assess pain for patients 13 years or older. Patients will be asked to rate their pain a scale
of 0-10. Zero represents no pain; a rating of 5 would indicate that the patient is experiencing moderate pain, and a rating of 10 would indicate the worst imaginable pain.

b. The Wong-Baker Faces Pain Scale, consisting of graduated facial expressions of pain, will be used for patients, ages 5-12 and those unable to comprehend the numerical scale. Zero will represent no hurt and a rating of 10 would indicate the patient is experiencing the worst possible hurt.

c. The FLACC Pain Scale is used if the patient is unable to self-report pain and for ages <5 years.

d. The Neonatal Intensive Care Unit uses a pain scale appropriate to their patient population and follows their unit-specific policy.

e. CPOT (Critical-Care Pain Observation Tool) a behavior assessment scale for the intubated and/or unconscious patients. Facial expression, body movements, muscular tension, resistance to passive movements, compliance with ventilator settings or vocalization is assessed.

5. If pain is present, a more comprehensive assessment is performed, which may include:

a. Intensity (Numerical 0 -10, Wong-Baker Face Scale, FLACC, CPOT)

b. Quality

c. Location(s) (All pain locations are assessed)

d. Onset

e. Duration

f. Variation

g. Alleviating and aggravating factors

h. Present pain management regimen and effectiveness

i. Medication history

j. Presence of common barriers to reporting pain and using analgesics

k. Past interventions and response

l. Manner of expressing pain

m. Effect of pain on activities of daily living, sleep, appetite, relationships, emotions and concentration.

n. Pain goal, expressed as measures of intensity and function.

o. Physical examination:
   1) Mental status examination
   2) Motor and sensory examination
3) Reflexes  
4) Gait  
5) Maneuvers targeted to pain diagnoses  

6. Documentation of pain, for all patients, should include the following:  
   a. Type of pain and/or location  
   b. Intensity scale  
   c. Level of consciousness  
   d. Respiratory rate  
   e. Activity  
   f. Side effects  
   g. Medication  
   h. Patient and family education  
   i. Treatment goal  

7. Staff shall be educated about pain assessment, including the availability of nonpharmacological interventions.  

C. Treatment  

1. Pain is managed by pharmacological treatment, nonpharmacological treatment, and interventional procedures.  
   a. Pharmacological treatment may include non-opioids, opioids, and adjuvants.  
   b. Nonpharmacological treatment may include physical interventions and cognitive behavioral strategies.  
      1) Physical interventions may include:  
         a). Heat  
         b). Cold  
         c). Electrical stimulation (eg., TENS)  
         d). Exercise  
         e). Physical/Occupational therapy  
         f). Immobilization  
         g). Manipulation  
         h). Massage  
         i). Acupuncture  
      2) Cognitive behavioral strategies may include:  
         a). Distraction
b). Relaxation  
c). Guided imagery  
d). Biofeedback  
e). Hypnosis  
f). Other coping strategies

2. LSUHSC-S provides safe medication prescription or ordering.

a. Pain medication shall be ordered to be given as a specific dose with a regular schedule.  
b. PRN orders shall include specific indications for specific dosing. Example: Time ranges such as “every 2-3 hours prn” are not acceptable. A specified interval such as “every 3 hours prn pain” is acceptable.  
c. Range orders shall be avoided unless accompanied by a sliding scale. Example: Dose ranges such as 4-10 mg. Morphine IV every 3 hours are not acceptable unless it is tied to a measurable pain severity measure (i.e. For pain rating 5-7 administer morphine 5 mg. IVP every 2 hours prn pain; For pain rating 8-10 administer morphine 10 mg IVP every 2 hours prn pain).  
d. Specific protocols shall be used for PCA and epidural analgesia.  
e. Only one long-acting agent shall be prescribed at a time.

D. Patient Education

1. Patient education may focus on fears commonly held by patients in pain, including:  

a. Fear of drug addiction,  
b. Fear of drug dependence,  
c. Fear of drug tolerance,  
d. Fear of appearing uninformed or unable to understand, and  
e. Fear of inability to function normally.  

2. Educational content may include:  

a. Definitions of physical dependence, drug tolerance, and addiction  
b. Explanation of pain intensity scales:
1) Numerical pain scale (0-10)
2) Wong-Baker Faces pain scale (0-10)
3) FLACC Pain Scale (0-10)
4) CPOT (0-8)

c. Explanation of treatments:
   1) Pharmacological
   2) Procedural
   3) Non-pharmacological

3. Potential media for patient education may include, but is not limited to:
   a. Educational sessions documented in chart
   b. Written materials such as, handouts, posters and brochures.
   c. Audio- and videotapes
   d. Patient surveys

E. Discharge

Discharge notes shall include reference to physical needs, emotional needs, and symptom management.

Administrator

8/20/09

Date
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

REHABILITATION SERVICES

Purpose:

To define the scope of services of the Rehabilitation Services Department in the assessment and provision of care of LSU Health Sciences Center patients.

The Rehabilitation Services Department consists of the sections of Physical and Occupational Therapy and provides evaluation and treatment for the inpatient and outpatient population at LSU Health Sciences Center. Evaluation encompasses the performance of life span and functional age appropriate evaluation. Therapy is performed at the patient’s bedside or in the Rehabilitation Services Department. Department support personnel have the responsibility to transport patients to and from the department and to assist in the provision of patient care in those areas where they have received competency training.

Policy:

1. Rehabilitation Services are provided by qualified personnel to hospitalized patients upon physicians’ orders.

2. Data related to therapy status is collected/assessed on admission by nursing and medical staff. Consults may be initiated to Rehabilitation Services by physicians at this time or as needs for Rehabilitation Services are identified.

3. Physicians who question whether a patient can benefit from Rehabilitation should consult with the department. A Rehabilitation Services consult should be ordered for patients who have:

   a. Movement Dysfunction
   b. Ambulating difficulty
   c. Burns or non-healing wounds
   d. Cognitive impairment
   e. Developmental involvement
   f. Upper extremity or hand dysfunction
   g. Difficulty in functional activities including activities of daily living
   h. Disability adjustment concerns
4. It is the policy of the Rehabilitation Services Department to provide a comprehensive functional assessment and assessment/evaluation for those patients requiring rehabilitative intervention. Rehabilitation assessments are performed within 48 hours of consult for inpatients, if deemed necessary by the on-call physician. The on-call physician is notified to consult the on-call Rehabilitation Services personnel to manage emergency consults after clinic hours on weekends and holidays.

5. Other services include development of treatment plans, delivery and documentation of care/patient response, consultation, reevaluation, discharge recommendations and patient/family education. Home program documentation is also included.

6. Outpatient therapy is available to patients unable to complete therapy while hospitalized and for patients referred by physicians from outpatient clinics or the community. Physician referrals must be signed by the physician and include the patient’s diagnosis and reason for referral to Rehabilitation Services.

_____________________
Administrator

6/18/09
Date

Clinical Board Approved: 11/21/00, 6/17/03, 6/20/06, 6/16/09
Written: 3/97
Reviewed: 8/99, 5/06, 5/09
Revised: 10/00, 6/03
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

SPEECH-LANGUAGE PATHOLOGY SERVICE

Purpose:

To describe the provision of speech-language pathology services for patients of LSUHSC.

Policy:

1. Data related to speech-language status is collected/assessed on admission by nursing and medical staff.
   A. Outpatient - Consultation forms completed by physicians shall be forwarded to the Speech - Language Pathologist in the Otolaryngology/Head & Neck Surgery Clinic as needs for Speech - Language Services are identified.
   B. For inpatient consults, attach consult to the chart and call the Otolaryngology Clinic.

2. Speech - Language consult should be ordered on patients with speech, language, or dysphasia problems, including the following:
   A. Education related to speech - language disorder
   B. Swallowing evaluation – (Bedside and Videoflouroscopy)
   C. Head and neck cancer preoperative counseling
   D. Voice restoration following total laryngectomy
   E. Fitting voice prostheses
   F. Stroke evaluation/rehabilitation
   G. Traumatic brain injury / Closed head injury evaluation / Rehabilitation
   H. Other concerns within the scope of practice of Speech-Language Pathology
3. Speech - Language assessments are performed by qualified personnel within 48 hours of consult, if deemed necessary by the on-call Otolaryngology/Head & Neck physician. Consult the on-call physician to manage emergency consults after clinic hours, weekends or holidays.

Administrator

7/27/09

Date

Approved by Clinical Board: 8/15/00, 7/15/03, 9/19/06, 7/21/09
Written: 5/97
Revised: 8/99, 8/00, 5/03, 8/06
Reviewed: 7/09
Policy number changed: 5/1/01
Purpose:

To define the services provided by the Pastoral Services Department for patients and employees of LSU-Health Sciences Center-Shreveport.

Policy:

The Pastoral Care Department focuses on the patient’s, families’ spiritual well being and provides support to the staff.

1. Pastoral Care Services provides spiritual support to patients/families:
   a. During emergencies, deaths and codes.
   b. During pre-surgery prayer.
   c. During daily rounds in ICU's/ER's.
   d. During visitation of new admits per staff request.
   e. Referred by a physician/nurse.

2. Pastoral Care Services holds Sunday Worship services on the Psychiatric Unit and in the main Chapel. Other services are held as scheduled.

3. Pastoral Care Services provides religious literature to patients/families from various denominations, prayer books, Bibles, and other material such as our Daily Bread, The Upper Room, and Guideposts. These are available from the chaplain’s office.

4. Pastoral Care Services Staff shall document spiritual assessment/reassessments and interventions in the progress note section of the medical record. Spiritual reassessments are conducted on an ongoing basis as needed.

5. Pastoral Care Services provides support to staff during debriefing sessions and after severe crisis situations on units as requested.
6. Pastoral Care Services are available 24 hours a day, seven days a week. To obtain assistance from Pastoral Care Services, the switchboard must be notified to determine Chaplain-on-call and pager number.
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

SOCIAL SERVICES DEPARTMENT

Purpose:

To define the department’s role as an integral part of the hospital’s provision of health care.

To ensure that the provision of health care services to the patient and their family promotes optimal psychosocial functioning. “Social Services” intervention is defined as those activities performed with the specific intent to prevent or treat a social and emotional dysfunction arising from or exaggerated by illness or injury.

Services:

- Direct coverage to the NICU and Emergency Medicine Department (EMD). Services may include rehab/nursing home placement, transportation, medicines, shelter, equipment, counseling, etc.
- Enrollment in Pharmaceutical Indigent Patient Programs
- Financial benefits counseling and referral
- Emergency community referral for basic life essentials (food, shelter, clothes)
- High Risk Groups assessment and intervention, esp. for follow-up services.
- Support Groups
- Schedule interpreter service through contracted agencies.
- Assessment and referral of suspected abuse and neglect cases
- Newborn adoption coordination

Procedure:

Social Services responds to written and verbal referrals from any source (i.e., physician, hospital staff, patients, families, community). The referral shall specify the nature of concern. Social Services shall generate an assessment and intervention, as appropriate.

Evaluating the Patient for Services:

Psychosocial needs and available resources shall determine what, if any, social services can be provided. The social worker is responsible for sharing this information with the patient care team.
Recording Services Rendered:

Summary recordings shall be noted in the medical record of any ongoing contact with the patient and family. Intervention shall be entered on the Progress Notes or the Case Management Progress Notes (SN 6801) in the patient’s medical chart.

Participation in Patient Care Conferences:

Participation in patient care conferences shall be upon the request of the physician, case manager, or other patient care team member.

Hours:

**Hours** – M-F 0800 to 1700. An Administrative House Manager shall be available for emergency coverage after hours, weekends and holidays. Social Services staff shall be available via beeper for telephone consultation.

Approved by Clinical Board: 5/15/01, 6/17/03, 3/21/06, 5/19/09
Written: 5/1/01
Reviewed: 4/09
Revised: 5/03, 3/06, 4/09
PERSONNEL AUTHORIZED TO ORDER MEDICATIONS

Purpose:

To establish who is given medication prescribing privileges. For the purpose of this policy medication orders are those orders, either written or verbal, for a medication that is scheduled for administration by a licensed/credentialed provider to the patient while receiving care in an LSUHSC-S patient care area.

Policy:

1. The prescribing of medications for patients shall be limited to licensed (granted by the Louisiana State Board of Medical Examiners) practitioners of medicine and dentistry who are members of the medical staff (including Clinical Fellows in training) or house staff (including international physicians practicing under the Graduate Education Temporary Permit) as approved by LSUHSC-S.

2. All medication orders written by medical students must be countersigned by the above before such orders may be executed. It is the responsibility of the medical student to have orders countersigned by an authorized, licensed individual.

3. Authorized Physician Extenders may write discharge prescriptions as per Hospital Policy #5.4.11.

Administrator

10/17/07
Date
GUIDELINES FOR PHYSICIAN EXTENDER PRESCRIPTIVE AUTHORITY

Purpose:
To establish rules governing the writing of prescriptions by Physician Extenders (physician assistants and nurse practitioners) at LSUHSC-S. Prescriptive authority for Physician Extenders (PE) shall be limited to writing prescriptions for patients who will obtain their medications through pharmaceutical agencies not affiliated with LSUHSC-S. Prescriptive authority, as defined by this policy, does not allow for the ordering of medications, procedures, tests or services of any kind for inpatients.

Policy:

1. The physician extender must maintain a valid license with the State of Louisiana and be credentialed to practice within their defined scope of practice as delineated by LSUHSC-S.

2. The physician extender must meet the qualifications for, and apply for and obtain, prescriptive authority from their respective state board.

3. The physician extender must be approved by their supervising physicians to use their prescriptive authority under these guidelines.

4. The physician extender shall only write prescriptions for patients registered into the LSUHSCS service area in which the PE normally functions. The PE shall write prescriptions only during those times when they are on duty and working and only within their assigned service area.

5. The physician extender shall document in the patient’s medical record all medications for which a prescription was written and the name and credentials of the individual signing the prescription.

6. The physician extender shall only write prescriptions for medications with appropriately justified indications and for those medications listed on the formulary that has been approved by the Pharmacy and Therapeutics Committee for use in the department/service in which the PE works.
7. The physician extender shall not prescribe controlled substances.

8. Departmental Formulary Guidelines will be developed by the department chair or designee and maintained specific to the service area in which the physician extender is working.

9. The Departmental Formulary Guidelines will be reviewed periodically by a committee composed of supervising physicians and physician extenders within the department. Any proposed additions to the formulary or changes to the guidelines will be submitted to the Pharmacy and Therapeutics Committee for approval.

10. The department/service may impose stricter limitations on prescribing than those presented in these general guidelines.

11. Each department shall develop and present for approval to the Pharmacy & Therapeutics Committee a mechanism for monitoring individual physician extender’s prescribing practices to ensure compliance with Hospital and departmental guidelines. The results of monitoring shall be included in the PE’s bi-annual evaluation of performance in the credentialing and reappointment process by their respective Department Chair.

12. Failure to adhere to this policy will subject the physician extender and supervising physician to the peer review process and possible loss of prescriptive privileges for the physician extender.

 ____________________________
 Administrator

 4/23/07 ______________________
 Date

Approved by Clinical Board: 4/17/07
Written: 3/07
Reviewed:
Revised:
POST-MORTEM CARE

Purpose:

To provide guidelines for appropriate care of the body, notification of the family/significant other, and coroner notification as appropriate, following death.

Policy:

1. In-Patient Unit

When a patient expires on an in-patient unit, nursing personnel shall be responsible for ensuring that post-mortem care is properly completed (see Nursing Policy P-60 POST-MORTEM CARE).

2. Ancillary Departments

If a patient expires in an ancillary department, the unit or clinic that the patient was admitted to will send staff to the ancillary department to prepare the body for delivery to the morgue. The body will remain in the ancillary department until readied for transport to the morgue.

a. Staff in the ancillary department should provide assistance to the nursing staff during the preparation of the body as needed.

b. If there is family on the unit of origination, the family should be escorted to the ancillary department (accompanied by a nursing staff member), if they wish to view the body before it is transported to the morgue. Privacy should be afforded the deceased and the family member. Ancillary staff shall be supportive of the grieving family as necessary and be aware that the readying and viewing of the body may take time, so the room may not be available for use for 1 – 1 ½ hours.
3. OR, PACU, ECC or Outpatient (Clinics)

If the patient expires in the Operating Room, Post Anesthesia Care Unit, Emergency Care Center or Outpatient Clinic, these departments will prepare the body as needed for family viewing and transport to the morgue. (Refer to Nursing Policy P-60, Post Mortem Care)

4. Labor Unit

In the event of a spontaneous abortion (miscarriage) the mother shall be given the option of burial. If the mother declines burial, the “products of conception” are sent to pathology and handled as a specimen. (Only) if the mother chooses to bury the products of conception the following procedures are followed:

a. Declare the “products” a death
b. Notify Admitting
c. Obtain a funeral home release from the mother
d. Notify the LSUHSC-S Birth Certificate clerk to prepare a death certificate

Definitions

a. **Live Birth** – Complete expulsion or extraction from it’s mother of a product of human conception, irrespective of the duration of pregnancy which after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. *Birth certificate is completed.*

b. **Spontaneous fetal death (stillbirth)** – has occurred when the delivery does not result in a live birth, and gestation age is estimated at 20 weeks or greater, or if weight is 350 grams or more. *Fetal death certificate is completed.*

c. **Neonatal death (includes non-viable)** – death of any live-born neonate before the neonate becomes age 28 days. *Example: if the infant was born with any vital signs for any period of time they would be considered a live birth.*
Therefore, a birth certificate and death certificate must be completed.

5. The Administrative House Manager shall be notified of all deaths.

Approved by Clinical Board: 4/20/04, 1/18/05, 3/18/08
Written: 3/04
Revised: 3/04, 11/04, 2/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PATIENTS LEAVING AWOL
WITHOUT NOTIFICATION/PERMISSION

Purpose:

To delineate the procedures that staff are to take when an inpatient leaves a nursing unit, for reasons other than medical purposes, and does not return for an extended period of time and does not notify the nursing personnel. This policy does not address the patient who leaves Against Medical Advise (AMA).

Policy:

A. When a patient is gone from his/her inpatient room for more than 30 minutes and the staff does not know their whereabouts, hospital personnel shall make an effort to locate the patient and instruct them to return to their room. Measures to locate the patient should include checking public areas such as the cafeteria, smoking areas, and the front of the hospital. Staff may request the assistance of University Police in looking for the patient if they are unable to leave the patient care unit.

B. For patients who leave the inpatient unit for longer than two (2) hours for reasons other than scheduled treatments, tests, procedures or surgery, the nursing staff will notify the Administrative House Manager (AHM) and the patient’s attending physician, indicating the measures taken to locate the patient. If a search by the staff fails to locate the patient, the AHM shall advise staff to discharge the patient from the computer. Nursing staff shall document in the medical record that the patient was not in the room, estimated time the patient has been gone and what efforts were made to locate them.

C. Should the patient return to the inpatient unit once discharged from Invision, they are to be instructed to proceed to the Emergency Care Center where they will be triaged and evaluated. If readmission is determined to be appropriate, medical and nursing staff will follow all normal admission procedures.
D. This procedure is not applicable for patients signing out AMA, but for those who leave the facility without authorization for an extended period of time.

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Administrator

8/22/07
Date

Approved by Clinical Board: 9/21/04, 8/21/07
Written: 7/04
Reviewed: 7/07
Revised:
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

FALLS

Purpose:

To promote proactive practices for patient care planning which minimize the risk for falls. To minimize the risk of falling without compromising the functional independence of patients. To identify the components of LSUHSC Fall Prevention Program.

Definition:

A fall is a sudden, uncontrolled and unintentional downward displacement of the body to the ground or other object, excluding falls from violent blows or other purposeful actions. The fall may be witnessed or un-witnessed (patient found on the floor, ground or other object) and may or may not result in a physical injury. (This definition does not include an assisted lowering of a patient to a chair or the floor.)

Policy:

1. Patients shall be assessed for fall risk factors during admission assessment, daily assessments, and as the patient condition warrants. Assessments and periodic reassessments shall include the potential risk associated with the patient’s medication regimen. If determined to be at risk, a plan of care for the patient shall be developed proactively that utilizes interventions to reduce the risk of patient harm resulting from falls.

2. Documentation of patient/family education regarding fall risk factors shall be placed in the medical record.

3. LSUHSC Falls Prevention Program requires that a visible marker (leaf symbol) be placed on the inpatient’s door and above the patient’s bed when a patient has been identified as at risk for falls. Patients will also be identified for falls prevention with an orange wrist band; additionally, an orange page advising caregivers that the patient is at risk is placed in the front of the patient’s medical record.
4. The staff is responsible for implementing falls precautions, including frequent patient monitoring, using supplied fall prevention equipment, assessment of patient and maintaining a safe environment.

5. A patient who has experienced a fall shall have an immediate physical assessment, MD notification, and the event documented in the medical record and variance report: including a date/time, description of fall, location of fall, patient physical assessment, current medications, and other related factors that are pertinent.

6. A variance report is completed for every fall during shift of occurrence and forwarded to Quality Management. A fall resulting in a major injury (fracture, head injury, death) shall be reported immediately to the Unit Manager or Administrative House Manager (after-hours).

7. The Nursing Falls Prevention Quality Council and Falls Committee promotes proactive practices for patient care planning which minimizes the risk for falls; works to develop a falls prevention program that reduces the risk of patient harm resulting from falls; collects and evaluates falls data on a monthly basis; and makes recommendations based on data and trends, as appropriate.

___________________________
Administrator

10/23/09
Date

Approved by Clinical Board: 4/19/05, 6/19/06, 10/20/09
Written: 3/05
Revisions: 8/06, 9/09
Reviews: 9/09
Purpose:

To define a safe process to convey important information about a patient’s care when transferring care responsibility from one physician to another, one nurse to another, or among other licensed or unlicensed personnel, or when a patient leaves LSUHSC-S for another site of care.

Background: In the course of patient care it is often necessary to transfer responsibility for a patient’s care from one physician or nurse to another. The primary objective of a “handoff” is to provide complete and accurate information about a patient’s clinical status, including current condition and recent and anticipated treatment. The information communicated during a handoff must be complete and accurate to assure safe and effective continuity of care.

Policy:

Handoffs follow a standardized approach and include the opportunity to ask and respond to questions. A handoff is a verbal and/or written communication, which provides information to facilitate continuity of care.

1. Persons Affected

   a. This policy applies to all healthcare personnel who take responsibility for who discharge or send a patient to other sites for care.

   b. It also affects staff in other areas of LSUHSC-S (such as diagnostic and treatment area professional staff) who may need to communicate information when a patient changes location of care.

2. Definitions and Additional Information

   a. A “handoff” or “report” occurs each time that an inpatient, emergency room patient, clinic patient, observation patient or any other patient:

      1). Moves to a new unit
2). is transported to or from a different area of LSUHSC-S for care (e.g. diagnostic/treatment area)

3). is assigned to a different nurse, temporarily (e.g. lunch break) or longer (e.g. shift change)

4). is assigned to a different physician temporarily (e.g. night float) or longer (e.g. rotation change)

5). is discharged to another institution or facility from LSUHSC-S into the care of a physician or nurse or is transferred to LSUHSC-S from another institution or facility

Each of these situations requires a structured handoff with appropriate communication.

b. In some areas of LSUHSC-S, a handoff also occurs among non-licensed personnel, i.e. NA to another staff member in the same position. A consistent approach to handoff communication is encouraged and it is the prerogative and responsibility of the manager of each area to evaluate the best approach to assure effective communication. This may include developing tools for the non-licensed staff handoff, which use the same principles and approach as that mandated by this policy for nurses and physicians.

c. **Additional characteristics** of a high quality handoff:

1). Handoffs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information.

2). Handoffs include up-to-date information regarding the patient’s care, treatment and services, condition and any recent or anticipated changes.

3). Interruptions during handoffs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

4). Handoffs require a process for verification of the received information, including repeat-back or read-back, as appropriate.
5). The receiver of the handoff information has an opportunity to review relevant patient historical data, which may include: previous care, treatment and services.

3. Responsibilities

a. Department Managers:

1). Department Managers ensure that the handoff and report form, or verbal-handoff guideline, designed for use on their unit is consistent with the needs of patients in the unit, and is used consistently and correctly.

2). They also ensure that staffing supports interaction of the sending and receiving nurse with minimal interruptions and with the opportunity to ask questions.

3). Department Managers evaluate handoffs among non-licensed staff such as NA staff and determine whether structured handoff approaches are appropriate.

b. Healthcare Personnel

1). Comply with handoff policy and procedures; resolve discrepancies and concerns timely.

2). Applies to all licensed and non-licensed healthcare personnel, such as technologies, NA, etc.

c. Physician Leadership as Designated by Clinical Chair in Each Department:

1). Establish the process for and maintain the performance of handoff procedures in accordance with the requirements in this policy.

2). Ensure that house staff provides information needed for timely, accurate, complete and effective handoff in accordance with the requirements in this policy.
d. Physicians (attending and house staff):

Comply with handoff policy and procedures; resolve discrepancies and concerns timely.

Procedure:

1. Medical Staff and Residents:

   a. Handoff procedures and information transfer forms/guidelines for physicians are developed and implemented by each service according to the needs of that service. The handoff forms or guidelines may be in either paper or electronic format, and must include clinical information agreed upon by physicians in that service as being integral to the provision of safe and effective patient care for that patient population.

   b. Each service also develops and implements a handoff process that is in keeping with the shift / rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.

   c. Each handoff process must include the opportunity for the oncoming physician to ask questions and request information from the reporting physician.

   d. Within each service, handoffs will be conducted in a consistent manner, using a standardized handoff form or guideline.

2. Transferring physician:

Handoff verbal &/or written should include at a minimum (as applicable)

   a. Patient name, location, age/date of birth
   b. Patient diagnosis/problems, impression
   c. Important prior medical history
   d. DNR status and advance directives
   e. Allergies
   f. Medications, fluids, diet
   g. Important current labs, vitals, cultures
   h. Past and planned significant procedures
i. Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc)
j. Plan for next 24+ hours
k. Pending tests and studies which need follow up
l. Important items planned between now and discharge

3. Receiving physician:

Review handoff form or receive verbal handoff, and resolve any questions with transferring physician.

4. Nurses:

a. Each nursing unit is responsible for implementing the information transfer forms, guidelines for verbal handoff or supporting procedures that are in keeping with handoff principles. The handoff may be in either verbal, paper or electronic format, and must include clinical information agreed upon by nursing staff on that unit as being essential to the provision of safe and effective patient care for that patient population and that facilitates the smooth transfer of information from nurse to nurse.

b. General Medicine and Surgery Patient Care Units may use a Kardex, but are required to use a report sheet.

c. Refer to the Medication Reconciliation Policy (Hospital Policy # 8.21) for handoff of medication information.

d. Each handoff process must include the opportunity for the oncoming nurse or receiving nurse to ask questions and request information from the reporting nurse.

e. Handoffs will be conducted in a consistent manner, using a standardized handoff form or guideline.

f. When moving a patient for transfer, discharge, or transport, the sending and receiving nurses should review written documentation forms if possible. If not, the receiving nurse should have contact information and be able to contact the sending nurse so that any questions can be asked and answered.
g. At the conclusion of the handoff conversation, dispose of Kardex and/or report sheet at the appropriate time in a secured container.

5. Forms:

Transferring Patients, Sending Patients to Other Departments, or Discharging Patients:

a. Nursing Forms

1). The Transfer-Discharge Summary (S/N 1116) is completed when transferring or discharging to another patient care unit or agency by the transferring-discharging unit. The receiving unit or facility reviews the summary and asks for additional information if needed from the sending unit.

2). The Inpatient Transport Summary (S/N 7280) will be used when a patient is going to another department when a nurse is not going to stay with the patient. Prior to leaving the floor, the nurse will complete and it will be used by the receiving department to do a patient status report prior to the patient returning to the unit. Exception: The pre-op checklist (S/N 1185) will be completed on patients that are going to surgery, cardiac cath, and special procedures.

   a). If there were any complications, unusual features of the procedure, or additional care is required to follow up on the procedure and recovery, OR for any reason at the judgment of the sending nurse, then the sending nurse provides additional handoff information verbally via phone call to the receiving nurse.

   b). If vital signs or other critical information is communicated, repeat-back and read-back techniques are used to verify accuracy of receipt.

3). The Patient History and Discharge Record (S/N 1048) is completed by the RN/LPN on all patients discharged from the hospital.
4). **Discharge Instructions** (S/N 1199) is completed by the RN/LPN on all patients discharged home.

   b. Physician Form

   The **Memorandum of Inter-Hospital Transfer** (S/N 1303/1330) will be completed by the MD prior to transferring a patient to another acute care facility.

   __________________________

   Administrator

   _1/19/07____________________

   Date

Approved by Clinical Board: 4/18/06, 1/16/07
Written: 3/06
Revised: 11/06
Reviewed: 11/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

PATIENT HANDOFF

Purpose:
To define a safe process to convey important information about a patient’s care when transferring care responsibility from one physician to another, one nurse to another, or among other licensed or unlicensed personnel, or when a patient leaves LSUHCS for another site of care.

Background: In the course of patient care it is often necessary to transfer responsibility for a patient’s care from one physician or nurse to another. The primary objective of a “handoff” is to provide complete and accurate information about a patient’s clinical status, including current condition and recent and anticipated treatment. The information communicated during a handoff must be complete and accurate to assure safe and effective continuity of care.

Policy:
Handoffs follow a standardized approach and include the opportunity to ask and respond to questions. A handoff is a verbal and/or written communication, which provides information to facilitate continuity of care.

1. Persons Affected
   a. This policy applies to all healthcare personnel who take responsibility or who discharge or send a patient to other sites for care.
   b. It also affects staff in other areas of LSUHCS (such as diagnostic and treatment area professional staff) who may need to communicate information when a patient changes location of care.

2. Definitions And Additional Information
   a. A “handoff” or “report” occurs each time that an inpatient, emergency room patient, clinic patient, and observation or ambulatory surgery patient. Each of these situations requires a structured handoff and communication.
      1) Moves to a new unit
      2) is transported to or from a different area of LSUHCS for care (e.g. diagnostic/treatment area)
3) is assigned to a different nurse, temporarily (e.g. lunch break) or longer (e.g. shift change)

4) is assigned to a different physician temporarily (e.g. night float) or longer (e.g. rotation change)

5) is discharged to another institution or facility into the care of a physician or nurse is transferred into LSUHCS from another institution or facility.

b. In some areas of LSUHCS, a handoff also occurs among non-licensed personnel, i.e. NA to another staff member in the same position. A consistent approach to handoff communication is encouraged and it is the prerogative and responsibility of the manager of each area to evaluate the best approach to assure effective communication. This may include developing tools for the non-licensed staff handoff, which use the same principles and approach as that mandated by this policy for nurses and physicians.

c. **Additional characteristics** of a high quality handoff:

1) Handoffs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information.

2) Handoffs include up-to-date information regarding the patient’s care, treatment and services, condition and any recent or anticipated changes.

3) Interruptions during handoffs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

4) Handoffs require a process for verification of the received information, including repeat-back or read-back, as appropriate.

5) The receiver of the handoff information has an opportunity to review relevant patient historical data, which may include: previous care, treatment and services.

3. **Responsibilities**

a. **Department Managers:**
1) Department Managers ensure that the handoff and report form, or verbal-handoff guideline, designed for use on their unit is consistent with the needs of patients in the unit, and is used consistently and correctly.

2) They also ensure that staffing supports interaction of the sending and receiving nurse with minimal interruptions and with the opportunity to ask questions.

3) Department Managers evaluate handoffs among non-licensed staff such as NA staff and determine whether structured handoff approaches are appropriate.

b. Healthcare Personnel

1) Comply with handoff policy and procedures; resolve discrepancies and concerns timely.

2) Applies to all licensed and non-licensed healthcare personnel, such as technologies, NA, etc.

c. Physician Leadership as Designated by Clinical Chair in Each Department:

1) Establish the process for and maintain the performance of handoff procedures in accordance with the requirements in this policy.

2) Ensure that house staff provides information needed for timely, accurate, complete and effective handoff in accordance with the requirements in this policy.

d. Physicians (attending and house staff):

Comply with handoff policy and procedures; resolve discrepancies and concerns timely.

Procedure:

1. Medical Staff and Residents:

a. Handoff procedures and information transfer forms/guidelines for physicians are developed and implemented by each service according to the needs of that service. The handoff forms or guidelines may be in either
paper or electronic format, and must include clinical information agreed upon by physicians in that service as being integral to the provision of safe and effective patient care for that patient population.

b. Each service also develops and implements a handoff process that is in keeping with the shift/rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.

c. Each handoff process must include the opportunity for the oncoming physician to ask questions and request information from the reporting physician.

d. Within each service, handoffs will be conducted in a consistent manner, using a standardized handoff form or guideline.

2. Transferring physician:

Handoff verbal &/or written should include at a minimum (as applicable)

a. Patient name, location, age/date of birth
b. Patient diagnosis/problems, impression
c. Important prior medical history
d. DNR status and advance directives
e. Allergies
f. Medications, fluids, diet
g. Important current labs, vitals, cultures
h. Past and planned significant procedures
i. Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc)
j. Plan for next 24+ hours
k. Pending tests and studies which need follow up
l. Important items planned between now and discharge

3. Receiving physician:

Review handoff form or receive verbal handoff, and resolve any questions with transferring physician.

4. Nurses:

a. Each nursing unit is responsible for implementing the information transfer forms, guidelines for verbal handoff, and supporting procedures that are in keeping with handoff
principles. The handoff forms may be in either paper or electronic format, and must include clinical information agreed upon by nursing staff on that unit as being essential to the provision of safe and effective patient care for that patient population and that facilitates the smooth transfer of information from nurse to nurse.

b. General Medicine and Surgery Patient Care Units may use a Kardex, but are required to use a report sheet.

c. Refer to the Medication Reconciliation Policy (Hospital Policy # 8.21) for handoff of medication information.

d. Each handoff process must include the opportunity for the oncoming nurse or receiving nurse to ask questions and request information from the reporting nurse.

e. Handoffs will be conducted in a consistent manner, using a standardized handoff form or guideline.

f. The sending and receiving nurses should review the form / information together, if possible. If not, the receiving nurse should have contact information and be able to contact the sending nurse so that any questions can be asked and answered.

g. At the conclusion of the handoff conversation, dispose of Kardex and/or report sheet at the appropriate time in a secured container.

5. Forms:
Transferring Patients, Sending Patients to Other Departments, or Discharging Patients:

a. Nursing Forms

1) **The Transfer-Discharge Summary** (S/N 1116) is completed when transferring or discharging to another patient care unit or agency by the transferring-discharging unit. The receiving unit or facility reviews the summary and asks for additional information if needed from the sending unit.

2) **The Inpatient Transport Summary** (S/N ) will be used when a patient is going to another department when a nurse is not going to stay with the patient. Prior to leaving the floor, the nurse will complete and it will be used by the receiving department to do a patient status report prior to the patient returning to the unit. **Exception:** The pre-op checklist (S/N 1185)
will be completed on patients that are going to surgery, cardiac cath, and special procedures.

a) If there were any complications, unusual features of the procedure, or additional care is required to follow up on the procedure and recovery, OR for any reason at the judgment of the sending nurse, then the sending nurse provides additional handoff information verbally via phone call to the receiving nurse.

b) If vital signs or other critical information is communicated, repeat-back and read-back techniques are used to verify accuracy of receipt.

3) Verbal reports are given when patients are transferred from the EMS, Clinics, Anesthesia, PR or PACY to a patient care unit. The verbal report content shall be consistent each time a patient is transported to an inpatient unit.

4) The Patient History and Discharge Record (S/N 1048) is completed by the RN/LPN on all patients discharged from the hospital.

5) Discharge Instructions (S/N 1199) is completed by the RN/LPN on all patients discharged home.

b. Physician Form

The Memorandum of Inter-Hospital Transfer (S/N 1303/1330) will be completed by the MD prior to transferring a patient to another acute care facility.

Administrator

4/25/06

Date

Approved by Clinical Board: 4/18/06
Written: 3/06
Revised:
Reviewed:
ADULT VACCINATION PROGRAM/POLICY

Purpose:

In keeping with the Centers for Disease Control (CDC) Guidelines, LSUHSC-S will administer the Pneumococcal Vaccine and the Influenza Vaccine to hospitalized patients that meet the given criteria. Preprinted orders will be utilized to assure all patients are screened and to promote compliance.

Policy:

A. **Influenza Vaccine**

1. Each October, November, December, January, February and March the Influenza Vaccine will be offered to all eligible inpatients prior to discharge.

2. Education will be provided to the patient prior to the administration.

3. Education will include the side effects and risk of complications and the time period of susceptibility until antibody protection develops.

4. Criteria to administer the Influenza Vaccine include:
   - 50 years and older
   - Long term care patients
   - Heart disease
   - Lung disease, including asthma
   - Kidney disease
   - Metabolic disease, including Diabetes
   - Anemia and other blood disorders
   - HIV
   - Immune system disorders
   - Long term steroid use
   - Cancer patients
   - Bone marrow or organ transplant patients

B. **Pneumococcal Vaccine**

1. The Pneumococcal vaccine will be offered to hospitalized patients that meet the criteria.
2. Preprinted orders will be used to assure that all patients are screened to identify those eligible for the vaccine and promote compliance.

3. All patients receiving the vaccine will be educated prior to administration of the vaccine.

4. The education shall include side effects and risk of complications of receiving the vaccine versus not taking the vaccine.

5. Criteria for the Pneumococcal Vaccine include:
   - 65 years and older
   - Heart disease
   - Lung disease
   - Sickle cell
   - Alcoholism
   - Leaking cerebral spinal fluid
   - Long term steroid use
   - Bone marrow or organ transplant
   - HIV/AIDS
   - Damaged or no spleen
   - Diabetics
   - Liver cirrhosis
   - Hodgkin’s disease
   - Lymphoma
   - Leukemia
   - Cancer patients
   - Kidney failure
   - Nephrotic syndrome

C. Prior to discharge all qualifying patients shall be screened and the Pneumococcal and/or Influenza Vaccine administered when the patient is medically stable.

Administrator

4/22/09

Date
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

SHOCK TREATMENT AND RESUSCITATION TEAM (START)

Purpose:

To provide guidelines for rapid assessment of patients with deteriorating conditions prior to cardio/pulmonary arrest.

1. Rapid Response teams (RRT) bring critical care expertise to the patient bedside to prevent unnecessary deaths.

2. The team provides communication among the primary healthcare team to improve patient outcomes.

3. In short, the role of the START team will be:
   a. assess
   b. stabilize
   c. assist with communication
   d. educate and support
   e. assist with transfer, if necessary

4. START (Shock Treatment and Resuscitation Team) encompasses both inpatient and outpatient settings. There are five teams that are incorporated into START. Each team is developed best suited for the areas patient environment.
   a. START: In – Patient
   b. STARTed: Emergency Department
   c. STARTped: Pediatric
   d. STARTacd: Outpatient clinics
   e. STARTfwcc: Feist Weiller Cancer Center

I. START: In – Patient

A. Policy:
1. Each unit will be educated prior to the initiation of the rapid response team.
   
a. Education will be performed yearly after initial instruction.
b. Once education performed each unit will have access to criteria and pager #.

2. Patients who show any of the following signs meet START criteria:
   
a. Systolic blood pressure < 90 mm hg
b. Heart rate < 45 or > 130 bpm
c. Respiratory rate < 10 or > 30 bpm
d. Acute change in saturation < 90% despite O₂
e. Change in urinary output to < 50 ml in 4 hours
f. Altered mental status
g. Nurse or Physician discretion

3. If a patient meets the above criteria the RN will notify the START team using LSU pager system 4321.

4. The floor will then page the patient’s primary physician.

5. A member of the START team will return the call within 5 minutes and find out the patient location and condition.

6. The START team will respond to the patient’s bedside within 10 minutes.

7. The START team will then assess the patient and collaborate with the primary physician and develop a plan for rapid care of the patient.

B. Responsible Parties:

1. Member of patient’s Primary Physician Team
   Intern/Resident/Attending
   
a. Answer page from floor
b. Respond to patient’s bedside within 15 minutes
c. Discuss and collaborate patient care with the START team member
d. Notify Critical Care if ICU bed is needed or any other concerns
2. **Primary Care RN**

   a. Assess START Criteria
   b. Contacts START team if patient meets START Criteria.
   c. Is available for collaboration with START team regarding patient’s plan of care.
   d. Completes START contact form.
   e. Continues to care for patient unless patient is to be transferred to unit.
      1.) If transfer needed:
         a). Calls report to unit
         b). Assist with transport
   f. Completes START Evaluation form.

3. **START Team RN**

   a. Wears the START pager during shift
   b. Hands off pager to next shift
   c. Assures pager in working order at beginning of shift
   d. Calls all numbers back within 5 minutes of pager sounding
   e. Obtains patient information and patient location
   f. Notifies House Supervisor if 2 calls occur at once
   g. Responds to patient bedside within 10 minutes
   h. Assesses patient with the assistance of primary nurse
   i. Collaborates with START team RT, primary nurse, primary physician and assists to develop a plan for rapid care of the patient
   j. Contacts Critical Care resident or fellow if needed
   k. Assists in determining if patient needs to be transferred to the unit
   l. Assists with the care of the patient until stable or transferred to the unit
   m. Completes START Record

4. **START Team RT**

   a. Wears the START pager during shift
   b. Hands of pager to next shift
   c. Assures pager in working order at beginning of shift
   d. Calls all numbers back within 5 minutes of pager sounding
   e. Obtains patient information and patient location
   f. Responds to patient bedside within 10 minutes
g. Assesses patient with the assistance of START team RN and primary nurse
h. Collaborates with START team RN, primary nurse, primary physician and assists to develop a plan for rapid care of the patient
i. Assists in determining if patient needs to be transferred to the unit
j. Assists with the care of the patient until stable or transferred to the unit
k. Completes START Record
l. Performs follow – up on all START calls that remain on current unit
m. Contacts Critical Care Coordinator office with patient information (5-7610)

5. **Critical Care/ RT Coordinator**
   a. Assist as needed on all START calls while in – house
   b. Performs follow – up on all START calls

6. **House Supervisor**
   a. Assists START team as needed
   b. If 2 calls occur at once assists in rapid triage to assure presence to both patients as soon as possible.

II. **STARTed: Emergency Department**

   A. **Policy:**

   1. Each staff member will be educated regarding the START process in the Emergency Department
      a. Education will be performed yearly after initial instruction.

   2. Non – traumatic shock patients who show any of the following signs meet START criteria:
      a. Systolic blood pressure <90mmHg despite resuscitation with 2L of Crystalloid (Plasmalyte or Ringers)
      b. Initiation of vasopressors
      c. Acute Organ dysfunction
         1.) Altered level of consciousness
2.) Tachypnea, Hypoxia on FIO₂ > 40%
3.) Jaundice, elevated liver enzymes, hypoglycemia
4.) Tachycardia, arrhythmias, altered hemodynamics
5.) Oliguria or urine output <0.5cc/kg/hr except with renal failure
6.) Coagulopathy: decreased platelets, increased INR, increased ESR, increased CRP or increased D – Dimer
7.) Metabolic acidosis +/- elevated lactate
d. Physician or nursing discretion

3. If a patient meets the above criteria the RN will notify the START team using LSU pager system 4321.

4. A member of the START team will return the call within 5 minutes and find out the patient location and condition.

5. The START team will provide the above information to the Critical Care Fellow and the fellow/RN will respond to the patient’s bedside within 10 minutes.

6. The START team will then assess the patient and collaborate with the Emergency Care Attending physician and staff to develop a plan for rapid care of the patient.

B. Responsible Parties:

1. Primary Care RN
   a. Assess START Criteria
   b. Contacts START team if patient meets START Criteria
   c. Is available for collaboration with START team regarding patient’s plan of care
   d. Completes START contact form
   e. Continues to care for patient unless patient is to be transferred to unit
      1.) If transfer needed:
         a). Calls report to unit
         b). Assist with transport
   f. Completes START Evaluation form

2. START Team RN
Hospital Policy Manual  
Policy number: 5.45  
Effective Date: 7/01/08

a. Wears the START pager during shift  
b. Hands of pager to next shift  
c. Assures pager in working order at beginning of shift  
d. Calls all numbers back within 5 minutes of pager sounding  
e. Obtains patient information and patient location  
f. Documents appropriate information on START Record  
g. Notifies Critical Care Fellow of patient and information

3. **Critical Care Fellow**
   
a. Responds to patient bedside within 10 minutes  
b. Assesses patient with the assistance of Emergency Care Attending  
c. Collaborates with START team RT, primary nurse, primary physician, Emergency Care Attending and assists to develop a plan for rapid care of the patient  
d. Assists in determining if patient needs to be transferred to the unit  
e. Assists with the care of the patient until stable or transferred to the unit.

4. **Critical Care/ RT Coordinator**
   
a. Assist as needed on all START calls while in – house

5. **House Supervisor**
   
a. Assists START team as needed.  
b. If 2 calls occur at once assists in rapid triage to assure presence to both patients as soon as possible.

III. **STARTped: Pediatric**

A. **Policy:**

1. Each unit will be educated prior to the initiation of the Pediatric rapid response team (START).  
   
a. Education will be performed yearly after initial instruction.  
b. Once education is performed, each unit will have access to criteria and contact numbers.
2. All LSUHSC employees working on the Pediatric Ward or those employees who work on inpatient areas that care for pediatric patients have the ability to unconditionally request urgent medical assistance for a pediatric patient perceived to be in distress. This is intended to make sure that clinically deteriorating patients receive assistance before their conditions are an emergency.

3. Patient care personnel who recognize an acute deterioration in a patient’s status and summon the START team shall stay with the patient until the team arrives and are expected to remain with the patient throughout the START team activation unless otherwise instructed by the team.

4. Criteria for START team activation:
   a. Staff is concerned about a patient
   b. Acute change in heart rate
   c. Acute change in systolic blood pressure
   d. Acute change in respiratory rate
   e. Acute change in respiratory effort
   f. Acute change in neurological status
   g. Patient fails to respond to treatment
   h. In addition, the following objective measures of clinical instability are provided as a general reference guide. Please note that the numerical values do NOT need to be reached or exceeded before requesting a START team consultation. The most important activation criterion remains staff/family concern or intuition.

<table>
<thead>
<tr>
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<td>Infant (6 months)</td>
<td>&lt; 80 &gt;200</td>
<td>&lt;20 &gt;70</td>
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</tr>
<tr>
<td>Toddler (2 years)</td>
<td>&lt; 65 &gt;180</td>
<td>&lt;16 &gt;60</td>
<td>&lt;65</td>
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<tr>
<td>Pre-school (5 yrs)</td>
<td>&lt; 50 &gt;160</td>
<td>&gt;50</td>
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</tr>
<tr>
<td>School age (7yrs)</td>
<td>&lt; 50 &gt;150</td>
<td>&gt;45</td>
<td>&lt;75</td>
</tr>
<tr>
<td>Adolescent</td>
<td>&lt; 40 &gt;140</td>
<td>&gt;40</td>
<td>&lt;85</td>
</tr>
</tbody>
</table>

5. If a patient meets the above criteria, the RN will notify the START team by calling the Pediatric Intensive Care Unit (PICU) at 675-7221 or 675-7225.
6. The floor will then page the patient’s primary physician.

7. A member of the START team will return the call within 5 minutes and find out the patient location and condition.

8. The START team will respond to the patient’s bedside within 10 minutes.

9. The START team will then assess the patient and collaborate with the primary physician and develop a plan for rapid care of the patient.

B. Responsible Parties:

1. **Member of patient’s Primary Physician Team**
   
   Intern/Resident/Attending:
   
   a. Answers page from floor.
   b. Responds to patient’s bedside within 15 minutes.
   c. Discuss and collaborate patient care with the START team member.
   d. Notify PICU resident/attending if ICU bed is needed or for any other concerns.

2. **Primary Care RN:**
   
   a. Assess START criteria.
   b. Contacts START team if patient meets criteria.
   c. Is available for collaboration with START team regarding patient’s plan of care.
   d. Completes the Pediatric Notification form.
   e. Continues to care for patient unless patient is to be transferred to PICU. If transfer is needed:
      1). Call report to unit
      2). Assist with transport
   f. Completes Inpatient Evaluation form.

3. **START Team RN:**
   
   a. Obtains patient information and patient location.
   b. Notifies House Supervisor if 2 calls occur at once.
   c. Responds to patient bedside within 10 minutes.
   d. Assesses patient with the assistance of primary nurse.
e. Collaborates with START team RT, primary nurse, primary physician and assists to develop a plan for rapid care of the patient.
f. Contacts PICU resident or attending if needed.
g. Assists in determining if patient needs to be transferred to the PICU.
h. Assists with the care of the patient until stable or transferred to the unit.
i. Completes Inpatient START Record.
j. Performs follow-up on all START calls that remain on current unit.
k. Contacts PICU Manager with patient information.

4. **START Team RT:**

a. Obtains patient information and patient location.
b. Responds to patient bedside within 10 minutes.
c. Assesses patient with the assistance of START team RN and primary nurse.
d. Collaborates with START team RN, primary nurse, primary physician and assists to develop a plan for rapid care of the patient.
e. Assists in determining if patient needs to be transferred to the PICU.
f. Assists with the care of the patient until stable or transferred to the PICU.
g. Completes Inpatient START Record.
h. Performs follow-up on all START calls that remain on current unit.
i. Contacts PICU Manager with patient information.

5. **House Supervisor:**

a. Assists START team as needed.
b. If 2 calls occur at once, assists in rapid triage to assure presence to both patients as soon as possible.

IV. **STARTacd: Out – Patient Clinics**

A. **Policy:**

1. Each clinic will be educated prior to the initiation of the rapid response team.
   a. Education will be performed yearly after initial instruction.
2. Adult patients who show any of the following signs meet START criteria:
   a. Systolic blood pressure < 90 mm hg
   b. Heart rate < 45 or > 130 bpm
   c. Respiratory rate < 10 or > 30 bpm
   d. Acute change in saturation < 90% despite O2
   e. Change in urinary output to < 50 ml in 4 hours
   f. Altered mental status
   g. Nurse or Physician discretion

3. Pediatric patients who show any of the following signs meet START criteria:
   a. Staff is concerned about a patient.
   b. Acute change in heart rate.
   c. Acute change in systolic blood pressure.
   d. Acute change in respiratory rate.
   e. Acute change in respiratory effort.
   f. Acute change in neurological status.
   g. Patient fails to respond to treatment.
   h. In addition, the following objective measures of clinical instability are provided as a general reference guide. Please note that the numerical values do NOT need to be reached or exceeded before requesting a Pediatric START consultation. The most important activation criterion remains staff/family concern or intuition.

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</tr>
</tbody>
</table>
4. If a patient meets the above criterion the RN/designee will notify the START:
   
   a. LSU pager system #0221 (ACD and WHC)
   b. Overhead paging will be used in ACD, WHC, Comp Care, Eye Clinic and Viral Disease clinic areas. Announce three times in the patient’s location.

5. A member of the START will return the call within 5 minutes and find out the patient location and condition.

6. START will respond to the patient’s bedside within 10 minutes.

7. START will then assess the patient and collaborate with the primary physician in the clinic area and develop a plan for rapid care of the patient. If care is needed outside the clinic area, the START will collaborate and plan care for the patient.

8. Notify Shreveport EMS @ 911 if physician or START deems transport necessary.

9. Notify UPD @ 5–6165

B. Responsible Parties:

1. *Member of patient's Primary Physician Team*
   Intern/Resident/Attending
   
   a. Answer overhead page
   b. Respond to patient’s location within 15 minutes
   c. Discuss and collaborate patient care with the START team member
   d. Discuss with EMS plan of care for patient

2. *Primary Care RN*
   
   a. Assess START Criteria
   b. Contacts START team if patient meets START Criteria
   c. Is available for collaboration with START team regarding patient’s plan of care
   d. Completes START contact form
   e. Continues to care for patient until EMS arrives for transport
3. **START Team RN**

   a. Wears the START pager during shift  
   b. Assures pager in working order at beginning of shift  
   c. Calls all numbers back within 5 minutes of pager sounding  
   d. Obtains patient information and patient location  
   e. Responds to patient location within 10 minutes  
   f. Assesses patient with the assistance of primary nurse  
   g. Collaborates with START team RT, primary nurse, primary physician and assists to develop a plan for rapid care of the patient  
   h. Assists in stabilization until EMS arrives  
   i. Reports current plan of care to EMS upon arrival.  
   j. Completes START Record  
   k. Gives copy of START Record to EMS for transport

4. **START Team RT**

   a. Wears the START pager during shift  
   b. Assures pager in working order at beginning of shift  
   c. Calls all numbers back within 5 minutes of pager sounding  
   d. Obtains patient information and patient location  
   e. Responds to patient location within 10 minutes  
   f. Assesses patient with the assistance of START team RN and primary nurse  
   g. Collaborates with START team RN, primary nurse, primary physician and assists to develop a plan for rapid care of the patient  
   h. Assists with stabilization until EMS arrives.  
   i. Assists with completion of START Record.

V. **STARTfwcc: Feist-Weiller Cancer Center**

   A. **Policy:**

      1. Each area will be educated prior to the initiation of the rapid response team.

         a. Education will be performed yearly after initial instruction.
         b. Once education performed each unit will have access to criteria and pager #.
2. Adult patients who show any of the following signs meet START criteria:
   a. Systolic blood pressure < 90 mm hg
   b. Heart rate < 45 or > 130 bpm
   c. Respiratory rate < 10 or > 30 bpm
   d. Acute change in saturation < 90% despite O₂
   e. Change in urinary output to < 50 ml in 4 hours
   f. Altered mental status
   g. Nurse or Physician discretion

3. Pediatric patients who show any of the following signs meet START criteria:
   a. Staff is concerned about a patient.
   b. Acute change in heart rate.
   c. Acute change in systolic blood pressure.
   d. Acute change in respiratory rate.
   e. Acute change in respiratory effort.
   f. Acute change in neurological status.
   g. Patient fails to respond to treatment.
   h. In addition, the following objective measures of clinical instability are provided as a general reference guide. Please note that the numerical values do NOT need to be reached or exceeded before requesting a Pediatric START consultation. The most important activation criterion remains staff/family concern or intuition.

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4. If a patient meets the above criterion the RN/designee will notify the START:
   a. For adult patients LSU pager system #7002
   b. For pediatric patients LSU pager system #3337
   c. Overhead paging will be used in FWCC. Announce three times the location of the patient.
5. A member of the START will return the call within 5 minutes and find out the patient location and condition.

6. START will respond to the patient’s location within 10 minutes.

7. START will then assess the patient and collaborate with the primary physician in the clinic area and develop a plan for rapid care of the patient. If care is needed outside the clinic area, the START will collaborate and plan care for the patient.

8. Notify Shreveport EMS @ 911 if physician or START deems transport necessary.

9. Notify UPD @ 5–6165.

B. Responsible Parties:

1. Member of patient’s Primary Physician Team
   Intern/Resident/Attending
   a. Answer overhead page
   b. Respond to patient’s location within 15 minutes
   c. Discuss and collaborate patient care with the START team member
   d. Discuss with EMS plan of care for patient

2. Primary Care RN
   a. Assess START Criteria
   b. Contacts START team if patient meets START Criteria
   c. Is available for collaboration with START team regarding patient’s plan of care
   d. Completes START contact form
   e. Continues to care for patient until EMS arrives for transport
   f. Completes START Evaluation form

3. START Team RN
   a. Wears the START pager during shift
   b. Assures pager in working order at beginning of shift
c. Calls all numbers back within 5 minutes of pager sounding
d. Obtains patient information and patient location
e. Responds to patient location within 10 minutes
f. Assesses patient with the assistance of primary nurse
g. Collaborates with START team RT, primary nurse, primary physician and assists to develop a plan for rapid care of the patient
h. Assists in stabilization until EMS arrives.
i. Reports current plan of care to EMS upon arrival.
j. Completes START Record
k. Gives copy of START Record to EMS for transport

4. START Team RT
   
a. Wears the START pager during shift
b. Assures pager in working order at beginning of shift
c. Calls all numbers back within 5 minutes of pager sounding
d. Obtains patient information and patient location
e. Responds to patient location within 10 minutes
f. Assesses patient with the assistance of START team RN and primary nurse
g. Collaborates with START team RN, primary nurse, primary physician and assists to develop a plan for rapid care of the patient
h. Assists with stabilization until EMS arrives
i. Assists with completion of START Record.

_______________________
Administrator

6/18/08
Date

Approved By Clinical Board: 7/18/06, 6/17/08
Written: 1/06
Reviewed: 4/08
Revised: 4/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

DIABETES EDUCATOR

Purpose:

To define the roles of the Registered Nurse (RN) Diabetes Educator and the Registered Dietitian (RD) Diabetes Educator in the education of patients with diabetes in the inpatient and outpatient setting.

Policy:

1. A consult by a physician or nurse is required for Diabetes Educator Services.

2. Inpatient Consults– General Care Areas

   a. The Patient Care Services (PCS) RN Diabetes Educator will be consulted for patients being admitted with newly diagnosed diabetes, diabetic ketoacidosis, hyperglycemic, hyperosmoloar coma, uncontrolled diabetes, profound hypoglycemia in a known diabetic patient, pregnancy with diabetes, initiation of insulin therapy, any patient that the nurse or physician identifies a diabetes education deficit, and patients on an insulin pump. PCS RN Diabetes Educator or Inpatient Care Unit will contact the Family Practice/Comprehensive Care RN Diabetes Educator for Family Medicine patients’ diabetes education. Please refer to Nursing Policy D-10 for specific procedure information.

   b. The Hospital RD Diabetes Educator will be consulted for uncontrolled diabetes, diabetic ketoacidosis, gestational diabetes, or any patient that the physician identifies with a diabetes education deficit.

3. Outpatient Consults

   a. The PCS RN Diabetes Educator will receive consults from Ambulatory Care Clinics for adult diabetes education needs. The RN Diabetes Educator will set up an appointment for the individual patient. During working hours the RN Diabetes Educator can be called at 32542 or beeper #1808 if there is an urgent need for outpatient diabetes education.
b. The Family Practice/Comprehensive Care RN Diabetes Educator will receive consults for diabetes education needs. The RN Diabetes Educator will set up an appointment for the individual patient. During working hours the RN Diabetes Educator can be called at 55647 or beeper #1253.

c. The RD Diabetes Educator is consulted for diabetes patients as the physician sees appropriate.

4. RN Educator will instruct patients on the following as appropriate:

a. **Adult Diabetic Patient:** Basic explanation of diabetes, diabetes nutrition education and/or reinforcement of diabetes nutrition instruction by RD, medications as per physician order, insulin therapy as per physician order, blood glucose monitoring, hypoglycemia, hyperglycemia, long-term complications, exercise, sick day management, infection prevention and pregnancy (see Diabetes Education Form S/N 5984).

b. **Inpatient Pediatric Diabetic Patient:** Explanation of Type 1 and Type 2 Diabetes, insulin therapy as per physician order, sharps disposal, hypoglycemia and hyperglycemia signs and symptoms and treatment, use of glucagons pen, diabetic ketoacidosis, urine ketone checks, sick day rules, reinforcement of dietary guidelines, blood glucose monitoring, when to call the physician about blood glucose results, medical ID, instructions for home, carbohydrate to insulin ratio, infection prevention and pediatric booklet appropriate for age.

5. RD Educator will instruct patients on the following as appropriate:

a. **Outpatient/Inpatient Adult Diabetic Patient:** Definition of diabetes, long term complications, short term complications, carbohydrate counting, meal planning, label reading, fast food/dining out guidelines, blood glucose monitoring, signs/symptoms/treatment of hypo and hyperglycemia, medication management based on physician order, foot care, alcohol guidelines, sick day guidelines, weight loss/exercise guidelines, family support and infection prevention.

b. **Outpatient/Inpatient Pediatric Diabetic Patient:** Definition and explanation of diabetes, carbohydrate counting, meal planning, label reading, fast food/dining out guidelines, blood
glucose monitoring, signs/symptoms/treatment of hypo and hyperglycemia, medication management based on physician order, foot care, sick day guidelines, exercise guidelines, family support, infection prevention and will provide American Diabetic Association Wizdom kit for new onset diabetics.

c. **Ambulatory Care Outpatient Pediatric Clinic:** An RD CDE has demonstrated through certification testing the potential ability to instruct patients on the following, diabetes oral medication therapy, insulin therapy, use and administration of glucagon, use of blood glucose monitoring equipment. In order to instruct patients on these skills in the outpatient setting an RD CDE must demonstrate validated competency. The competency validation must be done by a qualified (RN CDE) observer with the knowledge, skills, and ability to perform the procedures as well as appropriate documentation of the competency validation in the RD CDE file.

d. **RD Educator** will request RN to obtain saline per physician order out of Diebold to educate patient on insulin injections.
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - 
SHREVEPORT

ANTICOAGULATION SAFETY

Purpose:

To provide safe and effective anticoagulation therapy through a collaborative approach.

Policy:

Upon the written order of a physician, Heparin, Low Molecular Weight Heparin (LMWH) and/or oral Warfarin therapy will be administered in a safe and cost-effective manner.

Inpatient Management:

1. Anticoagulation therapy will be defined as the therapeutic use of Heparin, Low Molecular Weight Heparin (LMWH) or Warfarin.

2. Protocols for use of these agents will be approved by the P&T Committee/Clinical Board and posted on the hospital website.

3. Indication for use of anticoagulation therapy will be documented in the chart.

4. The Pharmacy Department will review all orders for anticoagulation therapy.

5. Non-standard concentrations of Heparin will not be prepared by the Pharmacy Department unless the protocol, including an approved preprinted order form, has been approved by the P&T Committee.

6. A prescriber’s order is required for the use of all Heparin products including Heparin flush solutions.

7. Pharmacy will provide patient education on the safe and effective use of Warfarin therapy. Each patient will be educated based upon the patient’s level of comprehension. The education session and patient’s comprehension will be documented on the chart. Compliance aids, schedule cards and reminders, and drug information will be provided to patients as necessary.

8. Nutritional Services may be consulted for additional education.
9. A list of patients receiving Warfarin will be provided to Nutritional Services by the Pharmacy Department on a daily basis. Nutritional Services will use the list to identify patients who are on Warfarin and will enter a note to restrict high vitamin k foods in the diet provided by the hospital.

Outpatient Anticoagulation Therapy Management:

1. An anticoagulation service will be provided within the LSUHSC-Shreveport Medicine Clinic. Patients may be referred to this service through completion of the appropriate referral form. Policies and protocols for this anticoagulation service will be reviewed by the P&T Committee/Clinical Board on an annual basis.

2. Physicians who choose to manage their own patient's anticoagulation therapy will also be required to submit a clinic-specific policy to the P&T Committee/Clinical Board for approval on an annual basis.

______________________________
Administrator

2/19/09
Date

Approved by Clinical Board: 2/17/09
Written: 1/09
Reviewed: 
Revised:
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

DIAGNOSTIC IMAGING OF PREGNANT PATIENTS

Purpose:

Imaging of pregnant patients demand extreme caution as both the mother and fetus are at greater risk of radiation induced injury. The intention of this policy is to provide guidance to ensure that the ionizing radiation exposure to the mother’s torso and subsequently the fetus is minimized.

Policy:

1. Imaging exams that are scheduled or ordered through Invision on female patients of childbearing age require that the pregnancy status and last menstrual period be entered.

2. Before an imaging or interventional procedure, the radiology technologist will inquire from all female patients of childbearing age if they are pregnant or if there is a possibility they are pregnant. If the patient is unsure or does not recall their last menstrual period a pregnancy test will be performed.

3. If a patient is pregnant, the specific situation will determine the appropriate course of action.
   a. If the exam is to be above the abdomen or below the hips, the technologist is to proceed with the exam and use lead aprons to shield the abdomen and pelvis.
   b. If an exam places the fetus in the x-ray beam the technologist will contact the radiologist for guidance before proceeding with the exam.

   1) If the fetus is to be in the direct x-ray beam and the estimated dose is less than 100mGy, the radiologist and ordering physician should work to find options to obtain the needed diagnostic information without using ionizing radiation. If it is deemed necessary to perform the exam, the patient should be involved in the decision to proceed. The ordering physician should discuss with the patient the reason for the test
and inform the patient of the associated risks and benefits. The ordering physician will write a note in the chart stating that the exam is indicated for the management of the patient.

2) If the dose to be used is estimated to exceed 100mGy, a formal calculation will be conducted by a medical physicist. The patient and/or family will be counseled about the risks to the fetus. The ordering physician and radiologist will record in the chart the circumstances and medical justification for the exam. The patient will be required to sign an informed consent.

4. Radiology technologists will adhere to the following principles when imaging pregnant patients. Any deviations from these guidelines require an order from a staff radiologist.

   a. Exposures are limited to those specifically ordered or contained in the ordered protocol.
   b. Precise collimation and shielding will be used whenever possible.
   c. Breast shields are to be used on all female patients.
   d. Fluoroscopy will be limited to short bursts. All procedures are to be timed and the time is to be recorded in the Radiology Information System along with the kVp and mA.
   e. Repeat exposures due to technical errors are not to be performed without approval from the radiologist.
   f. For CT exams of the abdomen and pelvis the radiologist will be consulted to provide explicit instructions for the scan protocol in order to minimize dose.

   ________________________________
   Administrator

   __________
   Date

   8/20/09

   ________________________________
   Date

   Approved by Clinical Board: 8/18/09
   Written: 7/09
   Revised:
   Reviewed:
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

ABUSE AND NEGLECT

Purpose:

To establish guidelines for all hospital personnel to follow in the provision of treatment and mandatory reporting related to victims of suspected abuse, neglect, rape/sexual molestation and domestic violence.

Definitions:

A. **Abuse** is defined as the “infliction of physical or mental injury on an individual by other parties, including but not limited to such means as sexual abuse, exploitation, or extortion of funds or other things of value, to such an extent that his/her health, self-determination, or emotional well being is endangered.” (R.S. 14:403.2).

B. **Neglect** is defined as the refusal or failure of a parent or caretaker to supply the individual with necessary food, clothing, shelter, care, treatment, or counseling for any injury, illness, or condition of the individual, as a result of which the individual’s physical, mental or emotional health is substantially threatened or impaired.

C. **Domestic Violence** is “abuse committed against an adult or a fully emancipated minor who is a spouse, former spouse, co-habitant, former co-habitant or a person with whom the suspect has had a dating or engagement relationship.”

D. **Internal Abuse and Neglect** is defined as abuse or neglect that occurs while the patient is under the hospital’s care.

Abuse Policy:

A. If one or more of the following criteria are present, abuse/neglect should be suspected. Signs of abuse are not, however, limited to the examples given. High risk groups for abuse include the elderly, children and the handicapped.

a. Abuse/neglect as evidenced by:

   a. Discrepancies between history and injury and/or
b. Inconsistencies in the history in conjunction with criteria listed below.

2. Physical assault, (abuse) as evidenced by:
   a. unusual or unexplained bruising
   b. fractures
   c. burns
   d. repeated injuries
   e. head injuries, particularly in infants
   f. retinal hemorrhages in infants

3. Rape/Sexual Molestation, as evidenced by:
   a. bleeding, bruising or trauma to genitalia
   b. history of sexual assault as reported by patient
   c. repeated UTI unrelated to other causes
   d. pregnancy or sexually transmitted diseases in the infants and children
   e. sexual knowledge that exceeds the level of maturity
   f. abnormal mental status

4. Emotional or psychological abuse, as evidence by:
   a. withdrawn or excessively aggressive behavior
   b. inappropriate parent/child interaction
   c. depression
   d. conduct disorder
   e. suicidality

5. Neglect of Elders/Children
   a. lack of personal hygiene and/or appropriate clothing
   b. malnourished/dehydrated
   c. failure to thrive (height, weight and head circumference less than 5th percentile; plateau in the growth curve; or loss of two standard deviations on the growth chart.)
   d. lack of medical care
   e. over/under medicated
   f. lack of immunizations
   g. lack of heat and/or running water
6. Domestic Abuse

   a. unusual or unexplained bruising
   b. fractures
   c. burns
   d. repeated injuries
   e. head/face injuries
   f. ingestions
   g. non-substantiated complaints and/or delays in obtaining care
   h. third-party or object blamed for injury
   i. alleged self-injury

B. Reporting

1. A Licensed Healthcare Professional shall notify the appropriate authorities immediately and LSUHSC-S Social Services (57075) of all cases of suspected abuse/neglect. A Licensed Healthcare Professional shall notify LSUHSC-S Social Services of the suspected case(s) the next working day for reports that occur after hours. Outside Caddo/Bossier Parish: contact Case Management or Social Services for appropriate CPA numbers. Child abuse should be reported to CPA in the jurisdiction where it occurred.

2. Appropriate authorities are listed below:

CHILD (0-18 years old)
Caddo Parish Office of Community Services
Child Protection Agency  676-7622
1525 Fairfield Avenue (Hotline Number)
Shreveport, Louisiana  71101-4388

Bossier Parish  741-7340

ADULT (18 – 59 years old)
Adult Protective Services 1-800-898-4910
DHH/Bureau of Protective Services
P.O. Box 3518, BIN # 11
Baton Rouge, LA  70821

ELDERLY (60 years old and over)
Elderly Protective Services 676-5200
1525 Fairfield Avenue, RM. 538
Shreveport, LA  71101-4338

NURSING HOME RESIDENTS

Coordinator 676-5200
Ombudsman – Council On Aging
Office of Community Services

REHABILITATION HOSPITAL RESIDENTS

Program Manager 504/342-0138
LA Bureau of License
Standards for Rehab Hospitals
Baton Rouge, LA

DOMESTIC VIOLENCE AND OR SUSPECTED
RAPE/SEXUAL ASSAULT

1st Call Providence House Rape Crisis 698-7273

Local Police/Sheriff’s Department
Bossier 741-8610
Shreveport 673-7300
Desoto Sheriff 872-3956
Webster Sheriff 377-1515

3. Management for all Suspected Abuse/Neglect Cases
(excludes Sexual Assault Cases)

   a. All cases suspected of abuse/neglect shall be seen by
      the appropriate senior resident.

   b. If no evidence of abuse/neglect, the physician shall
      document the findings in the patient’s medical record.

   c. If suspicion of abuse/neglect, the physician shall
      manage immediate medical needs:
1). The physician shall record a concise history which includes the alleged cause of the injury, dates, times and evidence of injury or endangered condition.

2). The physician shall record why the findings represent suspected abuse/neglect and any concerns regarding the patient’s safety.

3). If the licensed Healthcare Professional has concerns for the patient’s safety, they may admit the patient for safety reasons.

4). To obtain photographs, contact medical communications (55275) from 7:30 a.m. – 5:00 p.m., Monday – Friday. Consents are required to take photographs except when the Child Protection Agency is involved and has requested pictures.

5). For adults, records shall be released only upon consent of the patient or guardian or by a court subpoena. For children, refer to management of suspected child abuse/neglect. (Section 5).

4. Management for Suspected Rape/Sexual Assault for anyone 17 or older. (See attached Caddo Parish Algorithm for Adolescent/Adult Sexual Assault)
   a. With patient consent, a referral to the Providence House Rape Crisis Center 698-7273, shall be made by a licensed healthcare professional or social services. The referral shall be documented on the patient’s medical record by the healthcare provider who makes the call.

   b. If the patient wants the police notified an MD or licensed healthcare professional shall notify the appropriate authority in the parish where the alleged assault occurred.
c. The original EMS Treatment Record shall remain on the patient’s medical record.

5. Management of Suspected Sexual Assault of anyone 16 and younger. (See attached Caddo Parish Pediatric Sexual Assault Algorithm)
   a. An MD or licensed healthcare professional shall notify the appropriate law enforcement agency of any sexual assault involving a victim 16 yrs and younger and any victim who is physically or mentally incapable of making an intelligent decision.
   b. An MD or licensed healthcare professional shall notify Office of Community Services (OCS) which handles child protection investigations on any sexual assault involving a victim 16 yrs and younger.
   c. After completion of the Coroner’s office algorithm (above) and stabilization by Pediatric emergency services, all cases 14 yrs and younger shall be referred to the CARA Center during Monday-Friday between 8:00 a.m. – 4:30 p.m. and to on call pediatrician for the CARA center after hours.

6. Management of Suspected Child Abuse/Neglect (0-18 yrs old) (Excluding Sexual Assault)
   a. Consultation of the SCAN Team is recommended for evaluation of suspected child abuse/neglect (refer to criteria previously listed).

      They are available during Monday-Friday between 8:00 a.m.–4:30 p.m. (SCAN means Suspected Child Abuse/Neglect). Contact the on-call pediatrician or CARA Center (681-7676)

   b. If the SCAN Team is not consulted, the appropriate senior resident must examine the child. Skeletal survey should be performed as indicated.
c. For children, obtain skull, chest, and long bone x-rays (scan series #4212). Repeat in 10-14 days, if possible. Ophthalmology consult and CT of head should be performed as indicated.

d. To obtain photographs, contact Medical Communications (55275) from 7:30 a.m.-5:00 p.m., Monday-Friday. After a report of suspected child abuse/neglect is made to the Child Protection Agency all persons shall cooperate fully with investigative procedures. If questions about photographs and consents in child abuse/neglect cases, contact legal affairs (55406) or social services (57075) during the day and the house manager (55150) after hours.

e. The physician, PA, RN or social worker shall report all cases of known or suspected child abuse by telephone to the Department of Social Services (57075) and The Office of Community Services 676-7622, followed by a written report within 5 days to the Child Protection Agency. Form OPS-CPI-2 shall be completed to the CPA as well. (As required by law). A copy of the clinic route sheet may be used as the written report. It shall be mailed/faxed to:

   Caddo Parish Only
   Child Protection Agency
   1525 Fairfield Avenue
   Shreveport, LA 71130
   Fax # 676-7307
   (0-18 years old)

f. The parents and/or guardian of the client shall be informed by the reporting party that the suspected injury has been reported, as required by law, to the appropriate protection agency. All CPA discharges must have a stat dictation with discharge.

g. Any child admitted who is a ward of the state must have a consent obtained through the appropriate judge in the respective parish. Foster care workers should be contacted to determine who may give informed consent.
7. Management of Suspected Violence

a. At the request of the patient if domestic violence is suspected, a licensed healthcare professional may contact the appropriate law enforcement on patients 18 yrs and older.

b. The information conveyed includes the patient’s name, whereabouts, injuries and the identity of the person who the patient alleges assaulted him/her.

c. A Licensed Healthcare Professional shall contact Social Services.

d. Social Services shall submit written documentation of suspected domestic violence to the local law enforcement agency on the next business day.

e. With patient consent, a referral shall be made to Providence House Crisis Center 698-7273 by licensed Healthcare Professional or social services. The referral shall be documented on the patient’s medical record by the licensed healthcare provider who made the referral.

Internal Abuse Policy:

A. When there is an allegation by the patient, family or other staff member that a patient has incurred abuse or neglect the following shall occur:

1. The patient, family or staff member shall report the incident to the nurse. If the primary nurse is in question the patient, family or staff member may go to the charge nurse or patient relations.

2. Supervisor personnel on duty shall be notified immediately of reported allegations of abuse; this includes the unit charge nurse/manager and Assistant Administrator for Patient Care Services. During off hours, the Administrative House Manager shall be notified, who will contact the Administrator On-Call.
3. The primary or charge nurse shall complete a variance.

4. Hospital Administration determines need to contact other ancillary departments (i.e. Human Resources, UPD).

[Signature]

Administrator

8/20/09

Date

Clinical Board Approved: 11/21/00, 8/19/03, 11/21/06, 8/18/09

Written: 7/82

Reviewed: 5/97, 10/97, 1/99, 7/03, 6/06, 4/09

Revised: 5/97, 10/97, 1/99, 7/03, 6/06, 4/09
ABORTION POLICY

Law:

Louisiana statutes specifically and expressly forbid any person employed by the State in a state health care facility to perform any abortion for any reason other than to prevent the death of the mother or in cases of rape or incest.

Purpose:

To define the abortion policy by the Louisiana Health and Human Resources Administration.

Policy:

1. A female patient, married or unmarried, who presents herself at LSUHSC-S with a complaint of being pregnant and requests an abortion, is to be evaluated as any other pregnant patient.

2. A patient requesting an abortion shall be appropriately tested, and if pregnant, referred to the OB Clinic. If, after evaluation, the attending physician believes the maternal risk of allowing the pregnancy to continue has a greater than 50% chance of causing the death of the mother, and a second member of the OB/GYN faculty concurs, the abortion may be performed in the University Hospital. Careful documentation must be entered in the patient’s medical record and signed by both physicians.

3. A patient requesting abortion for reasons of rape or incest shall satisfy LA Revised Statutes LA 40: 1299.34.5 and 40: 1299.35.7.

4. A minor, unmarried female does not require parental consent, nor does a married female need spousal consent for medical services related to pregnancy or abortion.

5. In those cases where an abortion is the appropriate therapy, LSUHSC-S house officers, staff physicians, and supporting staff who object to abortion on moral, ethical, or religious grounds are not compelled to perform the procedure.
6. All staff shall abide by LA Statute 40:1299.34. “No person employed by the state of Louisiana, by contract or otherwise, or any subdivision or agency thereof, and no person employed in any public or private social service agency, by contract or otherwise, including workers therein, which is a recipient of governmental assistance, shall require or recommend that any woman have an abortion. Notwithstanding anything contained herein to the contrary, this section shall not apply to a doctor of medicine, currently licensed by the Louisiana State Board of Medical Examiners pursuant to R.S. 37:1261 er seq., who is acting to save or preserve the life of the pregnant woman.”

7. The Report of Induced Termination of Pregnancy (see attached) must be completed by the physician performing the abortion. It is the physician’s responsibility to see that this report is forwarded to the State Office of Vital Records within fifteen (15) days of the performance of an abortion.

Vital Records Registry
Box 60630
New Orleans, Louisiana 70160

Reference: LA Revised Statutes LA 40: 1299.34.5
LA 40: 1299.35.7
LA 40: 1299.34

__________________________________________
Administrator

_________________________ 2/23/07 ________________
Date

Approved by Clinical Board: 9/19/00, 1/20/04, 2/20/07
Written: 1/83
Revised: 10/89, 3/95, 11/97, 11/03, 12/06
Reviewed: 8/00, 11/03, 12/06
Purpose:

To facilitate the process of obtaining organs for transplantation.

To assure that the state of Louisiana statutes regarding confidentiality of donor/recipient information are adhered to throughout the Medical Center.

To establish accounting and billing procedures that ensure proper and expeditious reimbursement to the Louisiana Organ Procurement Agency (LOPA), LSUHSC (hospital and school laboratories), and physicians involved in organ transplantation.

Policy:

1. Patients shall be certified as brain dead by two (2) physicians, one of which must be staff. No physician on the Transplant team may be involved in the determination of brain death.

2. No physician on the Transplant team shall write orders for a potential donor prior to the patient being declared brain dead.

3. Prior to the patient being accepted as a donor or before brain death has been declared, laboratory analysis may be done to aid in the screening of donor suitability. All charges pertaining to organ donation or donor evaluation will be borne by the LOPA.

4. The Donor Referral Line at the Louisiana Organ Procurement Agency shall be contacted for each death and/or eminent death (Glasgow Coma Scale (GCS)) score of less than or equal to 5, or a plan to discontinue mechanical or pharmacological support). Early LOPA involvement is recommended. The Notification of Referral Form shall be completed for all patient deaths, regardless of donor status. This Notification of Referral Form shall be completed for all deaths and all patients meeting the clinical trigger(s) and shall remain a permanent part of the patient’s medical record. If a family consents to donation the LOPA staff will provide the Consent for Anatomical Gift Form.
5. LOPA will contact the appropriate Coroner’s office to obtain clearance for organ recovery. In case of a trauma, the Coroner in the parish where the trauma occurred is notified by LOPA; the Coroner in the parish where the death is declared will be notified by the hospital staff.

6. A “Consent for Donation of Anatomical Gift” form shall be obtained prior to the procuring of the patient’s organs. (See Nursing policy, Organ Donation Suitability, 0-9 for further details).

7. The organ donor (after brain death has been declared) shall be discharged as a death via the Invision system. The organ donor shall be re-admitted with a new medical record number with the hospital service of Surgery Cadaver Donor (SCD). The patient’s name is dropped and an organ donor number is assigned. The patient’s social security number and date of birth are entered the same. LOPA’s address is entered as the patient’s address for billing purposes. All further charges are to be incurred by LOPA.

8. An Organ Donor Admission form shall be completed and submitted to Admitting for re-admission of the patient as a cadaver donor. Patient Processing shall prepare two (2) new addressograph cards and a new hospital face sheet.

9. Separate medical records shall be maintained, a death chart and donor chart. Both charts shall accompany the donor to the operating room. Nurses are responsible for completing nurses’ notes, Discharge Summary, Death Notification sheet and morgue tags prior to transporting to the operating room. If a donor is transferred from another hospital, the chart should include the information from the transfer hospital. After organ procurement is completed, both charts are sent to Admitting for preparation of the death certificate.

10. The donor chart shall contain:

   a. Original Face Sheet as admission to the Surgery Donor Services.

   b. Copy of the Brain Death Evaluation form or physician’s Progress notes declaring brain death.

   c. Copy of the Consent for Donation of Anatomical Gift.
d. Original physician’s orders, nurses notes, laboratory reports and any other documents of the normal course pertaining to the hospitalization of an organ donor.

e. Copies of the **Death Certificate** and **Funeral Home Release** forms.

<table>
<thead>
<tr>
<th>Responsible Party</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>1. Two Physicians (one must be staff) - Determines and documents brain death.</td>
</tr>
<tr>
<td>MD, RN</td>
<td>2. Notifies LOPA of potential organ donor.</td>
</tr>
<tr>
<td>MD, RN, RN APPLICANT, LPN</td>
<td>3. Completes the Notification of Referral Form for all patients.</td>
</tr>
<tr>
<td>MD, RN, RN APPLICANT, LPN</td>
<td>4. Contacts LOPA’s Donor Information Line (1-800-833-3666) for all cardiac deaths and patients meeting clinical trigger(s) to ascertain donor suitability.</td>
</tr>
<tr>
<td>LOPA Coordinator, RN, RN Applicant, LPN, MD</td>
<td>5. If patient is <strong>not</strong> a suitable donor as determined by LOPA, completes the Notification of Referral Form and places it in the medical record. (No further completion required.)</td>
</tr>
<tr>
<td>LOPA Coordinator</td>
<td>6. a. Discusses with family and obtains permission for organ donation.</td>
</tr>
<tr>
<td></td>
<td>b. Obtains written consent for organ donation by completion of Consent for Donation of Anatomical Gift.</td>
</tr>
<tr>
<td>LOPA Coordinator</td>
<td>7. Notifies appropriate Coroner’s office(s) and obtains permission for organ procurement, if applicable.</td>
</tr>
<tr>
<td>RN</td>
<td>8. a. Completes nurse’s notes, Discharge summary, morgue tags, death books and copies of chart.</td>
</tr>
<tr>
<td></td>
<td>b. Discharges patient via Invision using <strong>time of declared brain death</strong>.</td>
</tr>
<tr>
<td></td>
<td>c. Completes <strong>Organ Donor Admission</strong> form and submits to Patient Processing.</td>
</tr>
<tr>
<td>Responsible Party</td>
<td>Action</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>b. Prepares new hospital face sheet, two (2) addressograph cards, and any necessary copies of chart.</td>
</tr>
<tr>
<td></td>
<td>c. Submits face sheet and addressograph cards to nursing unit.</td>
</tr>
<tr>
<td>RN</td>
<td>10. Opens new chart as organ donor including:</td>
</tr>
<tr>
<td></td>
<td>a. Donor Face Sheet</td>
</tr>
<tr>
<td></td>
<td>b. Copy of Brain Death Declaration</td>
</tr>
<tr>
<td></td>
<td>c. Copy of appropriate consent forms</td>
</tr>
<tr>
<td></td>
<td>d. Organ Donor Admission Slip</td>
</tr>
<tr>
<td>M.D. (Transplant), LOPA</td>
<td>11. Writes order for donor maintenance until donor is transported to operating room.</td>
</tr>
<tr>
<td>representative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Prepares body and transports to morgue.</td>
</tr>
<tr>
<td></td>
<td>c. Submits both medical records to Patient Processing (Organ Donor Admission and Death Chart).</td>
</tr>
</tbody>
</table>
Hospital Policy Manual
Policy Number: 5.7
Effective Date: 8/01/08

Approved by Clinical Board: 1/12/01, 5/18/04, 5/15/07, 7/15/08
Written: 2/81
Reviewed: 2/04, 4/07, 5/08
Revised: 8/93, 11/98, 1/01, 4/04, 4/07, 5/08
ORGAN DONATION AFTER CARDIAC DEATH (DCD) PROTOCOL
Louisiana Organ Procurement Agency (LOPA)

Purpose:

The purpose of this protocol is to establish criteria for the identification of patients who can potentially be eligible for organ donation after cardiac death (DCD) and to establish guidelines in presenting the option of DCD organ donation to the patient’s legal-next-of-kin.

A. Medical Criteria:

1. The patient must have suffered a non-survivable brain injury or cardiac event such that patient death would be imminent subsequent to the removal of ventilator and vasopressor support. Furthermore, a patient can be considered DCD if the family has elected to make a patient a “do-not-resuscitate” and the above criteria can be achieved.

2. The potential DCD must be between the ages of 0 years (36 weeks gestation) and 70 years-of-age, and must not have tested positive for HIV or HepBsAg at the time of the initial referral. All other potential donor medical and social concerns will be presented to the on-call LOPA recovery surgeon by the representative for further consideration.

B. Referral of the DCD:

1. Should the patient’s death be determined as imminent by the attending physician, a patient’s nurse, upon direction of the physician, will be responsible for the referral. The consideration of and the discussion between the physician and the family regarding a terminal wean and/or disconnection from the ventilator should take place prior to and independent from any consideration of and discussion relating to the possibility of organ donation.

2. The patient will be referred to the Louisiana Organ Procurement Agency (LOPA) at 1-800-833-3666 for preliminary screening to determine if organ donation is a viable option.
3. Upon arrival at the hospital, the LOPA representative will need to contact the attending physician to discuss the patient’s clinical situation and develop a plan for presenting the option of organ donation to the family.

4. Upon arrival at the hospital, the LOPA representative will notify the nursing supervisor, charge nurse and primary nurse to review the hospital DCD policy if applicable, perform an assessment of the clinical situation / family dynamics and to formulate a plan of the potential procurement process.

5. If the patient meets criteria as a DCD as defined by LOPA criteria, the LOPA representative after consulting with the attending physician or designated hospital personnel, will approach the legal next-of-kin to present the option of donation and inform the family of the process involved.

6. If consent is obtained, a LOPA Consent for Donation of Anatomical Gift form and a hospital surgical consent form must be completed and filed in the patient’s medical record. The LOPA consent form will be completed in accordance to LOPA policy. The hospital surgical consent form must be completed by the physician and must contain a description of removal of ventilatory support, administration of medications, operating room preparation of the body, and the possibility that the patient may not cardiac arrest within the designated time criteria after the removal of the ventilator and thus require to be returned to previously discussed hospital designated area.

7. After consent is obtained, LOPA will be financially responsible for all subsequent and additional expenses incurred in the procedures to evaluate and preserve the donor’s organs or tissues. The patient shall be discharged and readmitted to LOPA by nursing personnel after pronouncement of death. The LOPA representative will contact the hospital and request a copy of the patient’s bill in order to discern fees associated with the donation process.

8. The LOPA representative will complete all LOPA and donor chart paperwork as per protocol. In the event of consent, LOPA will provide a representative to facilitate the donor process.
9. The Coroner’s Office must be contacted for clearance and instructions per LOPA policy. The LOPA representative shall be responsible for notification of the Coroner’s Office.

C. Medical Management and Recovery

1. The primary care attending physician or physician designated by attending shall continue full responsibility for the patient care until declaration of death.

2. Prior to declaration of death, LOPA will not order any changes or adjustments to the patient’s current medical therapy unless ordered by the patient’s attending physician. However, in accordance with the informed consent of the family, LOPA will request to perform necessary blood, urine, sputum testing and chest x-rays in order to evaluate end organ function, serologies, tissue typing and cultures. Should the patient require the insertion of any intravenous and or arterial-line catheters, necessary measures will be taken to minimize patient discomfort.

3. Any laboratory tests or procedures performed at the request of LOPA will be done at no additional cost to the family. LOPA will request an itemized patient bill for review of charges and payment. The terminal wean will be scheduled in accordance to hospital operating room availability as to not interfere with scheduled cases or emergencies.

4. The terminal wean may take place in either the critical care unit or operating room. The family may be present during the terminal wean if it is to take place in the critical care unit.

5. LOPA representatives, attending physician and operating room personnel will review hospital surgical/ procedure consent to ensure that consent has been obtained to prep, drape, and shave patient, to administer Heparin and Mannitol as appropriate. There must also be a “Do not resuscitate” order on the chart.

D. Medication Administration

No medications will be administered which could potentially hasten cardiac asystole. Intravenous Heparin and/or Mannitol will be administered as appropriate in the operating room prior to ventilator wean.
E. Transportation of Patient

1. A pre-recovery conference prior to transport should occur between the LOPA representatives, attending physician or designated physician and the operating room personnel (which may include anesthesiologist, circulating nurse, scrub nurse and/or surgical technician). The group will review the process of the terminal wean, administration of medication, where the recovery teams will wait, organs to be recovered.

2. The patient will be transported to the operating room with a respiratory therapist (to support ventilation), a critical care/attending physician or anesthesiologist (the physician cannot be associated with LOPA or a member or the organ recovery team) and the LOPA representative.

3. The patient will remain ventilated, be placed on a cardiac and blood pressure monitor and infusions will be maintained.

F. Operating Room Procedure

1. In the Operating Room, prior to the terminal wean, the patient will be surgically prepped and draped by the operating team and LOPA representative. The transplant recovery team will be available to assist in this process, however will not be present in the operating room during the terminal wean and until the patient is declared dead. Either the attending physician or a physician designated by the attending (not associated with transplant team) will perform the declaration of death in accordance with hospital protocol.

   a. Cold perfusion preservation and/or recovery of organs will not begin until five (5) minutes after death. The pronouncement of cardiopulmonary death will be documented in accordance with hospital protocol.

   b. No incision for the purpose of removing organs will be made until the patient meets cardiopulmonary death criteria. At the time death has been declared, the transplant recovery team will wait five minutes after cardiac death (as recommended by the IOM), then promptly enter the operating room to begin the process of surgically removing the organs in accordance to LOPA organ recovery protocol.
c. **LOPA** requests that designated hospital personnel record vital signs in five-minute intervals after disconnection of ventilator and cardiac cessation.

**Should cardiac cessation not occur within 60 minutes from ventilator cessation, the patient would be considered unsuitable for organ donation and returned to the hospital designated patient care area. The patient’s primary care physician and family will be notified. The physician shall provide orders for the continuation of care as appropriate.**

2. The **LOPA** recovery team will wait in a predetermined area during the terminal wean and pronouncement of cardiac death.

3. The pronouncing physician will determine the timing and how the ventilator will be weaned and pronounce the patient as discussed in Section C. The physician will write a pronouncement note and document the time of death in the patient’s chart. When the patient is pronounced, the recovery team will be immediately notified in order to expedite the organ recovery and minimize warm ischemic time.

4. The organ recovery will take place in accordance to **LOPA** protocol.

   a. Organ cold perfusion will be initiated with one liter of cold Lactated Ringer solution containing Heparin 30,000 units to be followed by University of Wisconsin (UW) solution. The recovery surgeon will specify the amount of UW to be used for cold perfusion of the organs.

   b. All kidneys considered for transplantation will be biopsied by the recovery surgeon and read by the hospital’s pathologist.
G. Post Organ Donation

1. The LOPA representative will notify the nursing supervisor at the time of case completion to discuss the post case process.

2. The LOPA representative will assist hospital personnel in preparing the body for the morgue and/or family viewing (if requested), and clean the operating room.

3. The LOPA representative will contact the family to inform them of the patient’s time of death and organs recovered; the coroner (if required) and the funeral home chosen by the family. The death chart and completed Funeral Home Release shall be sent to Admitting.

4. A post-case conference should be scheduled by the LOPA representative and hospital liaison to review the case with nursing staff, hospital administration and physicians as needed to further discuss the case and circumstance and to allow the staff to express personal or institution concerns as needed.

5. Post-case paperwork will be completed by the LOPA representative according to LOPA protocol.

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Administrator

9/17/08

Date

Approved by Clinical Board: 6/21/05, 1/16/07, 2/20/07, 9/16/08
Written: 5/05
Reviewed: 10/06, 8/08
Revised: 10/06, 8/08
AMBULATORY CARE DIVISION

Purpose:

The Ambulatory Care Division of the LSU Health Sciences Center encompasses the Ambulatory Care Clinics, Feist-Weiller Cancer Center, and the Emergency Department. The full spectrum of primary, routine, consultative, and specialty health care services are provided by physicians and allied health care professionals including diagnostic tests, minor surgical, and other procedures that do not normally require overnight care in the hospital setting. The care is made available via the operation of twenty-four (24) clinic sites, specialty and subspecialty, two (2) of which are satellite clinics. Most of the Ambulatory Care clinic sites are located in the Ambulatory Care Building. Feist-Weiller Cancer Center, one segment of the Ambulatory Care Division, is located in a separate free standing facility dedicated solely to the prevention, diagnosis, and treatment of cancer. Emergency Medicine, the final component of the Ambulatory Care Division, is provided in the Emergency Department of LSU Health Sciences Center.

Ambulatory Care services support three major functions:

1. The initial point of contact for professional health care services.
3. The referral center to the hospital, physicians and other services.

Operating hours for the clinics are Monday – Friday, 0800 – 1630 or until the clinic is complete. Clinic appointments are obtained either through the Centralized Appointment Desk, physician referral/approval (“closed” clinics) or by a patient requesting an appointment by calling the clinic (“open” clinics).

Policy:

Each clinic shall provide care for patients during scheduled hours according to guidelines established by the clinical service being provided in that location.
Hospital Policy Manual
Policy Number: 5.8
Effective Date: 7/01/09

Administrator

6/18/09
Date

Approved by Clinical Board: 1/16/01, 3/18/03, 6/20/06, 6/16/09
Written: 3/95
Revised: 4/98, 3/03, 5/06, 5/09
Reviewed: 1/01, 3/03, 5/06, 5/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PATIENT ASSESSMENT

Purpose:

To assure care provided to each patient is based on an assessment of the patient's relevant physical, psychological, and social needs.

Policy:

1. Each patient is assessed by qualified individuals upon admission to all LSUHSC care settings to identify the appropriate care or treatment needed and/or the need for further assessment. The physical, psychological and social status of each inpatient is assessed. The scope of assessment for each discipline is defined in departmental/hospital policies. The scope and intensity of the assessment is determined by:

   A. The patient's condition/diagnosis,

   B. The care setting,

   C. The patient's desire for care,

   D. The patient's response to any previous care, and

   E. The patient’s consent to treatment.

2. The assessment process for an adult, infant, child, adolescent or geriatric patient individualized. The following are assessed and documented as appropriate for the patient’s age and needs as outlined in the Medical Records Content/Documentation policy (Hospital Policy 6.5).

   A. The patient’s emotional, cognitive, language and communication needs, education, social, and daily activity needs;

   B. The patient’s developmental age, length or height, head circumference, and weight.
C. The effect of the family or guardian on the patient’s condition and the effect of the patient’s condition on the family or guardian;
D. The patient’s immunization status, and
E. The family’s or guardian’s expectations for and involvement in the patient’s assessment, initial treatment, and continuing care.

3. Inpatients are assessed continuously throughout their hospital stay. An initial assessment (first 24 hours) is documented within the admission progress note or on the history (SN 1032) and physical form (SN 1134) by the admitting physician as the basis for the plan of care to be rendered. If a history and a physical examination have been performed within 30 days before admission, a durable legible copy of this report may be used in the patient’s medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission. An RN assesses the patient’s need for nursing care in settings where nursing care is provided. Inpatients are screened for nutritional/functional needs within 24 hours of admission. Services are consulted as needed.

4. A duly licensed and credentialed staff physician will either perform or supervise the performance of a patient assessment as outlined in the Medical Staff Bylaws, Rules and Regulations Section on Health Information Management.

5. The scope of assessment for Advanced Practice RN’s (APRN)/Physician’s Assistants (PA) includes, but is not limited to, performing an initial/ongoing assessment of patients to determine need for medical attention, obtaining patient histories, performing exams, and requesting and interpreting laboratory/diagnostic studies. The APRN/PA identifies normal and abnormal findings, monitors the effectiveness of therapeutic interventions, and takes actions within the scope of their practice.

6. Continued assessments are documented throughout the patient’s medical record. A multidisciplinary approach is utilized for performing patient assessments based on the patient’s diagnosis, the care setting, the patient’s desire for care, and the patient’s response to any previous care, i.e., by physicians, nursing, Nutritional Services, Rehabilitation Services, Social Services, Case Management, Cardiopulmonary Services, etc.
7. Outpatient Assessment - Outpatients are assessed during the clinic visit by the physician/APRN. Each clinic’s nursing standard of patient care defines assessments performed by nursing staff prior to the physician’s exam. Follow-up visit assessments are performed by the physician/APRN as deemed appropriate for the patient’s condition.

8. Based on initial assessment of patient and established plan of care, reassessments are performed and documented throughout the care process and at follow-up appointments. Reassessment time frames are defined in departmental policy/bylaws, etc. Reassessment shall take place under a variety of conditions including, but not limited to, the following:

A. Reassessment of the patient shall be performed at regular intervals in the course of care by medical and nursing staff. Ancillary services involved in the patient’s care also perform reassessment as dictated by patient’s needs.

B. Reassessments are performed to determine a patient’s response to care/treatment.

C. Reassessment shall take place when there is a significant change in a patient’s condition or a change in diagnosis.

10. Assessment and reassessment are documented in the following reports:

A. Medical Staff:

1) History & Physical Examination

2) Progress Notes

3) Pre/Post Anesthesia Notes

4) Consultation Reports

5) Operative Reports

6) Discharge Summary

7) Outpatient Clinic Notes

B. Nursing Staff:
1) Patient History/Assessment Record & Discharge Record

2) Nursing 24 hour Patient Progress Report/Plan of Care

3) Outpatient Clinic Notes

C. Other assessments are performed and documented by Nutritional Services, Rehabilitation Services, Social Services, Home Care, Respiratory Care, Pastoral Services, Pharmacy, etc., as appropriate.

11. The plan of care will be reviewed regularly in consultation with or from written information provided by other members of the health care team and the patient/family. When warranted: The plan of care will be revised as appropriate to the patient’s condition and the ongoing assessment process.

12. Discharge planning needs will be included in the initial assessment and reassessment process, throughout the patient’s hospitalization. The patient/family will be involved in the discharge planning process as appropriate.

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Administrator

2/23/07

Date

Approved by Clinical Board: 9/19/00, 1/20/04, 2/20/07
Written: 2/94
Revised: 1/95, 8/97, 12/06
Reviewed: 2/00, 7/00, 12/03, 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

DEEP SEDATION/ANESTHESIA CARE

Purpose:

To establish guidelines for care of the patient as related to deep sedation/anesthesia care, including pre-anesthesia assessment.

Definitions

Deep Sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

Anesthesia - Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Operative/other invasive procedures - are those procedures involving puncture or incision of the skin or insertions of an instrument or foreign material into the body, including but not limited to percutaneous aspirations and biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantation, excluding venipuncture, intravenous therapy, and injection of radiographic contrast media.

Policy:

A. Staff competency/qualifications

1. Deep sedation and anesthesia are provided by qualified individuals.

2. Qualified individuals are trained in professional standards and techniques:
a. to administer pharmacological agents to predictably achieve desired levels of sedation, and

b. to monitor patients carefully in order to maintain them at the desired level of sedation.

3. Individuals administering deep sedation and anesthesia are qualified and have the appropriate credentials to manage patients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally.

4. Included in the qualifications of individuals providing deep sedation and anesthesia are competency-based education, training, and experience in:

a. Evaluating patients prior to performing deep sedation and Anesthesia; and

b. Performing the deep sedation and anesthesia to include methods and techniques required to rescue those who unavoidably unintentionally slip into a deeper-than-desired level of sedation or analgesia. Specifically:

1). Practitioners who have appropriate credentials and are permitted to administer deep sedation are qualified to rescue patients from general anesthesia.

2). Practitioners intending to induce deep sedation are competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation.

B. Staffing:

Sufficient numbers of qualified personnel (in addition to the licensed independent practitioner performing the procedure) are present during procedures using deep sedation and anesthesia to:

1. appropriately evaluate the patient prior to beginning deep sedation or anesthesia,

2. provide the deep sedation or anesthesia,
3. perform the procedure

4. monitor the patient, and

5. recover and discharge the patient either from the post-sedation or post-anesthesia recovery area or from the organization.

C. Equipment and monitoring
   1. Appropriate equipment for care and resuscitation is available for monitoring vital signs.
      a. Heart rate and oxygenation are continuously monitored by pulse oximetry.
      b. Respiratory frequency and adequacy of pulmonary ventilation are continually monitored.
      c. Blood pressure is measured at regular intervals.
      d. Continuous EKG monitoring is required in all patients.

D. A pre-anesthesia assessment, as documented on the Anesthesia Preoperative Record, is performed prior to beginning deep sedation and before anesthesia induction. This preanesthesia assessment is completed in all settings where operative and other invasive procedures are performed and anesthesia, as defined by above, is administered.

E. This assessment includes:
   1. data gathered through patient interview.
   2. pertinent physical examination.
   3. review of pertinent diagnostic data.

F. Documented observations will include:
   1. history of previous anesthetics (including adverse family history)
   2. drug allergies
3. medications, currently or recently in use
4. tobacco, drug and alcohol usage
5. dental or airway anomalies
6. presence of any intercurrent disease processes capable of affecting anesthesia.

G. The assessment will contain a responsible physician’s recommendations regarding anesthesia and premedication, the assignment ASA risk classification, and the formulation of an anesthetic plan. Patient's sedation or anesthesia care needs are communicated among providers.

H. Prior to sedation of the patient, deep sedation/anesthesia risks and alternative methods will be discussed with the patient. If the patient declines such risk information, this will be noted on the Anesthesia Preoperative Record.

I. Immediately before starting the anesthesia, the patient is re-evaluated by a licensed independent Anesthesia practitioner, who makes the determination that the patient is a suitable candidate to undergo the planned anesthetic.

J. Prior to administration of anesthesia, appropriate monitors are applied and continuous physiological monitoring is performed. The anesthetic is administered and an Anesthesia Record is maintained indicating the dosages of all drugs and agents, the type and amount of fluids, blood/blood products, all pertinent anesthetic interventions and their results, and any other events of importance.

K. At the end of the case, the patient is taken to an appropriate recovery area for care. (Note: TB patients are recovered in the OR.) The patient’s status is assessed and the care is transferred to appropriately trained personnel.

L. Patients shall be discharged from the recovery area by a licensed, independent practitioner, or when they meet criteria which have been approved by the medical staff. This discharge criterion is based upon the Aldrete Scoring System. Patients may be discharged with a score of 8 – 10 unless pre-operative condition precludes this. Any deviation from criteria shall be documented and the physician notified for written order.
M. Outcomes of patients undergoing deep sedation and anesthesia are collected and analyzed in the aggregate in order to identify opportunities to improve care.

Administrator

2/20/07
Date

Clinical Board Approved: 11/21/00, 1/20/04, 2/20/07
Written: 4/95
Revised: 12/97, 4/98, 10/00, 12/03, 12/06
Reviewed: 12/97, 4/98, 10/00, 12/03, 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

HANDLING MEDICAL RECORDS AND DOCUMENTS CONTAMINATED WITH BLOOD OR BODY FLUIDS

Purpose:

To prevent personnel exposure or environmental contamination from documents soiled with blood or body fluids.

Policy:

NOTE: A document soiled with any amount of body fluid, wet or dry, is considered contaminated.

1. Put on gloves when contaminated documents are noted.

2. With gloved hand, place contaminated item in clean plastic folder immediately.

3. Make a photocopy of contaminated documents. May need second person to operate photocopy machine to prevent contamination of this equipment.

4. Shred contaminated documents and then discard into regular trash. Remove gloves, discard into regular trash. If gloves and/or contaminated document are heavily soiled, discard into contaminated trash receptacle. Personal protective equipment (gloves, goggles, mask, and gown) will be available to personnel that come in contact with the internal working of the paper shredder. Paper shredder is labeled as contaminated.

5. After removal of gloves, wash hands for 10 seconds with antimicrobial soap (chlorhexidine soap).

6. For legal purposes, HIM shall stamp the photocopies, “This is a certified copy of the original document as the original document was contaminated with blood and/or products.”
7. If the copy machine or any surface becomes soiled with blood and/or body fluids, do not attempt to clean this area. Immediately notify Environmental Services to clean the contaminated area.

[Signature]

Administrator

10/22/03

Date

Approved by Clinical Board: 4/16/02, 10/21/03
Written: 12/94
Revised: 10/96, 7/99, 4/02, 9/03
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

VERBAL AND/OR TELEPHONE PHYSICIAN’S ORDERS

Purpose:

To establish guidelines for accepting, transcribing and confirming verbal or telephone physician’s orders.

Policy:

1. Physician verbal and telephone orders shall be utilized only in situations where the ordering doctor is not available to write the order and delay will result in a compromise in patient care. Every effort will be made to minimize the use of verbal orders.

2. Physician verbal and telephone orders shall only be accepted by the following healthcare professionals. Orders shall be appropriate and within the professional’s scope of practice:
   
   Registered Nurses  
   Registered Pharmacists  
   Licensed Respiratory Therapists  
   Certified/Registered EEG Technologists  
   Physical & Occupational Therapists  
   Licensed Dietitians  
   Licensed Medical Technologists  
   Licensed Medical Technicians (Clinical Lab)  
   Licensed Radiologic Technologists  
   Licensed Nuclear Medicine Technologists  
   Licensed Radiation Therapists  
   Physician Assistants  

3. Verbal orders for antineoplastic agents will not be accepted.

4. The verbal or phone order shall be documented by the professional who accepts the order and shall include:
a. Name of Patient
b. Date
c. Time
d. Instructions/order, including name of medication, strength, dose increment, frequency, route, quantity or duration, and age and/or weight of patient when appropriate. PRN orders must include specific time interval and indication.
e. Notation that order was a verbal or phone order
f. First and last name of physician issuing the order
g. Legal signature of healthcare professional receiving the order

5. All orders must include physician pager number.

6. Prohibited abbreviations shall not be used in documenting verbal orders.

7. The individual accepting the verbal order shall record and then read back the order in its entirety to the prescribing physician at the time the order is given, documenting that the order was “read back” (RB).

8. Verbal and phone orders may be transcribed by any staff member authorized to transcribe other physician orders. When orders are transcribed by unlicensed staff, they shall be countersigned by a licensed staff member prior to implementation.

9. Nursing staff shall tag all verbal orders with a “SIGN HERE & DATE” tag to alert the physician of the need to sign the verbal order upon return to the unit.

10. Nursing staff and other healthcare professionals are permitted to act upon verbal orders provided the orders contain the appropriate information and are within the scope of practice for said healthcare professional.

11. Verbal and telephone orders shall be signed or initialed by the prescribing practitioner as soon as possible, but not later than five (5) days after being given. When the ordering physician is unavailable, it is acceptable for another team member or the attending staff to authenticate the verbal order(s).
12. Physician extenders (physician assistants, advance practice nurses, etc.) may accept verbal orders from their supervising physician; the supervising physician shall countersign these verbal orders within 24 hours for inpatients and hospital emergency departments and 72 hours in all other cases.

13. Medical staff members, house officers and other practitioners (physician assistants, advance practice nurses, etc.) who fail to authenticate a verbal order are in non-compliance with the Rules and Regulations of the Medical Staff and may be subject to corrective action.

Administrator

8/20/09
Date

Approved Clinical Board: 10/19/99, 7/17/01, 12/17/02, 7/19/04, 6/20/06, 1/16/07, 1/15/08, 10/01/08, 8/18/09
Written: 2/97
Revised: 5/97, 2/98, 4/98, 10/99, 4/01, 1/03, 7/04, 5/06, 12/06, 12/07, 8/08, 7/09
Hospital Forms Review and Approval Process

Purpose:

To define the process for the review and approval of new forms, and changes to existing forms that are to become a permanent part of the patient’s medical record.

To ensure that the format and methods for storing data/information are standardized, whenever possible, and comply with the Hospital’s Information Management Plan.

Policy:

1. All forms, electronic, paper and pre-printed order sets, designed to become a permanent part of the patient’s medical record, must be submitted and approved by the Medical Records Committee prior to initial use.

2. Forms shall serve a useful purpose, be easily understood, provide sufficient space for recording required data, and conform to 8 ½ x 11 inches whenever possible.

3. Forms shall contain a minimum of abbreviations. The list of prohibited abbreviations approved by the medical staff shall be printed on all forms documenting free text information.

4. The original form must be deemed the chart copy. The distribution of other copies of the form shall be noted at the bottom of the form, i.e., chart copy, physician’s copy, etc.

5. Form numbers and/or bar codes will be assigned to all new medical record forms.

6. Multi-page forms will have page numbers and total pages on each page (i.e., 1 of 4, 2 of 4, 3 of 4, 4 of 4).

7. All standardized order sets will be reviewed at the time of re-order.
8. Standing order sets that reference pharmacy items must:
   a. be reviewed and approved by the Director of the Pharmacy/designee
   b. adhere to the approved formulary drug listing
   c. include the generic name of the drug
   d. clearly specify the dose and frequency
   e. indicate the reason or reasons for prn orders
   f. include an order for drug level monitoring, if appropriate
   g. be signed and dated by the physician according to hospital policy

9. The standard format for all forms is as follows:
   a. the name of the facility and title of the form in the upper left hand corner
   b. space for patient addressograph in the upper right hand corner
   c. have top holes pre-punched to facilitate binding in the patient’s medical record
   d. have title centered at the bottom of the page
   e. have “tumblehead” format for double sided forms with adequate clearance at the binding edge on the back of the form.

10. The Department of Purchasing is responsible for appointing a Forms Committee to oversee the process and to coordinate the development of forms with other organizational entities, such as the Hospital’s Medical Records Committee or the facility’s forms management contractor.
Procedure:

Person requesting the form shall:

1. Contact the Print Shop (55040) or the Hospital Forms Management Contractor to prepare a proof of the form. The telephone number of the current vendor may be obtained from Purchasing or the Director, Health Information Management.

2. Review the draft with the area or individuals who will be expected to participate in the completion of the form.

3. Submit the prepared proof to the Director of Health Information Management prior to the 10th of each month.

4. Attend or send a representative to the scheduled Medical Records Committee meeting to present the form and to answer any questions regarding the proposed form. Attendance is required to facilitate the review and approval process.

5. Contact the Director, Health Information Management following the scheduled meeting regarding the approval status of the form.

6. For questions or concerns related to the development or implementation of forms design, contact the Director, Health Information Management, the Print Shop Manager, or the Chairman, Medical Records Committee.

Approved by Clinical Board: 5/16/00, 4/17/01, 10/21/03, 9/19/06, 1/16/07
Written: 9/94
Revised: 6/97, 2/00, 3/01, 9/03, 9/06, 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

INFORMATION MANAGEMENT - EDUCATION AND TRAINING

Purpose:

Provide guidelines to equip staff with skills, tools and knowledge to insure that data is accurate, available, safe and confidential. Each department shall determine which information systems staff will utilize, and the level of access required, to perform their job duties. Department orientation shall include verification of competency in the use of all required information systems.

Policy:

I. Expectations

A. Department Responsibilities

1. Provides education and or training to all staff who are involved with data entry, data collection, data analysis or who encounter patient, employee or fiscal information.

2. Training must be provided, as appropriate, regarding software, programs or systems utilized.

3. Education and or training regarding information management tools and processes must be completed within
   a. 30 days of hire date
   b. 30 days of any change in job position or newly assigned role that requires additional skills.

B. Training, Education and Competency

1. Includes, as appropriate, but is not limited to:
   a. Data entry
   b. Data integrity
   c. Data security
   d. Access control
   e. Use and disclosure of data
   f. Backup, storage and retrieval of data
   g. Measurement instruments
h. Collection methodologies  
i. Analysis and interpretation methodologies  
j. Confidentiality  

2. Documentation in department personnel files regarding training, education and evaluation and/or competency assessment.  

II. Invision Information System  

A. Training Sessions  

1. Registration through Computer Services, extension 55420.  

2. Training sessions coordinated and conducted by Education Staff in Patient Processing.  

Class Schedule:  
http://www.sh.lsuhs.edu/infotech/ocs/userservices/Invision/Training/classtrain.html  

3. Training session content addresses basic functionality, which includes, but is not limited to, registration, order processing, charge/credit processing, and appointment scheduling.  

B. Training Documentation  

1. Certificate of completion given to each participant.  

2. Attendance records maintained in the hospital-wide education database.  

III. Education/Training Resources  

A. Training Opportunities  

Website reference and links to online calendars/schedules  
http://www.sh.lsuhs.edu - select Education, Other Training Programs  

B. Basic Computer Skills  

1. Training available through Project Care:  
http://www.sh.lsuhs.edu/training.html or call 675-6381.
2. Pre-requisite for Invision Clinical Information System classes

IV. Information Management Support

Help desk assistance with application or hardware within scope of services:

1. 675-5470, option 1 – Clinical Services

2. 675-5470, option 2 – Hardware/Software PC Support

Administrator

2/23/07

Date

Approved by Clinical Board: 3/20/01, 6/15/04, 2/20/07
Written: 5/98
Reviewed: 3/04, 12/06
Revised: 5/04, 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

HYBRID MEDICAL RECORD POLICY

Purpose:

The intent of this policy is to define the legal/hybrid medical record and to define for staff where the components of the hybrid medical (health) record reside so they can access, use, quickly assemble and disclose the information as necessary, regardless of the information's location or the media on which it is maintained.

Policy:

1. The legal medical record is the repository for information about the patient’s health history, past and present illness and documented care and treatments provided. Louisiana State University Health Sciences Center (LSUHSC), University Hospital is transitioning to an electronic patient record. Systems that are included as a part of this transition are:
   - Siemens Lifetime Clinical Record
   - Eclipsys Sunrise Record
   - General Electric (GE) Centricity

2. LSUSHC will maintain a hybrid medical record as the legal medical record. This record will include both paper and electronic documents for all patients who receive health care at the facility either as an inpatient or through hospital-based outpatient services.

3. Documents defined as electronic within the hybrid medical record must be contained within electronic systems that are viewable by all those in the organization who have the need and authority to access the information. These documents must also be able to be printed as a legal document by the Health Information Management staff authorized to provide release of information.

4. The electronic component is defined to include only the following:
   - Laboratory Results can be viewed in LCR
   - Radiology results can be viewed in LCR
   - Discharge Summaries and operative reports are viewable in Siemens’ LCR, Sunrise and Centricity
Family Medicine and Neurosurgery outpatient visit notes are viewable in LCR and GE Centricity

5. The paper component is defined to include all other clinical documentation defined as a component of the medical record, whether hand written on paper or created electronically and printed. Any document that does not meet the criteria for an electronic document must be printed and placed in the paper medical record.

6. Electronic medical record information cannot be altered after it is electronically signed. Errors may require an addendum report or some other mechanism specific to the approved application.

7. The following grid describes where and how to find specific document types that comprise the legal hybrid medical record. The grid can be used as a planning tool to ensure each major document type is addressed during the document’s transition from paper to electronic media.

Approved by Clinical Board: 2/20/07
Written: 12/06
Revised:
Reviewed:
### LSUHSC University Hospital
#### Hybrid Medical Record

**Legal Source Legend**

<table>
<thead>
<tr>
<th>Report/Document Type</th>
<th>Media Type</th>
<th>Source System Application (non-paper)</th>
<th>Electronic Storage Start Date</th>
<th>Stop Printing Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Progress Notes</td>
<td>P/E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Orders</td>
<td>P/E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Laboratory Results</td>
<td>E</td>
<td>Mysys</td>
<td>1998</td>
<td>10/8/05</td>
</tr>
<tr>
<td>Radiology Reports</td>
<td>E</td>
<td>Siemen’s RIS</td>
<td>1998</td>
<td>10/8/05</td>
</tr>
<tr>
<td>Medication Records</td>
<td>P/E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Consults</td>
<td>P/E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology Reports</td>
<td>P/E</td>
<td>Dictaphone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ/Tissue Donations</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Problem Lists (Summary Sheet)</td>
<td>P/E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Records</td>
<td>P/E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent Forms</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advance Directive</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses’ Notes</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flow Sheets</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Medicine O/P Notes</td>
<td>E</td>
<td>GE Centricity</td>
<td>08/29/06</td>
<td>08/29/06</td>
</tr>
<tr>
<td>Feist-Weiller Cancer Center O/P Clinic Notes</td>
<td>P/E</td>
<td>Sunrise Disease Mgt.</td>
<td>11/16/2006</td>
<td></td>
</tr>
</tbody>
</table>

**P/E** – All electronically created documentation is printed and filed in the medical record.

**E** - All reports are available in electronic medical record; no printing required.

**P** - All hard copy paper documents are filed in the patient’s medical record.
SECURITY, CONFIDENTIALITY AND INTEGRITY OF INFORMATION

Purpose:

To outline minimal guidelines for insuring reliable, accurate, confidential and secure information resources.

Definitions:

A. AIC: Availability, Integrity and Confidentiality

B. Security: The protection of information to insure availability, integrity and confidentiality (AIC).

C. Information Resources: Includes, but is not limited to, computers, faxes, telecommunication hardware, software, storage media, computer sign on codes, medical records documentation, and information stored, printed and/or processed by a computer system.

D. Storage Media: Includes, but is not limited to, paper, magnetic media, optical disk, film and other methods of retaining information.

E. Integrity: Protecting information from accidental or unauthorized intentional change.

F. Information Browsing: Viewing of information by unauthorized or legitimate user.

G. LSUHSC-S Confidentiality Statement: A signed statement that verifies the individuals understanding of the information security standards and implications for inappropriate access or disclosure of information.

H. Access: Permissions, rights and privileges to perform a set of functions.

I. User ID/Password: Personal identification keys that authorizes a specific user to access information resources and establishes accountability for transactions.

J. Accountability: Responsibility is assumed for actions performed when interpreting, handling, and transmitting, transcribing or reporting information.
K. Audit or Activity Logs: Detailed documentation of events (read, write, etc.)

L. Protected Health Information (PHI): Individually identifiable health information that relates to the past, present, or future healthcare services provided to an individual.


N. Protected Health Information (PHI): Individually identifiable health information that relates to the past, present, or future healthcare services provided to an individual as described by HIPAA rules.

O. ePHI: Electronic PHI (Protected Health Information) or information transmitted or viewed electronically such as faxing or displaying on computer screens.

P. ITSP: Information Technology Security Plan outlines plans for implementing information technology security “best practices” to address procedures and plans of healthcare and educationally related information security needs. It insures AIC of all information assets associated with LSUHSC-S.

Policy:

A. Administrative Responsibilities

1. LSUHSC-S Human Resource Management

   a. Newly appointed faculty, staff and volunteers or other personnel authorized to access LSUHSC-S information assets shall receive information regarding the facilities’ standards regarding the AIC of information and use of information resources.

   b. Newly appointed faculty, staff and volunteers or other personnel authorized to access LSUHSC-S information assets shall be presented with the LSUHSC-S Confidentiality Statement for signature. (See Appendix A – LSUHSC-S Confidentiality Statement.)
c. A copy of the Confidentiality Statement shall be filed in the permanent record in Human Resource Management and a copy shall be given to the individual.

2. LSUHSC-S Department Manager/Supervisor/Head
   
a. Faculty, staff and volunteers or other personnel authorized to access LSUHSC-S information assets shall receive “department specific” orientation and periodic review of access to LSUHSC-S information assets, security and appropriate processing of information relative to their job function and role that should include, but not be limited to:

   1). log in and sign off procedures
   2). lawful or legitimate information browsing
   3). release of information
   4). access rights
   5). processing and handling of information resources and storage media
   6). accountability and audit logs

b. All non-compensated observers, students, vendors, or other persons conducting business with LSUHSC-S shall receive specific instructions on the principles of appropriately processing information received or observed within the facility.

c. Affiliations agreements shall require that all persons associated with the agreement be informed, understand, and comply with the standards of AIC prior to entry into the facility.

d. Departments who acquire and are responsible for maintenance of information systems shall establish policies and procedures consistent with facility standards and recommended guidelines.


B. Access

1. System administrators (database, hardware, security, etc.) shall:
a. Define system and network access policies, procedures and controls to ensure the AIC of LSUHSC-S information assets.

b. Provide guidance and expertise to application administrators for operation of their application.

2. Application administrators (generally departmental resources assigned management tasks associated with an application) shall:

   a. Define application access policies and procedures, including assignment of user ID and password, for any system containing restricted, confidential or personal information.

   b. Define policies and procedures to ensure the AIC of the information within their applications and in accordance with facility standards.

   c. Provide mechanisms for audit purposes in accordance with facility standards.

   d. Define password expiration policies and procedures in accordance with facility standards.

   e. Shall comply with all applicable facility polices, administrative directives or memorandums that address server based systems, networks, security and integrity of data, and maintenance of systems.

3. Provisional access

   a. Computer Services shall:

      1) Coordinate department requests for application access approval with designated application data owners and ensure approved access results in appropriate permissions for access.

      2) Coordinate department requests for updating application access upon user transfer according to current business need.

      3) Remove user access upon termination or dismissal.
b. Department administrative personnel responsible for the supervision of individual users must submit:

1) A detailed request in writing (memo, approved access form, email) specifying specific access requirements, suitable to the employees job role (read, write, amend, etc.), to the appropriate owner.

2) The Louisiana Revised Statute 14.73.1 et seq. and Administrative Directive 2.8.9 dictates access to information or systems without the consent of appropriate authorities constitutes illegal activity and the person(s) involved are subject to enforceable penalties that may include fine and imprisonment.

3) Review access rights periodically to ensure that the rights granted are relevant to the assigned responsibilities for that individual.

4) Notify Computer Services and data owners within three (3) days:
   - of termination or resignation of personnel.
   - of transfer of personnel to another area, unit or department.

c. Data owners are responsible for approving or denying application access based on valid business need for access. Only the minimum necessary access may be approved.

4. The authorized user shall be accountable for:

a. Properly safeguarding data under their control and/or direction according to its level of sensitivity.

b. Maintaining the integrity of data.

c. Accessing only the data and automated functions for which s/he is authorized, in the course of normal business activity

d. Password control (in accordance with ITSP):
   1). password not easily guessed
2). inadvertent disclosure
3). immediate change if suspected disclosure
4). report of any suspected misuse by another individual

   e. Appropriate logoff from the application(s).

   f. Safeguarding information, including ePHI, and resources available in the course of their job duties.

Refer to [http://www.lsuhsc-s.edu/cs/InfSec.php](http://www.lsuhsc-s.edu/cs/InfSec.php) for information regarding security issues and policies.

C. User termination or transfer

   1. Department administrative personnel must insure that:

      a. Personnel who separate from the facility complete the Employee Clearance process.

      b. Appropriate system administrators receive notification of separation or termination of individuals who do not complete the Employee Clearance process or who involuntarily separate from the department.

         This notification shall be made as soon as possible, but no later than three working days from last date of service.

      c. Appropriate system administrators receive notification when employees transfer to another unit, area or department.

      d. Timely review of staff’s access to systems is performed when job duties or assigned role is modified within the department.

   2. Application administrators shall:

      a. Disable access as soon as possible after receiving notification of separation or termination or notice of transfer.

      b. Shall comply with all applicable facility policies, administrative directives or memorandums that address server based systems, networks, security and integrity of data, and maintenance of systems.

D. Securing Information
1. Storage Media

a. Used to access, retrieve, and communicate confidential or sensitive information shall be maintained in accordance with facility standards. (See appropriate Chancellor Memorandums and or Administrative Directives).

b. Are safeguarded against theft, tampering, and unauthorized access.

c. Identified as confidential or sensitive information shall be labeled as “CONFIDENTIAL” and stored in areas that are restricted only to authorized personnel. Prior to discarding any CONFIDENTIAL storage media, the information shall be rendered unusable.

d. Maintained to comply with all applicable facility polices administrative directives or memorandums.

2. Request for Information/Records

a. Requests for health record information shall be made available only to those employees, medical staff members, support staff, students, etc. displaying their identification badges.

b. All requisitions for the retrieval of medical records shall contain the patient’s name, medical record number, current date/time and requesting party’s name. The requesting party’s telephone number and room number are also required for records requested for administrative purposes.

c. Telephone request for patient-identifiable information are discouraged and limited to emergency situations (emergency requests are usually generated by physicians or other ‘key’ hospital/physician office staff). Telephone request shall be handled using a ‘call-back’ procedure to verify the identity of the requesting party.

d. Release or disclosure of protected health information should be referred to the HIM department for disposition. Guidelines for disclosure are outlined in Hospital Policy #6.3 and LSUHSC-S HIPAA Policies.
e. Facsimile transmission of patient information is addressed in Hospital Policy 6.3.1.

f. Voice messages containing confidential information should not be left on answering machines.

g. Shall comply with all applicable facility policies, administrative directives or memorandums.

3. Patient Medical Records

a. Medical record folder displays two warnings reminding of the obligation to maintain confidentiality and security of information: “Confidential Health Information” and “This folder may not be removed from the hospital premises”.

b. Medical records are transported to patient care areas and administrative offices via the pneumatic tubes, dumbwaiter, carts and/or courier staff. All staff transporting medical records must ensure the privacy of patient-identifiable information during the transport process. Medical records and/or carts loaded with medical records shall not be left unattended during the transport process.

c. The primary medical record and any secondary records (diagnosis and procedure cross indexes, etc) are stored in areas directly controlled and monitored by the Health Information Management Director.

d. Records are to be maintained in the patient care areas in locations that are not accessible by unauthorized individuals.

e. The original medical record shall not be removed from the hospital premises except upon receipt of subpoena duces tecum, court order or state statute.

f. Shall comply with all applicable facility policies, administrative directives or memorandums.

4. Disposing/Discarding Patient Identifiable Information

a. Copies of reports containing confidential information shall be rendered unusable (shredding) when no longer needed.
b. Labels containing patient identifiable information must be rendered illegible when discarded.

c. Shall comply with all applicable facility policies, administrative directives or memorandums.

5. Hardware and System Access

a. Personnel who are the primary user of a personal computer must maintain an approved anti-virus software package. Failure to do so will result in loss of ability to connect to the campus network.

b. Remote access to systems shall be governed in accordance with facility standards.

c. Screen savers, auto logoff, screen shields, or other means must be utilized to prevent unauthorized view of computer systems that contain sensitive or confidential data.

d. Data control and production areas shall be accessible only through a secured entrance by authorized personnel; unauthorized personnel must be accompanied by authorized personnel.

e. Shall comply with all applicable facility policies, administrative directives or memorandums.

E. Security and Privacy Violations

1. Security and Privacy violations are described in Chancellor’s Memorandums, LSUHSC-S Confidentiality Statement, LSUHSC-S HIPAA policies and other applicable hospital policy resources.

2. Reported incidents:

a. Will be investigated by administrative staff to determine if the events were intentional due to an individual’s negligence, accidental mistake, improper training, or misunderstanding the information resource and or policy.

b. May result in suspension of an individual’s access.
c. May result in disciplinary action up to and including termination. Violations, also, may constitute a criminal offense, Louisiana Revised Statutes 14.73.1 et seq.

d. Shall comply with all applicable facility policies, administrative directives or memorandums.


Administrator

8/20/09
Date

Approved by Clinical Board: 3/20/01, 7/20/04, 7/17/07, 8/18/09
Written: 3/98
Reviewed: 3/04, 12/06, 6/07, 7/09
Revised: 4/98, 2/01, 7/04, 12/06, 6/07, 7/09
LSUHSC-S CONFIDENTIALITY AGREEMENT

Louisiana State University Health Sciences Center has a legal and ethical responsibility to safeguard the privacy of all patients and protect information that is defined as confidential. Confidential information includes oral communication, information contained in manual documentation as well as information stored in the facilities computer systems. Patient, personnel, financial and other business records contain confidential information.

I understand that information regarded as confidential must be maintained in the strictest of confidence. As a condition of my affiliation with LSUHSC-S, I hereby agree that I will not at any time during or after my affiliation with LSUHSC-S, disclose any confidential information to any person, other than as necessary in the course of my affiliation with LSUHSC-S, and when accompanied by the appropriate, authorized personnel. I understand that I am directly responsible for the accuracy and completeness of data entries which are entered into the facilities storage media.

Information in the facilities storage media may be accessed only by authorization from the Assistant Dean for Information Technology; computer system access is granted only to persons who have submitted a written application, and have been issued user identification codes. I understand that all user identification codes and passwords are confidential, and may not be shared or disclosed to any other person.

It is a crime punishable by fine and or imprisonment to reveal user identification codes or passwords (La. R.S. 14.73.1 et seq.). Using another employee’s user identification code/password or giving your user identification code/password to another person may result in disciplinary action, which may include suspension and/or termination.

I understand that it constitutes a Security violation to fail to sign off when leaving the computer unattended; accessing any medical or employment record without appropriate need or approval; requesting another employee to access my employment or medical record; allowing another employee to utilize my password; accessing medical or employment records without having a legitimate reason; using another employee’s access code, revealing confidential information of patients, employees or business/financial details, etc. All security violations will be reported to and investigated by the appropriate authorities.

My signature below indicates I have read the Security, Confidentiality and Integrity of Information Policy and have been given the opportunity to have any questions regarding this statement explained to me, and the failure to abide by this agreement may result in disciplinary action, including dismissal from employment, according to the
Civil Service Rules and Regulations, LSU System Guidelines, applicable Medical Staff By Laws and Louisiana State Law.

______________________________     __________________________
Printed Name                                               SIGNATURE

______________________________
Social Security No.

______________________________
Date
GENERAL POLICY ON THE USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION (PHI)

Purpose:

To establish guidelines for disclosing protected health information to ensure the protection of the patient’s right to privacy and confidentiality. Any and all disclosures of protected health information made to any individual, agent or entity, which are not pursuant to an authorization and are not part of treatment, payment or operations, must be accounted for according to the Health Insurance Portability and Accountability Act. See HIPAA Policy Number 2.5, Accounting of Disclosures for Protected Health Information. The LSUHSC-S Disclosure Log can be accessed at www.sh.lsuhsc.edu/compliance/hipaa.

Policy:

1. The medical records of a patient are the property and business records of the healthcare provider.

2. The original medical record may not be removed from the hospital premises except upon receipt of a subpoena duces tecum, court order or state statute.

3. LSUHSC-S may not use or disclose protected health information (PHI), except as permitted or required under the Heath Insurance Portability and Accountability Act of 1996 (HIPAA), other federal laws, Louisiana state laws and hospital policies and procedures.

4. LSUHSC-S may use and disclose protected health information for:

   • its own treatment, payment or healthcare operations
   • treatment activities of a healthcare provider
   • the payment activities of another covered entity or healthcare provider
   • the healthcare operation of another covered entity or healthcare provider, if each entity has or had a relationship with the individual who is the subject of the PHI being requested and the disclosure is:

      a. for a purpose listed in the definitions of healthcare operations; or
b. for the purpose of healthcare fraud and abuse detection

- another covered entity that participates in an organized healthcare arrangement with LSUHSC-S for any healthcare operation activities of the organized healthcare arrangement.

5. The privacy and confidentiality of health information is the right of each patient seeking healthcare at LSUHSC-S. All protected health information (both written and verbal) is strictly confidential. Use and disclosure of PHI based on patient authorization shall be done only after completion of a valid authorization and obtaining the patient’s signature.

6. A valid authorization must contain at least the following elements and must be in plain language:

a. A specific and meaningful description of the information to be used or disclosed
b. The name or other specific identification of the person (s) or class of person (s) authorization to use or disclose the information.
c. The name or other specific identification of the person (s) or class of persons to whom LSUHSC-S may make the use or disclosure.
d. A description of each purpose of the requested use or disclosure. The statement ‘at the request of the individual’ is sufficient when an individual initiates the authorization and does not provide a statement of the purpose.
e. An expiration date or event that relates to the individual or the purpose of the use or disclosure. The statement ‘end of the research study,’ ‘none,’ or similar language is sufficient if the authorization is for a use or disclosure for research, including for the creation and maintenance of a research database or repository.
f. Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative’s authority to act for the individual.
g. If the authorization is signed by a personal representative or the individual, a description of the representative’s authority to act for the individual.
h. A statement of the individual’s right to revoke the authorization in writing and either:
• A reference to the revocation right and procedures described in the notice, or
• A statement about the exceptions to the right to revoke and a description of how the individual may revoke the authorization

i. A statement about the ability or inability of LSUHSC-S to condition treatment, payment, enrollment or eligibility for benefits on the authorization:
• The covered entity must state that it will not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization or
• The covered entity must describe the consequences of a refusal to sign an authorization when the covered entity conditions research-related treatment, enrollment or eligibility for benefit, or the provision of healthcare solely for the purpose of creating protected health information for a third party on obtaining an authorization

j. A statement that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the rule.

7. A patient or the patient’s legally authorized representative may examine all, or a designated part, of the patient’s healthcare information (excluding information used for internal quality assurance, peer review, audit and committee purposes).

8. The information will be made available for examination during regular business hours or a copy will be provided, if requested.

9. A facsimile copy of the authorization to disclose protected health information will be honored. PHI will be sent by facsimile only when the original record or mail-delivered copies will not meet the needs for treatment, payment or operations. (see Hospital Policy 6.3.1)

10. The following authorizations require special instructions:

- Use and Disclosure of Protected Health Information for Facility Directory Purposes (see HIPAA Hospital Policy #3.2)
- Use and Disclosure of Protected Health Information for Marketing Purposes (see HIPAA Hospital Policy #3.3)
11. Permitted Uses and Disclosures of Protected Health Information (an individual's oral or signed authorization is not required):

a. To the individual patient (patient identification is required prior to disclosure)
b. For treatment reasons, to obtain payment or for healthcare business operations
c. Incidental to a use or disclosure, i.e., overheard conversations, sign-in sheets
d. Pursuant to an oral agreement with the individual to make such disclosures to a relative or friend
e. As required by law
f. For public health activities
g. To a government authority, including a social service or protective service agency authorized by law to receive reports about an individual whom LSUHSC-S reasonably believes to be a victim of abuse, neglect or domestic violence.
h. To a health oversight agency
i. To any judicial or administrative proceeding (an authorization is not needed, but the disclosure must comply with other requirements of the privacy regulations for judicial disclosures and any state law requirements)
j. To a court pursuant to a court order or court subpoena.
k. In response to a law enforcement request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; a victim of crime; or for information about an individual who is on or is suspected to be a victim of a crime.
l. About an individual who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the individual if LSUHSC-S has a suspicion that such death may have resulted from criminal conduct.
m. To a law enforcement official that LSUHSC-S believes in good faith constitutes evidence of criminal conduct that occurred on the premises of LSUHSC-S.
n. To a law enforcement official if LSUHSC-S is providing emergency healthcare in response to a medical emergency other than on the premises of LSUHSC-S.

o. To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

p. To funeral directors consistent with applicable law as necessary to carry out their duties with respect to the decedent.

q. To organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating donation and transplantation.

r. To prevent or lessen a serious and imminent threat to the health safety of a person or the public or to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat or to identify or apprehend an individual.

s. To the extent necessary to comply with Louisiana Workers’ Compensation statutes.

t. To a business associate for the purpose of raising funds for its own benefit – demographic information and dates of healthcare provided to the patient.

u. To an individual when requested under ad as required by the access or accounting requirements of the HIPAA Privacy Regulations.

v. To investigate or determine LSUHSC-S compliance with the HIPAA Privacy Regulations.

w. To the Poison Control Center to assure that safe and effective treatment recommendations are rendered.

12. Uses and Disclosures of Protected Health Information Requiring an Individual’s Signed Authorization:

a. Armed Forces

b. Current or prospective employer

c. Fund Raising

d. Insurance carrier for the purpose of determining eligibility for coverage

e. MAP unit (Medicaid Assistance Program) for determination of benefits

f. Marketing

g. Patient’s attorney for litigation

h. Psychotherapy notes

i. Request for photocopies of medical records
j. Research
k. School referrals and school evaluation

13. Subpoena Duces Tecum

A healthcare provider shall disclose records of a patient who is a party to litigation pursuant to a subpoena issued in that litigation, whether for purposes of deposition or for trial and whether issued in a civil, criminal, workers' compensation, or other proceeding, but only if: the healthcare provider has received an affidavit of the party or the party's attorney at whose request the subpoena has been issued that attests to the fact that such subpoena is for the records of a party to the litigation and that notice of the subpoena has been mailed by registered or certified mail to the patient whose records are sought, or, if represented, to his counsel of record, at least seven days prior to the issuance of the subpoena; and the subpoena is served on the healthcare provider at least seven days prior to the date on which the records are to be disclosed, and the healthcare provider has not received a copy of a petition or motion indicating that the patient has taken legal action to restrain the release of the records. If the requesting party is the patient or, if represented, the attorney for the patient, the affidavit shall state that the patient authorizes the release of the records pursuant to the subpoena. No such subpoena shall be issued by any clerk unless the required affidavit is included with the request.

Unless the subpoena or court order otherwise specifies, it shall be sufficient compliance therewith if the healthcare provider delivers by registered or certified mail, at least forty-eight hours prior to the date upon which production is due, or delivers by hand on the date upon which production is due a true and correct copy of all records described in such subpoena.

The records shall be accompanied by the certificate of the healthcare provider or other qualified witness, stating in substance each of the following:

a. That the copy is a true copy of all records described in the subpoena.

b. That the records were prepared by the healthcare provider in the ordinary course of the business of the healthcare provider at or near the time of the act, condition, or event.
If the healthcare provider has none of the records described, or only part thereof, the healthcare provider shall so state in the certificate, and deliver the certificate and such records as are available.

The healthcare provider shall be reimbursed by the person causing the issuance of the subpoena, summons, or court order in accordance with the provisions of R.S. 40:1299.96.

Out of State Subpoenas – subpoenas by courts of other states are not valid, unless accompanied by a medical authorization. Questions regarding out of state subpoenas should be directed to Compliance and/or Legal Affairs.

14. Confidentiality of HIV test result; disclosure:

a. Except as otherwise provided by law, no person who obtains, retains, or becomes the recipient of confidential HIV test results in the course of providing any health or social service or pursuant to a release of confidential HIV test results may disclose such information pursuant to a written authorization to release medical information when such authorization contains a refusal to release HIV test results.

b. Notwithstanding the provisions of Subsection A, HIV test results may be released to the following:

1) Any person to whom disclosure of medical information is authorized by law without the consent of the patient.

2) Any agent or employee of a health facility or healthcare provider if:
   a) The agent or employee is permitted access to medical records.
   b) The health facility or healthcare provider is authorized to obtain the HIV test results.
   c) The agent or employee provides healthcare to the patient or maintains or processes medical records for billing or reimbursement purposes.

3) A healthcare provider or health facility, when knowledge of the HIV test results is necessary to provide appropriate care or treatment to the patient and afford the healthcare provider and the personnel of the health facility an opportunity to protect themselves from transmission of the virus.
4) A health facility or healthcare provider, in relation to the procurement, processing, distributing, or use of a human body or a human body part, including organs, tissues, eyes, bones, arteries, blood, semen, or other body fluids, for use in medical education, research, therapy, or transplantation.

5) Any health facility staff committees or accreditation or oversight review organizations authorized to access medical records, provided that the committee or organization shall only disclose confidential HIV test results:
   a) To the facility or provider of a health or social service.
   b) To a federal, state, or local government agency for the purposes of and subject to the conditions provided in Paragraph (6) of this Subsection.
   c) To carry out the monitoring evaluation, or service for which it was obtained.

6) A federal, state, parish, or local health officer when the disclosure is mandated by federal or state law.

7) An agency or individuals in connection with the foster care programs of the Department of Social Services or an agency or individual in connection with the adoption of a child.

8) Any person to whom disclosure is ordered by a court of competent jurisdiction.

9) An employee or agent of the Board of Parole of the Department of Public Safety and Corrections to the extent that the employee or agent is authorized to access records containing HIV test results in order to implement the functions, powers, and duties with respect to the individual patient of the Board of Parole, Department of Public Safety and Corrections.

10) An employee or agent of the office of probation and parole of the Department of Public Safety and Corrections, division of correction services, to the extent the employee or agent is authorized to access records containing HIV test results in order to carry out the functions, powers, and duties, with respect to patient of the office.

11) A medical director of a local correctional facility, to the extent the medical director is authorized to access records containing HIV test results in order to carry
out the functions, powers, and duties with respect to
the patient.

12) An employee or agent of the Department of Public
Safety and Corrections, to the extent the employee or
agent is authorized to access records containing HIV
test results in order to carry out the Department of
Public Safety and Corrections functions, powers, and
duties with respect to the patient.

13) An employee or agent who is authorized by the
Department of Social Services, office of rehabilitative
services to access records containing HIV test results
in order to carry out the Department of Social
Services, office of rehabilitative services functions,
powers, and duties with respect to the protected
patient.

14) An insurer, insurance administrator, self-insured
employer, self-insurance trust, or other person or
entity responsible for paying or determining payment
for medical services to the extent necessary to secure
payment for those services.

c. A state, parish, or local health officer may disclose
confidential HIV test results when:
1) Disclosure is specifically authorized or required by
federal or state law.
2) Disclosure is made pursuant to a release of
confidential HIV test results.
3) Disclosure is requested by a physician pursuant to
Subsection E of this Section.
4) Disclosure is authorized by court order.

d. No person to whom confidential HIV test results have been
disclosed pursuant to this Part shall disclose the information
to another person except as authorized by this Part,
provided, however, that the provisions of this Subsection
shall not apply to the individual or to a natural person who is
authorized by law to consent to healthcare for the individual.

e. Physician Disclosures
1) A physician may disclose confidential HIV test results
under all of the following conditions:
a) Disclosure is made to a contact, or to a public
health officer for the purpose of making the
disclosure to said contact.
b) The physician reasonably believes disclosure
is medically appropriate, and there is a
significant risk of infection to the contact.
c) The physician has counseled the patient regarding the need to notify the contact, and the physician reasonably believes the patient will not inform the contact.

d) The physician has informed the patient of his or her intent to make such disclosure to a contact and has given the patient the opportunity to express a preference as to whether disclosure should be made by the physician directly or to a public health officer for the purpose of said disclosure. If the patient expresses a preference for disclosure by a public health officer or by the physician the physician shall honor such preference.

2) When making such disclosures to the contact, the physician or public health officer shall provide or make referrals for the provision of the appropriate medical advice and counseling for coping with the emotional consequences of the knowledge of the information and for alteration of behavior to prevent transmission or contraction of HIV infection. The physician or public health officer shall not disclose the identity of the patient or the identity of any other contact. A physician or public health officer making a notification pursuant to this Subsection shall make such disclosure in person, except where circumstances reasonably prevent doing so.

3) A physician shall have no obligation to identify or locate any contact.

4) A physician may, upon the consent of a parent or guardian, disclose confidential HIV test results to a state, parish, or local health officer for the purpose of reviewing the medical history of a child to determine the fitness of the child to attend school.

5) A physician may disclose confidential HIV test results pertaining to a patient to a person authorized by law to consent to healthcare for the patient when the physician reasonably believes that disclosure is medically necessary in order to provide timely care and treatment for the patient and, after appropriate counseling as to the need for such disclosure, the patient has not and will not inform the person authorized by law to consent to healthcare. The physician shall not make such disclosure if, in the judgment of the physician, the disclosure would not
be in the best interest of the patient or of the individual authorized by law to consent to such care and treatment. Any decision or action by a physician pursuant to this Paragraph and the basis thereof shall be recorded in the patient's medical record.

f. A physician may choose, notwithstanding any other provision of law to the contrary, not to disclose the results of a confidential HIV test to a person upon whom such a test has been performed when in the medical opinion of the physician the disclosure of such results would be medically contraindicated.

15. Birth/Death Certificates

Certified copies of death and birth certificates may be obtained from the Caddo Parish Health Unit, 1035 Creswell, Shreveport, Louisiana. The certified copy is usually available within one hour of the request. There is a fee for obtaining the certified copy.

16. Adoptions

Requests for disclosing information regarding an adoption shall be referred to the agency, which handled the adoption. The name and phone number of the adoption agency (if known) may be provided, however, no further information shall be disclosed by the facility. Access to the records shall be prohibited.

17. Child Custody

Disclosure of medical records and other protected health information pertaining to a minor child, including but not limited to medical, dental and school records shall not be denied to a parent solely because the parent is not the child’s custodial parent or domicile parent.

18. Minors

Protected health information for minors (patients less than 18 years old) may be released for treatment, payment and hospital operations without the patient’s or parent’s consent. The parent’s signature is required for all other requests for protected health information for minors with the exception of emancipated minors. A legal custodian of a minor shall be required to present documentation to support the legal custody of the child prior to releasing medical information. A non-legal custodian shall be
authorized to give consent to receive medical or education services for which parental consent is required by executing an affidavit. The affidavit shall not be valid for more than one year after the date on which it is executed.

19. News Media

All inquiries for protected information from newspaper reporters, television stations or other news media shall be referred to the Coordinator, Information Services, at extension 55408 for disposition.

20. Patients Currently Hospitalized

Requests for disclosure of information for patients currently hospitalized shall be discouraged when possible. When it is not possible, the nurse station should be contacted to obtain the patient’s medical record along with the authorization to disclose protected health information. The record should be photocopied as quickly as possible and immediately returned to the nurse station.

21. Verbal/Telephone Requests

Verbal requests for protected health information by authorized and/or unauthorized persons shall be discouraged and be limited to emergency situations. Emergency requests are usually generated by physicians or other ‘key’ hospital/office staff. Telephone requests should always be handled using a ‘call-back’ procedure to verify the identity of the requesting party.

22. Photocopy Fees

A patient shall have a right to obtain a copy of his/her protected health information upon furnishing a signed authorization and upon payment of a reasonable copying charge, not to exceed one dollar per page for the first twenty-five pages, fifty cents per page for twenty-six to five hundred pages, and twenty-five cents per page thereafter, a handling charge not to exceed fifteen dollars for hospitals and seven dollars and fifty cents for other healthcare providers and, actual postage. The individuals named herein shall also have the right to obtain copies of patient x-rays, microfilm and electronic and imaging media, upon payment of reasonable reproduction costs and a handling charge of twenty dollars for hospitals and ten dollars for other healthcare providers. In the event a hospital record is not complete, the copy of the records
furnished hereunder may indicate, through a stamp, coversheet, or otherwise that the record is incomplete.

NOTE: The Privacy Rule (HIPAA), effective April 14, 2003 overrides the handling charge for patient requests, only. Patients cannot be charged a handling charge for obtaining a photocopy of their medical records, but may be assessed a per page fee.
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

FAX POLICY FOR TRANSMITTING PATIENT INFORMATION

Purpose:

To define the minimum guidelines and procedures that must be followed when transmitting protected health information via facsimile.

Policy:

1. Limited and specific protected health information (PHI) may be faxed when mail-delivered copies will not meet the needs for treatment, payment or healthcare operations.

2. Within LSUHSC-S facilities results, tests, transcribed reports, physician orders may be faxed to expedite patient care services. Department must define parameters for retention and destruction of this faxed information.

3. The sender must limit the information transmitted to the minimum necessary to meet the requester’s needs.

4. Fax numbers shall be verified before faxing documents.

5. The availability of the authorized receiver shall be verified by phone before sending the information.

6. All fax machines used for patient care or patient related services shall be located in secure areas that are not accessible to the general public.

7. A specific individual shall be assigned to monitor the fax machine. This individual shall be responsible for:

   a. Checking the fax machine at regular intervals for incoming information. Each department is responsible for ensuring that incoming faxes are properly handled.

   b. Reading the cover letters and following any instructions for verifying receipt of documents.

   c. Notifying the individual to whom the fax is addressed.
8. All patient information should be accompanied with a cover letter containing a "Confidentiality Notice"; i.e.:

The documents accompanying this telecopy transmission contain confidential information, belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents as soon as possible. Thank you.

9. Misdirected faxes that contain patient information must be reported to the Compliance Office and the disclosure must be logged on the LSUHSC-Shreveport HIPAA disclosure log located at www.sh.lsuhsc.edu/compliance/hipaa/.

_______________________
Administrator

[Signature]

10/23/09
Date

Approved by Clinical Board: 8/15/00, 10/21/03, 11/21/06, 10/20/09
Written: 11/97
Reviewed: 8/00, 10/06, 9/09
Revised: 9/03, 10/06, 9/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

LOUISIANA POISON CONTROL CENTER
(Release of Information)

Purpose:

To establish guidelines governing patient information transfer between LSUHSC-Shreveport and the Louisiana Poison Control Center.

Policy:

1. In order to facilitate patient care, LSUHSC-S healthcare providers may consult with the Poison Control Center without the patient’s consent. Referral to the Poison Control Center is considered part of a patient’s treatment for purposes of HIPAA and sharing of a patient’s protected health information can occur without the patient’s authorization. All healthcare providers at LSUHSC-S shall continue to cooperate fully with the Louisiana Poison Control Center.

2. If there is any question regarding the authenticity of the phone request from the Poison Control Center, the healthcare practitioner should end the phone conversation and initiate the return call to 1-800-222-1222 (national Poison Center telephone number) to assure the identity of the other party.

3. After disclosure to the Poison Control Center the patient’s information shall be entered into the PHI disclosure log by the individual provider of the information. The disclosure log can be accessed on the LSUHSC-Shreveport Compliance Website.

_____________________
Administrator

_____________________
Date

7/27/09

Clinical Board Approved: 6/17/03, 6/20/06, 7/21/09
Written: 6/03
Reviewed: 5/06, 7/09
Revised: 7/09
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. All clinical entries in the patient’s medical record shall be accurately dated, authenticated and legible.

B. Content of the Medical Record

1. The content of the medical record, which includes written and electronic documents, must be sufficiently detailed, legible and organized to enable:

   • the practitioner responsible for the patient to identify the patient, provide continuing care, determine the patient’s condition at a specific time, review the diagnosis and therapeutic procedures performed and the patient’s response to treatment;
   • a consultant to render an opinion after a patient examination and review of the medical record;
   • another practitioner to assume patient care at any time;
   • and the retrieval of information required for utilization review, quality review, transfer recommendations, etc.

2. 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. The patient’s language and communication needs;
d. Emergency care provided to the patient prior to arrival, if any;
e. Documentation and findings of the patient’s assessment;
f. Conclusions or impressions drawn from the medical history and physical examination;
g. The diagnosis, diagnostic impression or condition;
h. The reason for admission or care, treatment and services;
i. The goals of treatment and the treatment plan;
j. Evidence of known advance directives;
k. Evidence of informed consent when required;
l. Diagnostic and therapeutic orders;
m. Diagnostic and therapeutic procedures and test results relevant to the management of the patient’s condition;
n. Operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
o. Progress notes made by authorized individuals;
p. Reassessments and plan of care revisions, when indicated;
q. Relevant observations;
r. Response to care, treatment and services provided;
s. Consultation reports;
t. Allergies to food and medicine;
u. Medications ordered or prescribed;
v. Medications dispensed or prescribed on discharge;
w. Every medication order documented as administered or not administered and any adverse drug reaction;
x. All relevant diagnoses/conditions established during the course of care, treatment and services;
y. Documentation of referrals and communications made to external or internal care providers and to community agencies;
z. Conclusions at termination of hospitalization;
aa. Discharge instructions to the patient and family; and
bb. Discharge summaries or a final progress note or transfer summary;
cc. Records of communication with the patient regarding care, treatment, and services, i.e., telephone calls or email;
 dd. Patient generated information.
3. Ambulatory care records generated in one of the hospital sponsored clinics require the following:

   a. Patient identification
   b. Relevant history of the illness or injury and of physical findings
   c. 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) Known significant operative and invasive procedures
      3) Known adverse and allergic drug reactions
      4) Known long term medications (including current medications, over-the-counter drugs and herbal preparations)

   The summary list is quickly and easily available for practitioners to access needed information. The list is filed in the same location in all patients’ charts.
4. 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. Documentation if the patient left against medical advice

C. Chart Rules and Regulations

1. History and Physical Examination

a. A complete history and physical examination shall be documented and filed on the patient's medical record within the first 24 hours of admission and prior to the performance of any surgery.

b. If a history and physical examination has been completed within thirty (30) days prior to admission, a signed, durable, legible copy of this report may be used in the patient's medical record provided there has been no subsequent changes. An updated entry must be documented within 24 hours after admission documenting any changes in the patient's condition when the medical history and physical examination are completed with 30 days before admission.

c. In the case of an 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.

d. 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 fontanels close (pediatric) as appropriate to patient's age & needs
10) Length/weight within the past 7 days (pediatric/adolescent)

e. The physical examination should reflect a comprehensive current physical assessment.

f. The recorded history and physical examination must be authenticated by a practitioner privileged to do so.

g. 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) Vital signs
   b) Assessment of mental status; and
   c) An examination specific to the procedure proposed to be performed and any co-morbid conditions.
2) Moderate Sedation:
   a) Vital signs
   b) Assessment of mental status
   c) An examination specific to the procedure proposed to be performed and any co-morbid conditions.
   d) Examination of heart and of lungs by auscultation.
   e) Allergies
   f) Family history of anesthesia problems
   g) Medication history
   h) Abnormal lab results

4. Deep Sedation, General, Spinal or Epidural Anesthesia:
   a. Complete Physical Examination
   c. Note: Anesthesia combinations require a physical relevant to the highest level of anesthesia provided.

5. Post Operative Documentation

Post operative documentation includes:

   a. Vital signs;
   b. Level of consciousness;
   c. Medications (including intravenous fluids);
   d. Blood and blood components;
   e. Any unusual events or post operative complications and management of such events;
   f. 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;
   g. Patient’s discharge from the Post sedation or post anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria;
   h. If discharge criteria are used, they are approved by the medical staff. Compliance with discharge criteria is documented, and
i. 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, the result of treatment and plans for future care. Whenever possible, each of the clinical problems shall be clearly identified and correlated with specific orders as well as results of tests and treatment.

c. An authenticated legible progress note is required daily to document medical necessity and acute level of care.

d. Progress notes must reflect the involvement of the attending physician in the patient’s care.

e. All progress notes must be signed and dated.

7. Consultations

Consultation reports shall be a part of the patient’s medical record and shall show evidence of a review of the patient’s record by the consultant, pertinent findings on examination of the patient, the consultant’s opinion, the consultants recommendations and the signature of the consultant.

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 must be obtained by a physician prior to any invasive and/or operative procedure from each patient or the patient's legally authorized representative. 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 progress 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 brief legible comprehensive operative progress note shall be entered into 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) Name of the surgeon and any assistants
2) Procedure(s) performed
3) Description of the procedure
4) Findings
5) Estimated blood loss
6) Specimens removed
7) Postoperative diagnosis

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) Provisional diagnoses,
2) a history and physical exam,
3) any abnormal lab,
4) brief description of the planned procedure(s),
5) planned anesthesia type, including risks, benefits and alternatives,
6) patient's previous drug history,
7) other anesthetic experiences,
8) any potential anesthetic problems

b. A documented post anesthesia visit shall note any intra-operative or post-operative anesthesia complications.

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

a. All orders for medications and treatment shall be in written by members of the medical staff and other practitioners involved in the care of the patient who may have been authorized to do so by the granting of privileges. These orders include those legibly written by medical staff members, house officers and other practitioners within the scope of their professional practice.
b. Verbal and telephone orders shall be accepted by the following healthcare professionals – registered nurses, registered pharmacists, licensed respiratory therapists, certified/registered EEG technologists, physical/occupational therapists, licensed dietitians, medical technologists/technicians, radiology technologists, nuclear medicine technologists, radiation therapists, and physician assistants. The healthcare professional accepting the verbal order must read the order back to the prescribing physician and document that the verbal order was read back.

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 practitioner shall countersign verbal and phone orders within five (5) days. When the ordering physician is unavailable, it is acceptable for another team member or the attending staff to authenticate the verbal order(s).

c. Physician extenders (physician assistants, advance practice nurses, etc.) may accept verbal orders from their supervising physician; the supervising physician shall countersign these verbal orders within 24 hours for inpatients and hospital emergency departments and 72 hours in all other cases.

12. Do Not Resuscitate (DNR)

DNR orders must be signed by an attending physician.

13. Transfers

When a patient is transferred within LSUHSC-S, from one level of care to another 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.
14. 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 or symbols):
10) Reason for Hospitalization:
11) Significant Findings (physical and laboratory):
12) Hospital Course:
13) Procedures performed and care, treatment and services provided:
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) Information provided to the patient and family (i.e., diet, medication, activity and follow-up, other discharge instructions):

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

e. All discharge summaries shall be authenticated by the responsible practitioner.

15. Countersignatures

All written entries by physician extenders (physician assistants, advance practice nurses, etc.) shall be reviewed, countersigned and dated by the supervising physician within 24 hours for inpatients and within 72 hours for clinic and other practice settings. The physician extender (physician assistant, advance practice nurse, etc.) and the supervising physician shall insure that all activities, functions, services, treatment measures, medical devices or medications prescribed or delivered to the patient by the physician extender are properly documented in written form in the patient’s medical record.

16. Signature Stamps

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.

17. Electronic Signatures

a. 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.

b. 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.

c. 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.

d. 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.

e. 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. The users are prompted to reset passwords every thirty (30) days and the passwords are known only to the user.

f. 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.

g. Siemens’ Physician Order Entry (POE or CPOE) provides electronic signatures by mapping the Invision/POE/Net Access Logon ID/Password to the six digit number assigned by the Medical Staff office. The six digit number is utilized to validate the status of the user by referencing a master profile. Physician Order Entry privileges are granted upon approval of the department chair or designee. The logon user name is assigned by Computer Services. The password is assigned by the user upon initial logon and requires entry of a new password at periodic intervals and disallows repetition of a password based on the past fourteen password resets. The password is not visible or cannot be viewed by anyone. After logging onto the application, the user’s name and credentials are automatically referenced and captured with each documentation entry. The user is prompted for re-entry of their password before the system allows completion of the entries on a record.

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

9/17/08

Date

Approved by Clinical Board: 8/15/00, 10/21/03, 1/16/07, 9/16/08
Written: 10/94
Revised: 9/97, 11/97, 5/98, 8/00, 10/03, 7/04, 12/06, 8/08
Reviewed: 12/06, 8/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

ACCURACY AND TIMELINESS OF MEDICAL RECORD DOCUMENTATION

Purpose:

To define general guidelines for documenting in the patient’s medical record.

Policy:

1. All entries must be legible, dated and signed.

2. Black or blue ink is recommended.

3. All original medical information must be included in the facility’s official paper or electronic medical record.

4. Abbreviations listed on the Prohibited Abbreviations List may not be used in the medical record.

5. Signatures should include the first name, last name, licensure status and pager number; initials alone are not acceptable.

6. Electronic signatures may be used as long as their use is consistent with appropriate policy/procedure.

7. Medical record entries must be completed in a timely manner. Records not completed within 30 days of discharge are considered delinquent.

8. Chart Completion Policy (Please see Chancellor’s Memorandum #17 for additional information)

   A. The Medical Records Department performs a weekly count of all incomplete and delinquent charts on Monday or the next business day if a holiday falls on Monday.

   B. A copy of the weekly chart count is e-mailed to the Hospital’s Medical Director, the Clinical Department Heads and Hospital Administration for review and corrective action.

   C. House Officers scheduled to rotate to local facilities are not exempt from their chart completion responsibilities at
LSUHSC-Shreveport during the time of rotation. House Officers scheduled to rotate to clinical sites outside the Shreveport Metropolitan area must complete all available incomplete records prior to departure.

9. A patient’s medical record is complete when the following criteria are met:

   A. Its contents reflect the patient’s condition on arrival, diagnosis, test results, therapy, condition and in-hospital progress and condition at discharge; and

   B. Its contents, including any required discharge summary or final progress notes, are assembled and authenticated; and

   C. All final diagnoses and complications recorded without the use of symbols and abbreviations.

10. The standard procedure for making changes or corrections to the medical record information is as follows:

    • Draw a single, thin line through each line of the inaccurate documentation, making certain that it is still legible
    • Date and initial
    • Add a note in the margin stating why the previous entry has been replaced
    • Enter the correction in chronological order
    • Indicate which entry the correction is replacing

    Never obliterate material in the medical record by scratching out, using liquid paper, felt tip markers, etc. Careless alternations create the appearance of tampering.

11. The Administration and medical staff shall provide for the ongoing program for standardization of the medical record format based upon the user needs.

12. Medical records shall be accessible 24 hours a day, seven days a week.

13. Health Information Management (HIM) shall be responsible for the release of any information for purposes other than treatment, payment and hospital operations or legally authorized reporting.
14. Deficient records for physicians protractedly unavailable to complete will be sent to the appropriate attending physician for completion. Records that cannot be completed after attending review will be referred to the Medical Records Committee for disposition. Upon determination by the Medical Records Committee the chart will be deemed complete for filing purposes. This designation will be noted on the record by placing a sticker on the face sheet with the date of the committee’s determination. The sticker states: “This chart has been filed incomplete by order of the Medical Records Committee.” The incomplete record will then be filed in the patient’s unit folder.

Reference: Chancellor's Memorandum 17

Administrator

_1/19/07________________
Date

Approved by Clinical Board: 3/20/01, 5/18/04, 1/16/07
Written: 10/94
Reviewed: 4/04, 12/06
Revised: 5/95, 4/98, 2/01, 9/03, 4/04, 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER -
SHREVEPORT

ABBREVIATIONS AND SYMBOLS

Purpose:

To establish standards for the use of symbols, acronyms and abbreviation in the patients’ medical records to improve patient outcomes.

To eliminate the use of potentially dangerous abbreviations and dose expressions used in prescribing medications.

Policy:

1. The Pharmacy and Therapeutic Committee and the Medical Records Committee approves and publishes a list of ‘Do Not Use’ Abbreviations in medical record documentation.

2. This list is approved by the Hospital Clinical Board.

3. The ‘Do Not Use’ Abbreviations List is posted on the facility’s web site at: http://www.sh.lsuhealthsc.edu/policies/policy_manuals_via_ms_word/ABBR.htm and in all patient care areas.

4. The use of symbols and abbreviations in making entries in the patients’ medical records is discouraged.

5. Abbreviations, symbols, acronyms, and/or initials are not acceptable in the final diagnosis, on consent forms, or in any information given to patients/families, such as educational materials.

6. Abbreviations with more than one definition may be used when the caregiver is reasonably able to identify the purpose/intent. When the intent is not clear, the abbreviations should be spelled out.

7. Uncommon abbreviations shall be spelled out on preprinted forms or a legend must be provided on the form.

8. Abbreviations for medications are discouraged. Unacceptable abbreviations that make an order unclear will be clarified with the
prescriber as part of routine pharmacist order intervention and clarification prior to implementation of the order.

9. The use of prohibited abbreviations will be monitored and reported through Medical Record Committee and Pharmacy and Therapeutic Committee.

10. The Hospital Clinical Board has adopted the following abbreviations as prohibited abbreviations:

PROHIBITED ABBREVIATIONS

The Clinical Board has adopted the following abbreviations as prohibited abbreviations at LSUHSC-Shreveport. Healthcare professionals are not allowed to use these when documenting in the medical record or on any form. Help your team; remind them that these abbreviations are not acceptable. These abbreviations have the potential to be misinterpreted, which can put the patient at risk.

<table>
<thead>
<tr>
<th>Prohibited Abbreviations</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U, u (unit)</td>
<td>Mistaken as zero, four, or cc</td>
<td>Write unit</td>
</tr>
<tr>
<td>IU (international unit)</td>
<td>Mistaken as IV or 10</td>
<td>Write international unit</td>
</tr>
<tr>
<td>QD, Q.D., qd, q.d., Q.O.D., QOD, q.o.d., qod (Latin abbreviation for once daily and every other day)</td>
<td>Mistaken for each other. The period after the Q can be mistaken for an “I” and the “O” can be mistaken for “I”</td>
<td>Write daily and every other day.</td>
</tr>
<tr>
<td>X.O - trailing zero . X mg - leading zero</td>
<td>Decimal point missing</td>
<td>Never write zero by itself after a decimal and always use a zero before a decimal point.</td>
</tr>
<tr>
<td>MS, MSO₄, MgSO₄</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate.</td>
<td>Write morphine sulfate or magnesium sulfate</td>
</tr>
</tbody>
</table>

11. A list of approved abbreviations is no longer required by JCAHO. A list of commonly used abbreviations is available on the website noted in this policy. More comprehensive lists of abbreviations, symbols and acronyms are available for reference through medical dictionaries or via the internet.
Approved by Clinical Board: 2/17/04, 1/16/07
Written: 12/03
Revised: 12/06
Reviewed: 12/06
USE OF ANIMALS FOR RESEARCH

Purpose:

To set forth procedures and guidelines for animal use experimentation and teaching when such involves University Hospital, the use of equipment, instrumentation, and/or space intended for human diagnostic, treatment, or monitoring. This policy statement includes the physical transport of animals to and from the Hospital, and the removal of equipment from the Hospital for use with animals for experimentation or teaching purposes.

Policy:

Before equipment and/or space intended for patient care can be used for animal studies, an Animal Resources Institutional Review Form must be submitted and approved by the Animal Care Use Committee (ACUC) for review. If Hospital equipment, instrumentation, and/or space is to be used in the procedures described in the protocol form, then a statement of approval from the individual responsible for the equipment, instrumentation, and/or space to be utilized must be included.

After approval from the ACUC and prior to initiation of work, a Standard Operating Procedures (SOP) document will be developed by the principal investigator, in conjunction with the individual from the Hospital responsible for the equipment, instrumentation, and/or space to be utilized during the animal procedures, and Animal Resources representative. Prior to granting “Full Approval” of any research protocol that requires the use of research animals within the University Hospital and/or the use of Hospital equipment on research animals, Standard Operating Procedures (SOPs) must be written and approved by the Director of Animal Resources, the Infection Control Department, the Safety Department, Hospital Administration, and various other entities/committees as applicable.

The following general guidelines will apply to all SOPs for animal use of University Hospital equipment, instrumentation, and/or space.

A. Whenever possible animal studies using Hospital equipment or instrumentation should be conducted outside the environs of the Hospital. If required equipment needed for the study cannot be moved, procedures for the transportation of the animals into and out of the Hospital must be arranged.
B. A supervisor responsible for patient use of instruments, equipment, and/or space should be in attendance when animals are used within the Hospital. If this is not possible, the principal investigator may be designated to fill this role by the department supervisor responsible for the use of the equipment, instrumentation, and/or space.

C. After use for animal studies, all equipment, instruments, and/or space must be returned to a status suitable for human patient use. This may require cleaning, disinfecting, recalibrating, etc. Any such activities will comply with existing hospital standards dealing with cleanliness of areas to be used for human patient care. Individual area standards will be followed in all cases.

D. Any unusual or unanticipated events occurring during the procedures (e.g., equipment malfunction, disturbances caused by animal subjects, etc.) must be reported in writing to the department supervisor responsible for the equipment/area used and the Director, Animal Resources.

These individuals are responsible for notifying the appropriate institutional officials of their respective institutions.

Any deviations from the approved animal protocol require approval from the ACUC. The request for a change may be made in the form of an addendum to the previously approved protocol or may require the submission of an entirely new protocol. Guidance may be sought from the Director of Animal Resources or Chairman of ACUC.

_____________________
Administrator

7/19/07
Date

Approved by Clinical Board: 5/15/01, 7/20/04, 7/17/07
Written: 2/94
Revised: 3/95, 5/01, 6/04, 6/07
Reviewed: 3/98, 6/04, 6/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

HANDLING OF FOREIGN OBJECTS CONSIDERED EVIDENCE, REMOVED FROM THE PATIENT’S BODY

Purpose:

To maintain the chain of evidence through proper handling and disposition of all bullets/projectiles, or other foreign bodies considered evidence that may be removed from a patient’s body.

Policy:

1. Upon removal from the body by the physician, all bullets/projectiles will be placed, unwrapped, in an appropriately sized plastic container, closed with a screw type lid, and sealed with the label that comes with the container. The label shall contain the patient’s name, medical record number, date of removal, and the physician’s name.

2. The Bullet/Projectile Evidence Receipt and Accountability Form (SN 6262) will be completed and signed by the M.D. and the nurse. This form is stocked in EMS and OR by the University Police Department (UPD) and may be obtained when needed for other areas by calling UPD at extension 6165.

3. Removal of the bullet/projectile will be documented in the appropriate section of the Medical Record, i.e.: Operative Report, Nursing notes, clinic notes, etc. If object is removed in the OR, nursing will also document in the appropriate OR log book at the nursing station.

4. Upon notification UPD will pick up the bullet/projectile and place in the evidence locker.
5. The appropriate public Law Enforcement Agency will be notified by UPD to pick up bullet/projectile and evidence receipt.

[Administrator's signature]

7/19/07

Date

Approved by Clinical Board: 5/15/01, 7/20/04, 7/17/07
Written: 8/95
Reviewed: 5/98, 6/04, 6/07
Revised: 5/01, 6/04
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

TRANSPORTATION SERVICES (EXTERNAL)

Purpose:

To provide appropriate means for the transporting of patients who must be sent to local hospitals or other designated areas for special tests or procedures.

Policy:

A. The physician shall be responsible for:

1. writing an order for transportation
2. designating what portion of patient’s medical record is to be photocopied and sent with the patient. (Originals will not be sent)
3. scheduling the test or procedure to be performed and
4. ordering IV to be changed to IV lock prior to transfer

B. During normal business hours 8:00 a.m. - 5:00 p.m. the Nursing Unit will contact the Case Manager. The Case Manager will be responsible for:

1. making the necessary arrangements for transportation and
2. notifying the nursing unit when transportation is available

NOTE: After hours the Administrative House Manager will be responsible for making the arrangements.

C. The physician or nursing unit shall be responsible for providing the following information when notifying the Case Manager or Administrative House Manager of the need for transportation:
1. patient’s name and medical record number, sex, age, and ordering physician
2. location (unit, room and bed number)
3. name of facility and department to which patient is to be transported
4. test or procedure to be performed
5. date and time for scheduled test or procedure and
6. mode of transport - wheelchair/stretcher/hospital courier

Approved by Clinical Board: 5/15/01, 7/20/04, 7/17/07
Written: 1/93
Reviewed: 10/96, 6/04, 6/07
Revised: 3/01, 6/04, 6/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

LOANING AND BORROWING EQUIPMENT AND/OR SUPPLIES

Purpose:

To delineate the procedure for loaning and/or borrowing equipment/supplies.

Policy:

I. Loaning

The loaning of equipment is limited to items needed immediately to ensure patient’s safety and well being, including equipment used directly and indirectly for patient care. Indirect patient care equipment includes items needed to ensure the smooth, uninterrupted operations of the hospital. (The borrower will make arrangements to pick up equipment/supplies.)

A. Equipment

1. Equipment may be loaned within the institution or an approved outside agency with approval of an Administrative House Manager, Department Manager or designee. There is no charge for loaned equipment.

2. Loaned equipment shall be checked prior to delivery to ensure that it has undergone recent inspection by Biomedical Engineering, as evidenced by a current inspection sticker.

3. All returned equipment must be sent to Biomedical Engineering for inspection.

B. Supplies

1. Supplies may be loaned to another hospital but must be replaced with an identical item or an item of equivalent value that is acceptable to the Lender. Custom supplies including those that are assembled by Central Medical Supply cannot be loaned.
2. Supplies may not be loaned internally; they may be transferred internally by completing an Internal Transaction Form to transfer the cost of the supplies from the seller to the buyer.

C. Delivery and return of the equipment or supplies is the responsibility of the Borrower.

D. Documentation

1. All loan transactions are recorded in a log maintained by each department: the inventory number, to whom and by whom the loan was made, and the expected date of return. In addition, an “Equipment/Supply Loan Borrow Record” (S/N 1112) is to be completed for loans to other hospitals.

2. When equipment and supplies are returned, the date and person receiving the return is indicated in the log. In addition, if an “Equipment/Supply Loan Borrow Record” (S/N 1112) was completed the same information is recorded on that form. Assurance of return of equipment and supplies is the responsibility of the Lender.

3. Periodically, the log should be reviewed by the appropriate department manager to ensure that the privilege of borrowing equipment and supplies from LSUHSC is not being abused and that the items are being returned in a timely manner (i.e. within ten days).

II. Equipment and Supplies borrowed by LSUHSC.

A. All borrowed equipment and supplies are recorded in the same log used for recording loans. The log includes the date, a description of the equipment or supplies, from whom and by whom the item was borrowed, and the expected date of return. In addition, an “Equipment/Supply Loan Borrow Record” (S/N 1112) must be completed for items borrowed from other hospitals.

B. Upon receiving borrowed equipment, the equipment shall be inspected by the Biomedical Department and a current biomedical inspection sticker should be verified.

C. When the borrowed item is returned, the date and the person returning the item is indicated in the log. In addition, if an
“Equipment/Supply Loan Borrow Record” (S/N 1112) was completed the same information is recorded on that form.

D. Transport of borrowed equipment/supplies:

1. During the day (8:00 a.m. - 4:00 p.m.) contact Hospital Administration to arrange for transportation of equipment/supplies.

2. After hours, holidays and weekends contact the House Manager who will make transportation arrangements with University Police. If the equipment/supply is very large, House Manager will send a second person to help Security with the transport.

Approved by Clinical Board: 4/17/01, 5/18/04, 5/15/07
Written: 9/96
Reviewed: 5/98, 3/04, 4/07
Revised: 3/01, 3/04, 4/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

CARE OF PERSONAL CLOTHING SOILED WITH A PATIENT’S BLOOD/BODY FLUID

Purpose:

To delineate policy regarding the laundering of an employee’s personal clothing, that becomes soiled with a patient’s blood/body fluids while on duty.

Policy:

1. An employee’s personal clothing (scrubs, uniforms, etc.) that become soiled with a patient’s blood/body fluids should not be taken home, but must be laundered by the Hospital Laundry.

2. The Hospital Laundry is open 0500 - 1800 Monday through Friday and 0600 - 1430 Saturday, Sunday and holidays. When the laundry is open, the employee shall go to the laundry and notify the Director/Assistant Director or Director/Supervisor in Charge that clothing has been soiled and scrubs are needed. The employee will then be provided a place in the laundry to change. Personal clothing will be laundered and returned to the employee as soon as possible, usually within the shift that it occurs.

3. When the laundry is not open, the employee shall contact the Administrative House Manager to obtain scrubs from the laundry.

   A. The soiled clothing is put into a plastic bag, sealed, labeled with the employee’s name, unit and unit phone number, and kept on the unit until the laundry opens the following day.
   B. The Unit Supervisor/Charge Nurse will assure that the soiled clothing is taken to the laundry when it opens. The employee will be notified by the laundry when the clothing is ready.

4. The employee will return the borrowed scrubs at the time the clean clothing is picked up from the laundry.
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

MANAGEMENT OF RADIATION PRODUCING EQUIPMENT

Purpose:

To ensure the timely notification of the System Radiation Committee of any radiation producing equipment that is acquired, relocated or removed from the LSUHSC – Shreveport hospital.

Policy:

1. The acquiring department shall notify the Hospital Radiation Safety Committee and/or the appropriate Administrator in writing of the anticipated purchase of any radiation producing equipment prior to the issuance of a purchase order. If equipment is being obtained as a donation, the receiving department shall notify the committee prior to the accepting the donation, specifying where the equipment is to be located and its’ anticipated use.

2. Prior to the relocation of radiation producing equipment within the facility or removal of equipment from the facility, the responsible department director shall notify the Hospital Radiation Safety Committee in writing of the plan. In addition, if the equipment is being moved into the medical school facility, the Medical School Radiation Safety Committee shall also be notified.

3. Physical Plant shall notify the Hospital Radiation Safety Committee of construction and/or additions/remodeling of facility that will house radiation-producing equipment prior to the beginning of construction.

4. The chair of the Hospital Radiation Safety Committee shall be responsible for notification of the Radiation Safety Officer of any acquisition or removal of equipment and any construction or renovations of space housing radiation producing equipment.

5. The Radiation Safety Officer shall:

   a. Notify the LSU System Radiation Safety Officer, in writing of pending purchase, acquisition, relocation or removal of radiation producing equipment.
b. Ensure that any radiation producing equipment entering the facility is registered with the Department of Environmental Quality.

c. Report the transfer of any such equipment to another state facility or state surplus to the Department of Environmental Quality.

6. Information required by Radiation Safety Committee:

a. Equipment Manufacturer

b. Equipment Model

c. Where it will be located

d. Use

e. Contact person/phone #

________________________
Administrator

3/19/09
Date

Approved by Hospital Radiation Safety Committee 6/20/2000
Approved by Clinical Board: 8/15/00, 11/18/03, 11/21/06, 3/17/09
Written: 6/00
Reviewed: 11/03, 10/06, 2/09
Revision: 11/03
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

CLINICAL ALARM SYSTEMS

Purpose:

To establish and identify guidelines for monitoring clinical alarm systems on hospital equipment.

Policy:

1. **Maintenance and Testing of Alarm Systems**
   User verification of proper alarm settings and functions are part of the equipment set-up recommended by all equipment manufacturers. Biomedical Engineering will test alarm systems on clinical equipment during periodic maintenance inspections and during technician rounds. Equipment with nonfunctional alarm settings, whether visual or audible, will be sent to Biomedical Engineering for repair.

2. **Appropriate Settings**
   Alarm settings are activated and appropriately monitored according to area/unit specific criteria or according to the patient’s medical condition/activity level.

3. **Alarm Audibility**
   Alarms are sufficiently audible with respect to distances and competing noise within the unit.

**Alarms are noted on the following equipment but are not limited to:**

- Pulse Oximeters
- Telemetry Monitors
- Ventilators
- Infusion Pumps
- Ventilator Heaters
- SCD Hose Machine
- Warming Blanket (Bear Huggers)
- Specialized Beds
- PCA Pumps
- Kangaroo Feeding Pumps
- CVVH Machines
Echo Machines
Balloon Pumps
Anesthesia Machines
Transport Monitors
D-Fib Packs
Call Bell
CCO Monitor
Portable Blood Pressure/Temperature Machine

Administrator

3/19/09
Date

Approved by Clinical Board:  1/21/03, 2/21/06, 3/17/09
Written:  1/03
Revised:  1/06
Reviewed:  2/09
USE OF CELLULAR PHONES

Purpose:

To define the appropriate use of cellular phones by employees, volunteers, patients, students, and visitors.

Policy:

Employee/student/volunteers:

1. The use of cellular phones or other electronic devices for personal phone calls, texting, or accessing of the internet for anything that is not work related is limited to those times when an employee or volunteer are on break from their work assignments.

2. Cellular phones or other electronic devices may be used in staff lounges/break areas, the cafeteria or designated smoking areas.

3. Cellular phones are not to be used by employees for personal business or social networking while in their work areas, including elevators, hallways, nursing stations, the Operating Room, any patient care or diagnostic area. Phones are to be turned off or on vibrate when the employee is not on break.

4. These devices are not to be used in patient rooms.

Patients/Visitors:

1. May use cellular phones as needed; use shall not be disruptive of others or interfere with the provision of care or treatment.
DELIVERIES OF MEDICAL DEVICES AND SUPPLIES DURING NON-STANDARD HOURS

Purpose:

To delineate the procedure for accepting, controlling, and tracking medical supplies and devices; packages; and letters that are delivered to the University by common carriers during times when the Receiving department is not available.

Policy:

1. At those times when the Receiving Department is not available, all medical supplies and devices, packages, and letters shall be taken to Central Medical Supply (CMS), Room KG-23. This counter (Dispatch Desk) will be available and personnel present 24 hours per day, 7 days a week, year round.

2. CMS will maintain a permanent log that shows the order information, delivery information, carrier name, charges (if any), any notifications done, and to whom the items are eventually signed out.

3. CMS person shall sign for and accept these items as per procedures set forth by the Receiving Department, retaining and copying all appropriate documentation for the items. CMS shall be responsible for the items until delivered or turned over to designated responsible parties.

4. If the delivery contains radioactive, biohazardous, or refrigerated material requiring special handling, the CMS person on duty shall immediately notify the University Police dispatcher. (CMS shall make a copy of all shipping documents and the copies will be sent with the delivery. CMS shall retain the originals until they can be turned over to the receiving department.) The carrier should remain until the University Police officer can escort this delivery person and items (with packing lists, delivery tickets, and so on) from CMS to a
place specially designated (usually G414D) as per University Police procedures.

5. Upon receipt of the package, letters, or materials, CMS personnel shall do one of the following:

a. If these items can be stored safely in CMS, they will be placed on a shelf designated for the purpose or in a readily available area near the CMS Dispatch Desk. Notifications will be made as described below. The items shall be clearly labeled as a “non-standard delivery needing further attention during normal business hours.”

b. If the items are designated for a particular doctor or clinician, CMS will notify the Hospital Switchboard to contact the recipient. Signatures will be obtained and copies will be made as per procedure, and the item released to the appropriate person or representative. If there is no response from the individual, the items will be stored in CMS until either the individual does take delivery or the items can be turned over to the Receiving Department for delivery, whichever comes first.

c. If the items are designated for a department, CMS shall notify the department by telephone, noting the time and to whom the call was made. Signatures will be obtained and copies will be made as per procedure, and the item released to the appropriate person or departmental representative. If there is no telephone response from the department, the items will be stored in CMS until either the department does respond or the items can be turned over to the Receiving Department for delivery, whichever comes first.

d. If the items are still present in CMS during normal operations hours of the Receiving Department, the CMS person shall immediately notify Receiving personnel who will, in turn, take possession of and have responsibility for the items.

6. Individuals picking up items shall be clearly identified with his or her name and signature written in the CMS log book. CMS shall retain the shipping and other receiving documents and turn these over to the Receiving Department at the earliest opportunity. The log book shall be the sole record retained by CMS.
Hospital Policy Manual
Policy Number: 7.17
Effective Date: 7/01/09

Administrator

6/18/09
Date

Approved by Clinical Board: 6/16/09
Written: 3/09
Revised:
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

EMERGENCY BIOMEDICAL SERVICE

Purpose:

To provide a system of emergency repair service to patient care, nurse call, and pneumatic tube equipment after regular business hours and on weekends and holidays.

Policy:

After hours Emergency repair of patient care, nurse call, and pneumatic tube equipment shall include those urgent situations where equipment service clearly cannot wait until the next business day.

A user that experiences equipment malfunctions or other operational errors in the equipment shall contact the Administrative House Manager to determine if it is justifiable to radio page the “On-Call” technician, or if the matter can wait to the next business day.

If an emergency is determined, the Administrative House Manager shall contact the LSU telephone operator requesting the Biomedical Equipment Technician “on-call” be paged. The on-call technician will contact the telephone operator for further information, department, contact person, etc. A standard “Work-Order” is still required as it serves as the primary tracking document for equipment repairs or service.

After the emergency situation has been attended to, the electronic technician will request the department to key in a Work-Order for the job (code BIOP). All repair actions, or other services performed, are entered by the technicians in the designated area of the Work-Order.

All work performed shall be entered into the historical record for that device. The record shall show date, indicate the nature of service/repair, action taken and repair technician’s name and time required completing the repair.

______________________________
Administrator

6/21/07

Date

Approved by Clinical Board: 4/17/01, 6/15/04, 6/19/07
Written: 4/89
Revised: 3/93, 3/98, 3/01, 5/04, 5/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER -
SHREVEPORT

BODY DONATION

Purpose:

To define the protocol for body donation at University Hospital.

Policy:

1. Any person wishing to donate his/her body should contact the Director of Anatomical Services, Department of Anatomy at extension 675-5320 or 675-5312. Bodies will not be accepted unless necessary paperwork is completed prior to death.

2. If the patient, at the time of death, has a donor card indicating he/she met and completed the necessary requirements to donate his/her body, the Department of Cellular Biology and Anatomy should be notified immediately at 675-5313, 8 a.m. – 5 p.m. Monday through Friday. If at night or on a weekend or a holiday, notify University Police at 675-6165.

3. The donated body must not be previously autopsied or embalmed. The Director of Anatomical Services reserves the right to reject any body that has damaged tissue. The Department of Cellular Biology and Anatomy will not accept body donation from persons with highly communicable diseases or if the person weighs 300lbs or more.

Administrator

8/22/07

Date

Approved by Clinical Board: 5/15/01, 8/17/04, 8/21/07
Written: 1/83
Reviewed: 3/95, 3/98, 4/01, 7/04, 7/07
Revised: 3/95, 3/98, 4/01, 7/04
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PAGER/BEEPER SYSTEM

Purpose:

To provide a communication system that establishes immediate one-way communication.

Policy:

1. All pagers/beepers shall be answered within ten minutes of a message being received. If a pager/beeper is not answered within this prescribed time frame, the individual initiating the page/beep will follow the chain of command until contact has been made with an appropriate staff member. A variance report shall be completed by the individual initiating the page/beep when response is not within the ten-minute time frame.

2. The pager/beeper system is owned and operated by LSU Health Sciences Center and is solely for the use of its staff. It provides a mechanism that allows for immediate access to staff facilitated by the Hospital Switchboard.

3. The Hospital Switchboard is responsible for the procurement and distribution of local pagers/beepers. To obtain local pagers/beepers – (25 mile radius) – requesting department submits an Internal Transaction (SN 1247) to the Hospital Switchboard A-1-14. The IT shall include the name of the person to whom the pager/beeper will be assigned and their office/contact telephone number. If the person will at any time be required to be on-call, a home or cellular contact number is required.

4. Telecommunications is responsible for the procurement and distribution of long range pagers/beepers. To obtain long range pagers/beepers – requesting department submits a memo indicating the type of pager/beeper requested and name of employee who will utilize it to Telecommunications Office G-112.

5. Funding for pagers/beepers and any repairs is the responsibility of the user department. User departments shall pay for replacement of pagers/beepers found to be obsolete or beyond economical repair. There is no monthly expense to the departments for local pager/beeper service. If the pager/beeper is lost or shows abuse other than normal wear and tear, the individual to whom it has been
assigned will be responsible for reimbursing the user department for the replacement cost.

6. Long range pagers/beepers incur a monthly charge which is billed to the user department by Telecommunications.

7. The Hospital Switchboard is responsible for facilitating the repair of local pagers/beepers.

8. Telecommunications is responsible for facilitating the repair of long range pagers/beepers.

9. To access the LSU local pager/beeper system, dial 675-7007 and follow the recorded prompts. A current pager/beeper list is maintained by the Switchboard and is available on the LSUHSC-S website (Navigation: Administration, Other Campus Services, Campus Directory).

10. Staff who have obtained pagers/beepers outside the institution are responsible for notifying the Switchboard by memo or email of their pager/beeper number.

11. Departments reassigning a previously issued pager/beeper to another person shall notify the Hospital Switchboard immediately of the reassignment by memo or email. The memo or email shall contain the pager/beeper number, the persons’ name and office/contact telephone number. If the person will at any time be required to be on-call, a home or cellular contact number is required.

Approved by Clinical Board: 2/17/04, 9/21/04, 8/16/05, 11/18/08
Written: 9/94
Revised: 3/97, 6/97, 2/00, 5/03, 2/04, 8/05, 10/08
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. (See Hospital Policy 7.6.1 for clarification of Coroner’s Case).
B. Permission: In general, the right to grant permission for the autopsy rests with the following persons IN THE ORDER NAMED:

1. Judically 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 person 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 house officer. 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 house officer 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 house officer 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

8/22/07

Date

Approved by Clinical Board: 5/15/01, 8/17/04, 8/21/07
Written: 2/83
Reviewed: 5/97, 2/98, 4/99, 3/01, 7/04, 7/07
Revised: 5/97, 2/98, 4/99, 3/01, 7/04
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

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.33:1563.

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 CADDOW PARISH
1031 Creswell
Shreveport, Louisiana 71101
(318) 226-6881

2. The Nursing Unit shall be responsible for notifying the Coroner’s
Office of a possible coroner’s case immediately upon the patient’s
death. (Reference Nursing Policy P-60)

3. 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

8/20/09
Date

Approved by Clinical Board: 3/19/02, 6/21/05, 7/15/08, 8/18/09
Written: 2/83
Revised: 10/95, 12/99, 2/02, 5/05, 5/08, 7/09
Reviewed: 4/98, 5/05, 5/08, 7/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

UNIVERSITY POLICE

Purpose:

To provide police service and assistance to all Louisiana State University Health Sciences - Shreveport patients, visitors, staff, faculty, students and the general public.

To safeguard from loss or destruction: all equipment, facilities and properties under LSUHSC-Shreveport jurisdiction.

Policy:

A. The University Police Department is staffed 24 hours a day, 7 days a week with State Commissioned Police Officers, Police Dispatchers and Facility and Ground Guards.

B. Those in need of immediate assistance from University Police should contact extension 6165.

C. The University Police Officers are responsible for:

   1. responding immediately to emergency calls from any LSUHSC area.

   2. enforcing Louisiana State Law and LSUHSC policies.

   3. assisting with vehicular difficulties.

   4. escorting employees to LSUHSC parking lots as requested.

   5. University Police physically patrol on lots at peak hours.

   6. orienting non-LSUHSC prisoner guards and forensic staff to their responsibilities while in the facility.

D. Any unusual or suspicious activity should be immediately reported to University Police.
E. Location and hours of operation:

Medical School
G-201 & 213
Monday – Friday
8:00 a.m. – 4:00 p.m.

Hospital
B1-1
24 Hours a day/7 days a week

Approved by Clinical Board: 5/15/01, 7/20/04, 7/17/07
Written: 4/95
Reviewed: 6/07
Revised: 4/98, 4/01, 6/04
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

POSTING OF ANNOUNCEMENTS

Purpose:

To provide for the posting of announcements/notices throughout LSUHSC –Shreveport while maintaining an appropriate environment within the facility.

Policy:

1. Employees of the institution, with the authorization of the responsible department director, may post announcements/notices on unlocked bulletin boards throughout the hospital. If the bulletin board is located in a common area, postings are allowed provided the posting is non-solicitous in nature (Administrative Directive 2.8.4) and in good taste.

2. Announcements of an educational nature or items of general interest may be posted, if desired, in the locked bulletin board on first floor main corridor by obtaining approval from Hospital Administration.

3. Posting of announcements/notices in non-designated areas is not allowed. At no time are announcements/notices to be posted on walls or surfaces other than a bulletin board.

Administrator

7/19/07

Date

Approved by Clinical Board: 5/15/01, 7/20/04, 7/17/07
Written: 4/95
Reviewed: 6/07
Revised: 3/98, 5/01, 6/04
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PHARMACY SERVICES

Purpose:
To establish responsibility for drug distribution and appropriate drug therapy for both inpatient services and the outpatient clinics within the guidelines of State & Federal Regulations, JCAHO and standards of practice.

Policy:

1. Pharmacy Location Hours Telephone
   Central Pharmacy AG-13 24 hours daily 675-5175
   Feist-Weiller Cancer Center B-410 8am-4:30pm M-F 813-1500
   Satellite
   ACC Pharmacy 1606 Kings Hwy 9-11am, 1-4pm M-F 813-1815
   Shreveport, LA
   Viral Disease 6670 St. Vincent Ave 8 am-4:30 pm M-F 862-9895
   Shreveport, LA

2. Pharmacy Services shall be responsible for responsive and accurate drug storage, distribution, appropriate and safe usage of drugs, inventory control, budget, patient billing for medications and all policies and procedures regarding such activities. Select department specific policies regarding medication distribution, administration and control shall be submitted to the P&T Committee for review prior to initiation. The pharmacy shall review all non-emergent/non-urgent medication orders prior to administration.

3. Drugs stocked in the hospital
   A. Only drugs approved for inclusion in the United States Pharmacopoeia, National Formulary, New Drugs or Accepted
Dental Remedies, or which are approved by the Hospital's P&T Committee, shall be eligible for use in the Hospital. Drugs requested by members of the Medical/Dental staff not listed in the above compendia, or not yet evaluated by the P&T Committee shall be obtained and considered tentatively approved only if the request is signed by the department head or service chief. Tentatively approved drugs shall be submitted to the P&T Committee for evaluation at the next scheduled meeting.

B. Drug products classified by the FDA as ineffective will not be stocked by the Hospital Pharmacy; possibly effective drugs may be obtained at the individual physician’s discretion.

C. The Pharmacy shall be responsible for informing the appropriate physician and nursing unit if a drug or dosage form is not immediately available.

D. LSUHSC Pharmacy will substitute generic equivalents of brand name drugs ordered. If the physician has reasons to believe the generic drug is not equivalent, such information should be documented and forwarded to the Pharmacy.

E. Pharmacy will not purchase over-the-counter non-formulary medications.

4. Compounding of Items

A. In situations where drugs not commercially available are widely used based on literature reports and where there exists a recipe for the preparation of these products, Pharmacy will prepare them when possible.

B. If a recipe is not available or if the product is to be made from non-sterile drugs or impure chemicals, the prescriber will submit a completed non-formulary request and the P&T Committee (or P&T Committee Chairperson/Medical Director in an emergent situation) will review the feasibility of Pharmacy mixing these products on an individual basis.

5. Drug packaging and Labeling

The Pharmacy Service shall be responsible for the proper packaging and labeling of all drugs or chemicals dispensed by the Pharmacy for use in patient treatment. Labels used by the Pharmacy shall be distinctive and not used by other Hospital departments.
All medications shall be labeled with:

- Drug name, strength and amount (if not apparent from the container),
- Expiration date when not used in 24 hours,
- Expiration time when expiration occurs in less than 24 hours
- For all compounded IV admixtures and parenteral nutrition solutions, the date prepared and the diluents
- Patient name
- Patient location
- Directions for use and applicable cautionary statements either on the label or attached as an accessory label (example: requires refrigeration or for IM use only)

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Administrator

2/23/07
Date

Approved by Clinical Board:  June 2000, 4/17/01, 2/17/04, 2/20/07
Written 3/95
Reviewed:  11/97, 12/06
Revised:  2/01, 1/04, 12/06
Combined 8.1, 8.1.4, 8.1.1, 8.1.3 and 2 new (1/29/04)
OUTPATIENT PRESCRIPTION AVAILABILITY

Purpose:
To define the status of outpatient prescription dispensing.

Policy:
It is policy that the hospital's Central Pharmacy dispense outpatient prescriptions only under the following circumstances:

1. Patients prescribed anti-tubercular medications may receive the first four weeks supply free of charge from Central Pharmacy. Social Services shall be given duplicate prescriptions to be provided (with other data) to the Office of Health Services and Environmental Quality for maintenance medications through the parish Health Unit.

2. Investigational drugs may be dispensed to discharge patients as dictated by protocol.

3. Viral Disease Clinic patients who meet financial eligibility may be dispensed medications free of charge at the Clinic Pharmacy if the medication is on the clinic’s approved formulary list. (See Viral Disease Clinic policies for eligibility.)

4. Employees screened by Occupational Health Clinic, or the Emergency Room after hours, who require post-exposure chemoprophylaxis for HIV following a blood/body fluid exposure or for Brucellosis exposure, may have a 3-day supply of medications filled free of charge in central pharmacy. Additional prescriptions will be given to the patient to have filled at a retail pharmacy. Workmen’s Compensation may be filed.

5. Patients screened by case management and enrolled in manufacturer’s patient medication programs are eligible to receive free medications through the ACC Pharmacy.
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

MEDICATIONS BROUGHT INTO HOSPITAL BY PATIENTS

Policy:

Patients are encouraged to bring medications and alternative/herbal remedies they are currently taking to the hospital at the time of admittance to assist the physician during the history procedure. Such medications and/or supplements should preferably be removed from the hospital premises at the conclusion of the admitting history procedure or should be packaged and stored with the patient’s other belongings as per Hospital Policy 2.4 (Patient Valuables) and returned to the patient at the time of discharge.

If it is necessary for a patient to continue therapy on a medication that is not normally available from the pharmacy (i.e., a non-formulary drug), the patient’s own supply may be used provided the conditions below are met. Herbal remedies and alternative medications will not be allowed.

1. A physician writes an order in the patient’s chart. The order must include the name, strength, dose, frequency and route to be administered. Writing “Patient may take own med” without the name, strength and dose of the medication is not considered a legitimate order.

2. The patient’s own medication is identified by a pharmacist.
   a. Since intravenous admixtures and total parenteral nutrition solutions cannot be positively identified, the patient’s supply of these medications may not be used.
   b. The patient’s home controlled substance may not be used. Exception: The pharmacy director/designee may allow use of:
      1). the patient’s own medications for treating ADD/ADHD/narcolepsy when deemed appropriate,
      2). pregabalin (Lyrica®)
   c. Any medication whose contents or integrity cannot be verified (e.g. opened oral liquids, ophthalmic solutions) may not be used.
d. If the medication cannot be identified, is adulterated, or otherwise unsuitable for use, the pharmacist will notify the patient’s physician, and the patient’s own med may not be used.

3. If the prescriber indicated that a patient may use their own medication, the drug order must be entered into the pharmacy computer system patient profile so that drug interactions, incompatibilities and patient allergies can be checked.

4. The nursing staff will send the patient’s home medication, along with a consult form (S/N 1186) to the pharmacy department for identification.

5. The medication is then returned to the patient care area to be stored with other medications and administered by a nurse. The completed consult form is added to the medical record.

6. Medications administered that are brought in by the patient must be recorded on the Medication Administration Record (MAR).

7. All existing IV’s shall be changed out upon admission to the hospital.

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Administrator

6/21/06

Date

Approved by Clinical Board: 5/16/00, 12/17/02, 4/19/05, 5/16/06, 6/20/06
Written: 11/99
Approved by P & T Committee 11/15/99
Revised: 4/01, 1/03, 3/05, 5/06, 6/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - 
SHREVEPORT 

CONTROL OF MEDICATIONS 

Purpose:

To define, control, and secure the handling of all medications, including controlled substances, in each patient care area, so as to conform to the policies of the Pharmacy and Therapeutics Committee, JCAHO, and Federal and State Regulations.

Policy:

Medications stocked in a patient care area should be secured in a locked Automated Drug Distribution System (ADS). This includes DEA Schedule II, III, IV and V Controlled Substances.

I. Departments with Automated Dispensing Machines

A. User Access

1. Only individuals authorized to administer, dispense or stock medications will be given access to the system.

2. An authorized unit manager must complete an ADS Account Application (attached) for each new user. The five (5) digit employee ID badge number that will serve as the user’s identification number must be entered on the application in the appropriate space. The completed application is sent to the Pharmacy Department.

3. Authorized Pharmacy Department personnel will assign the new user access to a dispensing machine or machines depending on the user’s primary work area. A password or personal identification number (PIN) is chosen by the user at the time of initial system entry. This PIN number along with the employee ID badge is used to gain system access. No other person, including Pharmacy personnel, shall have knowledge of a user PIN. PIN numbers are changed every 90 days.

4. Medications are removed from the ADS by authorized users per order of a licensed prescriber and are
administered to registered patients of the medical center. Staff (exception Residents) shall not routinely procure medications from ADS for personnel with access.

5. User training is the responsibility of unit personnel in the user’s primary work area. Once training is completed a written competency assessment is required. The manager for the user’s primary work area is responsible for assuring that proper training and competency assessment is performed.

6. Each unit manager will notify appropriate pharmacy personnel as soon as possible when an employee with ADS access rights terminates, transfers to another work area, or is demoted and no longer needs access privileges. Pharmacy personnel will remove user access to the ADS immediately once this notice is received.

B. Dispensing

Medications are stored in the ADS in a unit dose module, a drawer module, a supply cabinet or a locked refrigerator. Adequate supplies of designated medications are maintained in each ADS by the Pharmacy Department.

1. Unit dose module (UDM):

Most controlled substances are stocked in a UDM. The UDM dispenses a single dose of medication for each dose requested. Each user will assure the correctness of the drug and quantity dispensed by the UDM. Each user will report all failures by the UDM to dispense correctly through the use of a discrepancy button.

2. Drawer, supply cabinet, or refrigerator:

When a medication stored in one of these areas is requested, the drawer or door of the supply cabinet or refrigerator opens. The user then removes the requested drug and the requested number of doses. If a controlled substance, the user must count and enter into the ADS the number of doses remaining in the position.
3. Waste:
   a. If necessary to administer a partial dose of a controlled substance, an authorized witness must observe the entire waste. The disposal must render the product unrecoverable. User and witness must document waste in the ADS.
   b. Fentanyl patches should be folded in half with the stick sides together and disposed in the sharps container. The nurse removing the patch should be careful not to touch the sticky side of the patch. Document the waste on the patient’s MAR. A witness and signature are required.
   c. IV tubing containing a controlled substance shall be evacuated thoroughly and discarded.

4. Returns:

   All unused medications are to be returned to the ADS. When a return is entered into the ADS, the return drawer or the original supply position will open to allow placement of the medication. No partial or opened containers shall be returned to the ADS. Partial or opened container contents should be wasted as described above.

C. Discrepancies

   The ADS maintains a perpetual inventory for each stocked and returned controlled substance. A count discrepancy occurs when a user enters a count, either on a supply position or return drawer that does not agree with the count maintained by the ADS.

   1. All ADS users are responsible for the maintenance of accurate supply counts and accurate controlled substance records.
   2. Dispensing and count discrepancies are noted through the use of the ADS discrepancy button.
3. If a user fails or cannot note a discrepancy through the use of the ADS discrepancy button, then the user will submit a written explanation of the discrepancy to the Pharmacy Department through the use of a Problem Reporting Form. Problem Reporting Forms can be found on each unit where an ADS is located.

4. All controlled substance discrepancies must be resolved through the entry of an acceptable explanation into the ADS. Pharmacy personnel will attempt to resolve each discrepancy on the day that it is first noted through the use of available reports or contact with involved users or unit managers.

5. A variance report will be completed and submitted by Pharmacy to the Hospital Quality Management department for each discrepancy involving a controlled substance that cannot be resolved or explained in a timely manner.

6. Pharmacy management will monitor and track discrepancies and discrepancy resolution. Discrepancy reports will be submitted to Hospital and Nursing Administration and the Pharmacy and Therapeutics Committee when required.

D. ADS Problems

All problems with the ADS should be immediately reported to Pharmacy department personnel.

II. Medication Storage in Areas Without an Automated Dispensing Machine

Areas without an automated drug distribution system shall store medications according to the following guidelines. All such areas must request and be approved by the Pharmacy Department to store medications outside of the dispensing unit.

A. Medications are stored under conditions to ensure stability.

B. All medications including nonprescription medications are in locked containers in a room or are under constant surveillance by appropriate personnel.
C. Medications that are easy to confuse (sound alike and look alike drugs or reagents or chemicals that may be mistaken for medications) are segregated.

D. All medication storage areas are periodically inspected according to department policy to ensure medications are stored properly.

E. Medications and chemicals used to prepare medications are accurately labeled with:
   1. Contents
   2. Expiration dates
   3. Appropriate warnings

III. Emergency Drugs

A. The Special Care Committee reviews emergency medications stocked on crash carts periodically.

B. Pharmacy will provide crash cart medications in sealed drawers to Central Medical Supply (CMS) to be placed in cleaned, refilled crash carts immediately prior to locking. Reference Hospital Policy 5.12.1.

IV. Management of Automated Dispensing Machine Data

A. The ADS maintains electronic records of all transactions involving the medications stocked within. These records are not a substitute for proper charting of the administered medications.

B. Nursing Managers will analyze and respond to management reports that are generated from automated medication and documentation systems. Response to reports will be kept on file for one year.

V. Downtime Procedures – Electricity is available to ADS

A. The nurse or pharmacist identifies some or all computer system communications are disrupted and informs the opposite department (Nursing/Pharmacy).
B. The pharmacist calls computer services help desk to verify extent of system affected.

C. If diagnosis and repair can’t be completed quickly, pharmacy will contact the nursing house manager and request the switchboard to announce outage through the overhead paging system.

D. If the senior pharmacist determines that medication procurement for patients will be seriously affected by operating with partial computer information systems, the pharmacy will take the MedSelect server off-line. This will allow all stocked medications to be obtained through override. MedSelect will display a red header indicating network communications are interrupted. MedOrder will not be available.

E. The RN, RN applicant, or LPN will create a manual MAR (Medication Administration Record) using the previous day’s MAR and by reviewing physicians orders.

F. The nurse **shall not reboot** the automated dispensing machine, as this will cause the machine to become inoperable.

G. The patient care unit will write the floor/unit on all copies of physician orders sent to the pharmacy.

H. In the event that the pneumatic tube system is down and a stat dose is needed, the unit shall send a runner to obtain the medication. Routine medications can be picked up by anyone on the floor; a licensed nurse will pick up narcotics.

I. For more detailed information, refer to the MedSelect User Manual on your unit.

VI. Downtime Procedures – No electricity

A. Notify pharmacy immediately.

B. The pharmacy will provide keys to the units as needed.

C. The Charge Nurse will put the form “MedSelect – Backup Manual Transactions on the ADS. All medication transactions shall be documented on this form. The
pharmacy will pick these forms up after electricity has been restored. **This document does not replace the MAR.**

D. Please refer to the MedSelect User Manual on your unit for downtime procedure.

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Approved by Clinical Board 1/16/01, 4/20/04, 7/20/04, 6/21/05, 6/17/08
Written: 1/01
Revised: 2/04, 6/04, 5/05, 5/08
Reviewed: 12/03, 5/08
DIEBOLD/MEDSELECT COMPETENCY ASSESSMENT

Name __________________________  SS# ________________    Unit_________

<table>
<thead>
<tr>
<th>Procedure/Task</th>
<th>Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Log In</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Assignment of ID and PIN number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Machines that can be accessed by employee</td>
<td></td>
<td></td>
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<tr>
<td>3. How to log in</td>
<td></td>
<td></td>
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<tr>
<td>4. How to change PIN</td>
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<tr>
<td>5. What to do when you forget your PIN</td>
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<tr>
<td><strong>II. Patient Selection</strong></td>
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<td></td>
</tr>
<tr>
<td>1. How to pick a patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How to Find/Add a patient not on the screen (can only get overridden meds)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Explain importance of entering medical record number of patient added</td>
<td></td>
<td></td>
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<tr>
<td><strong>III. Machine Set Up</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Explain the difference in unit dose module, drawer module, supply cabinets, and refrigerator</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Med Order Display</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Explain the difference between medications written in black or gray print</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. black print means the medication is available from the machine</td>
<td></td>
<td></td>
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<tr>
<td>b. gray print means the medication is not available from the machine and must be dispensed as a patient specific order from the pharmacy</td>
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<tr>
<td>2. Explain reason why some medications are not available on the machine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. out of stock</td>
<td></td>
<td></td>
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<tr>
<td>b. position failed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. medication is seldom used or not stocked on machine</td>
<td></td>
<td></td>
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<tr>
<td>3. Demonstrate how to select medication by generic or trade name</td>
<td></td>
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<tr>
<td>4. Explain the significance of the number in parentheses after a medication name</td>
<td></td>
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<tr>
<td>5. Explain the significance of a dark black arrow to the right of the medications listed</td>
<td></td>
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<tr>
<td>6. Demonstrate that the dose will disappear from the screen after the scheduled medication is given</td>
<td></td>
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<tr>
<td>7. Observe that scheduled medication are displayed first, according to due time, then PRNs</td>
<td></td>
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</tbody>
</table>
### IV. Due Window
1. Observe that scheduled medications appear on the screen two (2) hours before they are due
2. Observe that only scheduled medication falling within the due time will be displayed

### V. Late Window
1. Observe that a medication not given by its due time will appear highlighted in yellow
2. Explain that after four (4) hours after due time the medication will no longer be displayed/available for dispensing
   a. A variance should be written per hospital policy

### VI. Dismiss
1. Demonstrate how a scheduled medication not administered for a clinical reason should be dismissed from the screen
   (if a scheduled medication is not dispensed, it will print to an error report)

### VII. Misc Buttons
1. Explain the rationale for the Hide Meds button
2. Explain the rationale for the Hide PRN’s button
3. Demonstrate the use of the Hide IV’s button

### VIII. Med Supply Button
1. Explain what Med Supply Button is used for (dispense medications or as override situation)
2. Demonstrate how to select medication “Kit” if applicable

### IX. Controlled Substances
1. Demonstrate how to count drug remaining in drawer/cabinet/refrigerator
2. Explain what happens when count is incorrect
3. Explain what to do when medication is not dispensed in the correct quantity
4. Demonstrate/Explain use of Discrepancy Button
5. Explain what to do when system says call the system Administrator

### X. Returns and Wastes
1. Explain importance of medication units (i.e. mg, mcg, vl) in return and waste
2. Demonstrate how to return medication to machine
3. Demonstrate/explain how to record and witness waste
4. Discuss/Explain how returning or wasting a full scheduled dose will return that dose to the MedOrder screen
Troubleshooting
1. What to do when the screen is blank
2. What to do when screen freezes
3. What to do when medication not displayed on screen

X. Procedure/Task

Printers
1. How to obtain paper for the printer
2. How to add paper to printer
3. How to read the printout

Logging Off
1. How to log off machine
2. Explain the importance of logging off after use

*Managers
1. How to request employee access from pharmacy
2. How to give temporary employee access
3. How to read discrepancy log
4. How to read reports
5. How to correct a counting discrepancy

Qualified Observer Signature ___________________________ Date ________
Employee Signature ______________________________________ Date ________

NOTE: When everyone on the unit has completed the checklist, send lists as a group to Patient Care Support/Education for documentation on computerized education record.
DIEBOLD AND MEDSELECT COMPETENCY CHECKLIST

Print Name: _______________________________

Unit: _______________________________

Date Reviewed CD Rom: ______________________

Date Competency Assessment Completed: __________________________

The above competencies have been met.

Qualified Observer Signature: __________________________ Date: ____________

Employee Signature: _________________________________ Date: ____________

*PLEASE RETURN THIS FORM TO YOUR MANAGER*
LSU HEALTH SCIENCES CENTER

ADS (DIEBOLD) USER ACCESS APPLICATION

LAST NAME: ___________________________ FIRST NAME: ___________________________

USER NUMBER: _____ _____ _____ _____ _____

(This number must be entered—5 digit number on back of employee ID badge)

USER’S PRIMARY WORK AREA: ___________

GROUP PROFILE (Check one)  (examples listed below)

☐ Nurse - Staff
☐ Nurse - Manager
☐ Nurse – Contract (ending date___________ )
☐ CRNA / SRNA
☐ No Controlled
☐ Other ________
☐ Physician - Anes
☐ Physician - Samples

☐ User has a signed copy of the LSUHSC Confidentiality Agreement in their employee file.

UNIT MANAGER
/AUTHORIZED SIGN: __________________________DATE: ____________

PHONE: ______________

SEND TO PHARMACY WHEN COMPLETE

INCOMPLETE APPLICATIONS WILL BE RETURNED

PHARMACY WILL CONTACT MANAGER WHEN USER IS ENTERED INTO SYSTEM

______________________________
For pharmacy use only

ENTERED into The Automated Drug Dispensing Machine:

BY: ______________ DATE: ______________

MANAGER CONTACTED: DATE: ___________ TIME: ___________ BY: ___________
ADS PROBLEM REPORT

Replace this form with LSUHSC form S/N #7152.
# MedSelect - BACKUP MANUAL TRANSACTIONS

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>MR #</th>
<th>MEDICATION (INCLUDE STRENGTH AND DOSAGE FORM)</th>
<th># DOSES DISPENSED</th>
<th># DOSES RETURNED</th>
<th>AMOUNT WASTED</th>
<th>RN SIGNATURE/CO-SIGNATURE (WASTE MUST INCLUDE CO-SIGNATURE)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>
USE OF PREFERRED MEDICATIONS (THERAPEUTIC INTERCHANGE)

Purpose: To optimize patient care within the framework of cost containment and treatment efficacy.

Policy: Pharmacists are permitted to convert medication orders to an approved equivalent as determined by the Pharmacy and Therapeutics Committee and approved by the Clinical Board. Medication and dose conversion will follow approved protocols. These protocols will be reviewed and revised as needed to ensure the achievement of the desired therapeutic outcomes and economic advantages.

Procedure

- Medication conversions shall be automatic.
- Pharmacists shall perform the conversion at the time of order entry. Orders shall be written according to Clinical Board protocol and shall contain the pharmacist’s signature.
- The pharmacist shall evaluate all new orders as to the need for dosage adjustment in patients with decreased renal function, and the physician contacted if dosage reductions should be considered.
- Use of alternative medications must be approved by the Associate Dean for Clinical Affairs or his designee.

1. **Low Molecular Weight Heparin Equivalency and Conversion Protocol**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Patient Type</th>
<th>enoxaparin dose (Lovenox)</th>
<th>change to dalteparin (Fragmin)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DVT/PE prophylaxis</td>
<td>Surgical High Risk</td>
<td>40mg SQ QD</td>
<td>5000u SQ QD</td>
</tr>
<tr>
<td></td>
<td>(abdominal, pelvis, &amp; lower extremity)</td>
<td>30mg SQ Q 12h</td>
<td>5000u SQ QD</td>
</tr>
<tr>
<td></td>
<td>Surgical Moderate Risk</td>
<td>30mg SQ QD</td>
<td>change to heparin</td>
</tr>
<tr>
<td></td>
<td>30mg SQ BID</td>
<td></td>
<td>5000u SQ BID</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>30mg SQ Q 12h</td>
<td>5000u SQ QD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>40mg SQ QD</td>
<td>5000u SQ QD</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>30mg SQ BID</td>
<td>change to heparin</td>
<td></td>
</tr>
</tbody>
</table>
OR dalteparin 2500u SQ QD 5000u SQ BID

DVT/PE treatment
All patients 1mg/kg SQ Q 12h
200u/kg SQ QD (max 18,000u/day)

Acute Coronary Syndrome Treatment
All patients 1mg/kg SQ q 12h
120u/kg SQ q 12h (max 10,000u SQ q 12h)

2. **ACE Inhibitors** –
   Fosinopril and Captoril will be the only available formulary agents. Therapeutic interchange will be based upon lisinopril 1 mg = benazepril 1 mg = quinapril 1 mg = moexipril 0.75 mg = ramipril 0.25 mg = trandalopril 0.1 mg = fosinopril 1 mg; enalapril total mgs/24 hours = fosinopril totals mgs once daily

3. **Alpha-1 Adrenergic Blockers** –
   Terazosin 2.5 mg = prazosin 1 mg bid = doxazosin (Cardura) 2 mg (exception – prazosin use for PTSD)

4. **Analgesics** –
   Hydrocodone/APAP 10/500 = Hydrocodone/APAP 10/325; Oxycodone/APAP 5/325 (Percocet-5®) to equivalent dose based upon oxycodone content

5. **Anesthetics/Sedatives** –
   Lidocaine 2.5%/Prilocaine 2.5% (EMLA®) topical = Lidocaine 4% (LMX®) topical
   Propofol (Diprivan) for injection = Propofol for injection

6. **Antiepileptics** –
   Phenobarbital 100 mg = Phenobarbital 97.2 mg

7. **Angiotensin Receptor Blockers** – Valsartan will be the only formulary agent. Therapeutic interchange will be based upon irbesartan 150 mg = candesartan 16 mg = telmisartan 40 mg = valsartan 80 mg; losartan 1 mg = valsartan 1.6mg

8. **Anticholinergics** –
   Chlorzoxazone/poxide/clindinium bromide (Librax®) capsules = L-hyoscyamine sulfate (Levsin®) 0.125

9. **Antihistamines** –
   Hydroxyzine pamoate (Vistaril®) = Hydroxyzine HCl (Atarax®)
   Desloratidine (Claritine®) 5 mg = Loratidine 10 mg

10. **Anti-infective Agents** –
    Fluoroquinolones –
Levofloxacin (all forms) 250mg/500 mg = Moxifloxacin 200 mg/400 mg respectively (all forms)

Carbapenems –
Imipenem/cilastin injection will be the only formulary agent. Dosing should be individualized to each patient.

11. **Antidepressants** –
   Bupropion (Zyban) 150 mg tablet = Bupropion (Wellbutrin SR) 150 mg SR tablet
   Paroxetine (Paxil CR®) 25 mg = Paroxetine (Paxil®) 20 mg

12. **Antiplatelet agents** -
   Aspirin 81 mg = Aspirin enteric coated 81 mg

13. **Beta Blockers** -
   Metoprolol long-acting (Toprol XL) 1 mg daily = Metoprolol 0.5 mg bid
   Carvedilol extended release (Coreg CR®) 10 mg capsule daily = Carvedilol (Coreg®) 3.125 mg oral tablet bid

14. **Calcium Channel Blockers (long-acting oral)** –
   a. Amlodipine/Felodipine – Felodipine 1 mg = Amlodipine 1 mg
   b. Nifedipine – GITS (Procardia XL) 1 mg = Nifedipine wax matrix (Adalat CC) 1 mg
   c. Nisoldipine (Sular) 4 mg = Amlodipine 1 mg

15. **Calcium Supplements** –
   a. Calcium carbonate 500 mg tablet = calcium carbonate 650 mg tablet
   b. Calcium citrate 950 mg tablet = calcium carbonate 650 mg tablet

16. **Combination products** –
   May be interchanged with individual products

17. **Diuretics** –
   Torsemide (Demadex®) 1 mg = Furosemide 2 mg

18. **H2 Antagonists (all forms)** –
   ranitidine 150 mg = nizatidine 150 mg = famotidine 20 mg

19. **Inhaled Anticholinergics/Beta Agonists** –
   Albuterol HHN q4h & Ipratropium HHN q6h = DuoNeb® HHN q4h,
   Albuterol HHN q6h & Ipratropium HHN q6h = DuoNeb ® HHN q6h
20. **Iron Supplements** –
Ferrous sulfate 300 mg = Ferrous sulfate 325 mg

21. **Magnesium oxide agents** –
400 mg = 420 mg

22. **Oral Hypoglycemic Agents** -
Glyburide: 1.5mg PresTab = 2.5mg glyburide regular release tablet
3 mg Pres Tab = 5 mg glyburide regular release tablet

Glipizide Extended Release: Equals equivalent total daily doses of
glipizide regular release dosage in 2
equal doses

Glimepiride (Amaryl) 1 mg = Glyburide 2.5 mg

Metformin (Glucophage XR) 500 mg = metformin immediate
release tablet in equivalent divided daily doses

Rosiglitazone (Avandia) 1 mg = Pioglitazone (Actos) 7.5 mg (max.
45 mg)

23. **Proton Pump Inhibitors** –
Omeprazole 40 mg = esomeprazole 20 mg = lansoprazole 30 mg =
rabeprazole 20 mg = Pantoprazole 40 mg
(exclusion for pediatrics – lansoprazole (Prevacid®) oral
tablet/granules/liquid for pantoprazole (Protonix®) oral doses less
than 40 mg with a 1mg to 1mg interchange equivalency with
maximum single doses of 30mg and 40mg respectively)

24. **Renal Replacement Oral Vitamins** –
All formulations = Vitamin B & C tablet (currently Nephplex)

25. **Sedatives/Hypnotics** –
Zolpidem CR (Ambien CR®) 6.25 mg = Zolpidem 5 mg

26. **Statins** –
fluvastatin 20 mg = lovastatin 20 mg = pravastatin 20 mg =
simvastatin 20 mg = atorvastatin 10 mg = rosuvastatin 10 mg

25. **Stool Softener** –
Docusate sodium (Colace) 100mg/10mL = docusate calcium
(Surfak) 240 mg
Administrator

10/23/09
Date

Approved by Clinical Board:  7/00, 9/02, 11/03, 11/21/06, 10/20/09
Reviewed:  10/03, 10/06, 9/09
Revised:  10/03, 10/06, 9/09
Louiana State University Health Sciences Center - Shreveport

Intravenous to Oral/enteral (IV to PO) Medication Switch Policy

Purpose:

The purpose of this program is to provide a process for changing certain parenteral medications to the oral/enteral route when medically appropriate. The key elements of the program are:

- To provide an oral/enteral dosage form with comparable bioavailability to the intravenous form, which could reduce length of stay
- To avoid the added risks associated with continued intravenous therapy
- To lower overall medication and associated costs to the patient and institution

Policy:

I. Histamine Receptor Antagonists

Eligible patients, as determined below, will be switched from the intravenous form of H2 Receptor Antagonists or Proton Pump Inhibitor to the oral agent when bioequivalency criteria are met and approved by the P&T Committee and Clinical Board.

A. Criteria: Patient must meet at least one of the Inclusion Criteria and none of the Exclusion Criteria:

1. Inclusion Criteria patient is:
   a. Able to eat regular or modified diet, or
   b. Receiving enteral nutrition by the oral route, or gastric or other appropriate enteral tube, or
   c. Receiving other medications by the oral route

2. Exclusion Criteria patient is/has:
a. Unable to swallow, or refuses medication, or is NPO for procedure

b. Severe nausea and vomiting

B. Procedure:

1. A pharmacist will review patient profiles to determine if patients are eligible for the IV to PO conversion of H2 Receptor Antagonists.

2. If a profile meets criteria, the pharmacist will:
   a. Write an order to discontinue the current intravenous drug.
   b. Write an order to initiate the equivalent therapeutic oral dosage.
   c. Place a bright colored sticker on the order noting that the administration route has been changed.

C. Orders that are changed back to the IV form will be referred for clinical review.

II. Anti-Infective Medication Switch

A. The purpose is to provide a process for changing certain parenteral anti-infective medications to the oral/enteral route when medically appropriate. Key elements of the program are:

1. To provide an oral/enteral dosage form with comparable bioavailability to the intravenous form.

2. Which could reduce length of stay associated with anti-infective therapy.

3. To avoid the added risks associated with continued intravenous therapy.

4. To lower overall medications and associated costs to the patient and the institution.

B. The Pharmacist is responsible for assessing the patient for IV-to-PO switch, implementing the change when appropriate, documenting the change in the medical record, and contacting the
patient’s physician. To be eligible a patient must meet at least one of the Inclusion Criteria and none of the Exclusion Criteria that follow:

1. Inclusion Criteria patient is:
   a. Able to eat regular or modified diet, or
   b. Receiving enteral nutrition by the oral route, or gastric or other appropriate enteral tube, or
   c. Receiving other medications by the oral route

2. Exclusion Criteria patient is/has:
   a. Unable to swallow, or refuses medication, or is NPO for procedure
   b. Severe nausea and vomiting, or gastrointestinal obstruction, or malabsorption syndrome, or biliary drain, or ileus, or severe diarrhea
   c. Experienced severe trauma within the last 72 hours
   d. Active gastrointestinal bleed
   e. Neutropenia (ANC<500)
   f. Documented CNS infection
   g. Documented endocarditis
   h. Pneumonia with AIDS
   i. Severely immunocompromised
   j. Documented Pseudomonas infection and on antibiotic<24 hours
   k. Candidemia treated less than 7 days
   l. Other infections which require extended intravenous anti-infective therapy

C. Anti-Infection Medications Appropriate For IV-To-PO-Switch:
1. Azithromycin,
2. Fluconazole,
3. Fluoroquinolones,
4. Metronidazole
5. Any other agents determined by the committee to have IV and PO bioequivalence.

Administrator

3/27/07

Date

Approved by Clinical Board: 6/00, 2/17/04, 3/20/07
Transferred to Hospital Policy Manual: 3/01
Revised: 2/04
Reviewed: 2/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

MEDICATION ASSISTANCE PROGRAM (OUTPATIENT)

Purpose:
To establish a process for LSUHSC-Shreveport outpatients to participate in programs offered by drug manufacturers that can offer assistance in providing medications to low-income/non-insured patients who meet certain standards.

Policy:

1. Application for Medication Assistance Process
   A. Physician writes prescription for formulary-approved prescription. (Scheduled substances are not allowed)
   B. Case Managers on the nursing units or clinics assist the patient in the completion of a Financial Assessment Form.
   C. Patient brings the written prescription(s) and completed Financial Assessment Form to the Social Services Office or an assigned Case Manager.
   D. Social Services/Case managers will utilize the M&D Cares computer program to process all patient medication requests. This will allow Pharmacy to track the medications and contact the respective user if problems arise. When medication arrives, pharmacy staff will process the prescription and notify the patient via mail that they may pick up their medications at the ACC Pharmacy.
   E. The Social Services Counselor completes the required forms, obtains the required physician signature on the application, and submits the application to the Drug Company.
   F. Prior to transmission of forms for medication assistance, Social Services or the responsible clinic’s social worker will ensure that “ATTN: PHARMACY” be added to the delivery-address area of said form(s).
2. Medication Shipping and Receiving Process

All Outpatient Medication Assistance Medications will be received by Shipping & Receiving and delivered to the ACC Pharmacy on the 2d floor of the Ambulatory Care Building.

3. Medication Distribution Process

A. Packages will be delivered to the ACC Pharmacy from Shipping and Receiving at a time mutually agreeable to both departments. Each package’s exterior should be labeled with the physician’s name and Medication Assistance Program.

B. Each mailed-in package contains the bottle(s) of medicine and documentation from the drug manufacturer with information such as: patient(s) name and the medicine(s) information.

C. Each package is opened and its contents recorded in the Pharmacy database.

D. Pharmacy will process medications in a manner suitable for legal dispensation.

E. Each medicine is logged out through the Pharmacy’s database when verified.

4. Patient Notification

A. When the prescription has been received, label made, and ready for checking by a pharmacist, the pharmacy technician will produce a medication notification letter to be sent to the patient.

B. Under no circumstances will patients be referred to the Main Pharmacy for medication pickup or order queries.

5. Patient Pick-Up

A. The patient will pick up the prepared medication(s) at a designated time at the ACC Pharmacy within 30 days of notification.

6. Unclaimed/Expired Medications – Pharmacy
Unclaimed Medications (not picked up within 60 days) and expired medications will be returned to the Pharmacy for disposal.

7. Prescription Quantities

The dispensing pharmacist may round up the prescribed quantity of chronic medication with no known discontinuation date to the manufacturer's full unopened bottle size, if the medication was received free through an indigent patient medication program.

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Administrator

10/23/09

Date

Clinical Board Approved: 11/20/01, 5/18/04, 11/21/06, 10/20/09
Written: 11/01
Reviewed: 3/04, 8/06, 9/09
Revised: 3/04, 8/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

DRUG RECALL

Policy:

A standard drug recall procedure shall be used to identify and assist in the removal of potentially defective products from throughout the institution.

Procedures:

1. Upon receipt of a drug recall notice, the Pharmacy Director (or designee) will assign personnel to visit and check each area of the hospital that is approved (known) to stock the recalled drug.

2. A Recall Record will be completed as each area is audited.

3. The involved product will be quarantined in Pharmacy until the drug is packaged and returned as per manufacturer’s instructions.

4. The Recall Record will be filed in Pharmacy and a copy sent to the Safety Office. If it is necessary to contact patients as a result of the recall, the Safety Office will make the contacts and provide appropriate follow-up information.

Administrator

7/27/09
Date

Approved by Clinical Board: 5/20/03, 6/20/06, 7/21/09
Written: 9/97
Revised: 11/00, 3/03
Reviewed: 5/06, 7/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

DRUG SHORTAGES

Purpose:

To establish a plan to evaluate and respond to shortages of pharmaceuticals so patients receive appropriate alternative therapy.

Policy:

Upon notification of a chronic drug stock outage or an impending long-term shortage, Pharmacy will investigate and implement alternate purchasing and dispensing practices. The Pharmacy and Therapeutics Committee (P&T Committee) may be involved in decisions related to “rationing” of the item(s).

Procedure:

A. Pharmacy’s Business Manager is notified of shortage and investigates reasons and expected duration of shortage. As a result, availability from other sources is determined and current stock levels are assessed.

B. If any of the following criteria are met, the shortage is termed critical.

1. There is no known release date and stock levels are at or below one-week supply.

2. There is a known release date, but stock levels are not sufficient to supply until that date.

3. There is no known release date and no supplies have been received from any sources for 7 or more days.

C. If a shortage is termed critical, the Business Manager, with the assistance of the Pharmacy Director and Assistant Pharmacy Directors and/or Chairman of the Pharmacy and Therapeutics Committee, will evaluate and initiate any of the following:

1. Inventory is pulled from all MedSelect stations and held in Central Pharmacy for patient specific dispensing.
2. Acceptable alternatives will be assessed and evaluated. Acceptable alternatives will be communicated and made available with equivalent dosing information. Communication may be sent through e-mail, written memorandum, and/or direct discussions with prescribers.

3. Specific restrictive guidelines may be initiated with P&T Committee’s approval, and communicated to hospital staff. Pharmacy staff is notified first to be the gatekeeper.

4. A drug shortage list will be updated and made available to hospital staff throughout the duration of the shortage.

D. A manufacturer representative for the affected drug will be contacted to assist Pharmacy in notifying appropriate staff of the shortage, updating Pharmacy on release dates, and, if available, securing stock directly from the manufacturer.

E. The Business Manager will communicate to the Pharmacy Director and Assistant Directors when the shortage has been resolved. A decision will be made, in conjunction with the P&T Committee, on the status of restriction guidelines. If the decision is to lift the drug’s restricted use, hospital staff will be notified.

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Administrator

____2/23/07__________
Date

Approved by Clinical Board: 1/20/04, 2/20/07
Written: 11/03
Reviewed: 12/06
Revised: 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER -
SHREVEPORT
MEDICATION ADMINISTRATION CHECK (MAK)

Purpose:

Provide additional measures of safety in the medication administration process. Provide online access to care providers for current patient medication information.

Policy:

A. Medication Administration Check (MAK)

1. Prior to giving medications with MAK the nurse must attend and complete a MAK class, pass the pharmacy test, and demonstrate competency.

2. MAK should be utilized for the delivery of all medications on MAK Nursing Units for patients that are on the unit census. Exceptions to this may be made when a physician supervises the ordering, dispensing and administration of the drug and in Code Blue situations.

3. Signatures in MAK are electronic.

B. Medications requiring countersignatures must be verified with another licensed nurse. If the system does not prompt for a countersignature or if the scan of the second nurse is overridden, the name of the nurse verifying the medication will be entered as free text in the reason field. If the system does not prompt for a co-signature, the nurse shall notify the manager during working hours and the manager shall report this to the Manager of Standards so that the issue can be resolved.

1. The second nurse verification requires the second nurse to review the physician’s order and to check the medication, dosage, route, time, and content.

2. The following medications require 2nd nurse verification: Heparin and other related anti-coagulants (intravenous or subcutaneous) – does not include Heparin Flushes, Insulin (intravenous or subcutaneous), Morphine and Demerol for PCA Pump (intravenous), and Chemotherapy (intravenous).

C. Definition of Terms:

1. Admin: The nurse who is presently logged into the system has administered medication.

2. Not Admin: The medication was not administered or was not administered by the charting nurse or was given prior to a patient being in a bed – so MAK was unavailable and the medication was
documented on the manual MAR, this includes medications given by Respiratory Therapy, Radiology, Anesthesia and admin in a Non-MAK unit. Use for missed dosed due to diagnostic procedures; document the reason and message the pharmacy if the schedule needs to be revised. Use for any medication withheld, document the reason and notify the physician, if appropriate.

D. Administration of Medication – The Nurse shall:

1. Prior to administration ensure that the correct medication has been selected, verify the medication is stable based on visual examination, ensure that the medication has not expired, determine that there is no contraindication for administering the medication, and check that the medication is being given at the correct time, in the prescribed dose, and by the correct route by scanning the medication barcode.

2. Using the patient’s addressograph card, stamp a card. Place the stamped card in the medication clear reusable plastic bag along with the patient’s medicine.

3. At the patient’s bedside, verify the patient’s name and medical record number and scan the patient’s armband. Advise the patient and/or family members about potential clinical adverse reactions, or other concerns when administering a new medication and discuss any unresolved, significant concerns about the medication with the patient’s physician, prescriber, and/or relevant staff involved in the patient’s care. Use the seven rights of medication administration.

4. Administer the medicine. All PO meds shall be opened at the bedside.

5. Chart the medication.

E. All medication orders in MAK must be verified against the original physician order.

1. When a medication order in MAK does not match the physician’s order, open an intervention for Pharmacy to review. A question mark will appear next to the order in question. When the MAK order has been resolved successfully, highlight the order and select “verify”.

2. If the incorrect order was resolved by discontinuing it and entering a new MAK order, go to the active work list, select the incorrect order and choose “not admin” and select “order entry error” as the reason. This will cause the incorrect order to drop off the active work list.

3. When verifying insulin to scale, the insulin scale can be seen under the dose detail button.

F. Bed Status Considerations: Charting on MAK can be done on all patients that are on the units’ patient census. Observation patients are set up in
Invision with a 104-outpatient record, but you can use MAK to chart their medications. **Before an Observation patient is changed to an inpatient status**, the clerk in conjunction with the nurse needs to ensure that the following is done in the following order to ensure that medications are given safely:

1. All medications that are due on the active work list are either *admin* or charted as *not admin*.
2. Print a MAR from Invision for OBS period for reference of medications that were administered.
3. Remove patient from personnel census list.
4. Have the physician re-write medication orders for the patient and send new orders to the pharmacy.
5. When the above items are complete, the clerk or nurse can call admitting to change the patient’s status to an inpatient status.

Reason: When a patient is changed from an observation patient status to an inpatient status, they are discharged in the computer system as an observation patient. This means all orders are discontinued automatically and the pharmacy needs a new set of orders.

G. 24-hour chart checks will be performed according to policy. By signing the 24 hour chart check as complete, the nurse confirms that:

1. All medications that are currently ordered for the patient are accurately listed on the medication summary.
2. Any discontinued medications are not listed as active medications.
3. All medications that have been given by the MAK unit shall not be listed on the active work list.
4. Any discrepancies have been resolved.

H. Nursing staff shall clean horizontal surfaces, handles and wand of the medication cart as needed. The approved hospital disinfectant cloth shall be used. The MAK cart should be sent for a thorough cleaning semiannually and as needed. Housekeeping shall clean filters every two weeks.

I. When a patient is in isolation the following procedure shall be followed:

1. The nursing unit will request an extra armband for the patient. The armband will be kept with the patient’s MAR/Medication bag, etc. that is in the nursing folder used for medication administration.
2. The nurse will **NOT** take the MAK cart into the room.
3. Once outside the isolation room, the nurse shall scan the patient’s armband and all medications, wash hands, go into the patient’s room, visually re-check the armband on the patient in the room,
give the medications, return to the cart and then chart the
administration of the medications.

J. Overriding a barcode is discouraged and when an override is done, the
nurse shall document the reason.

K. Medications given by another department or physician and not
administered by nursing.

1. All medications administered by other departments and appearing
on the Active Work list will be charted as “Non-Admin” with the
appropriate reason. Examples of “Non-Admin” reasons: RT to
give med, Radiology to give med, anesthesia to give med, and
admin in non-MAK unit.

2. This indicates that a member of another department or unit
administered the medication and documentation of these
medications will be in the responsible department’s documentation.

3. If a medication is listed on the Active Work list and the doctor
administrers the medications (i.e. Chemotherapy Agent), the nurse
will chart the medications as ADMIN. Then, from the charted list
the nurse will revise with the revised reason, “Dr. (Name) admin
med”.

4. If an investigational medication is listed on the Active Work list and
the medication is given by a clinical coordinator, the patient’s nurse
will chart the medication as ADMIN, and in the reason box will type
in Name of Clinical Coordinator that gave the medication (ex: J
Doe, stated admin). For medications that need a documented
completion time, the nurse will chart under admin dose on the
charted list, comp. and the time (ex: comp. 1330). If necessary,
the nurse can change the charted time that a medication was given
by revising the time on the charted list.

L. A nurse who gives a medication but does not chart it at the time that it was
given, may select the medication from the active work list for up to 24
hours past the time that the medication was scheduled, chart the
medication as administered, and then will revise the administered date
and time as appropriate. The revised reason in this instance shall be
“late entry of admin med.”

M. Medications administered in a non-MAK unit that show up on MAK on the
active work list.

1. Medications given on a non-MAK unit immediately prior to or after a
patient has been transferred in Invision to a MAK unit may show up
on the active MAK work list. In this instance, the MAK unit will chart
that the medication was “Non-Admin” with a reason of “Admin in
a Non-MAK unit”.
2. This indicates that a member of the transferring (non-MAK) department administered this medication and documentation of this medication is on the paper Medication Administration Record. The administration time will be the time that the Non-MAK unit documented on their paper Medication Administration Record.

3. In the case of a transfer from a non-MAK unit into a MAK unit, MAK medications will be verified against physician orders.

N. Transfer from a MAK unit to a Non-MAK unit.

1. The MAK unit shall check the active work list prior to transferring a patient to a Non-MAK unit to ensure that all medications that are due have been given and charted.

2. The MAK unit will print an Invision MAR and place it on the medical record.

O. Transfer from a Non-MAK unit to a MAK unit.

1. The Non-MAK unit shall check the MAR to ensure that all medications that are due have been given and charted.

2. The MAK unit shall review the manual MAR and ensure that the medications listed on the active work list of MAK are correct and match physician orders. At that time the MAK nurse shall write on the manual MAR the date and time that MAK charting started.

P. Chart Pharmacy Review Pending

1. This MAK feature should be utilized to enter an emergent medication order before the delivery of that medication when the clinical status of the patient would be compromised by the delay resulting from the pharmacist’s review. In order to use this feature, the medication has to be able to be overridden in Med Select.

2. In addition, it shall be used to enter new or revised medication orders that need to be administered during downtime. If the nurse needs to give a medication that is normally not overridden that medication will not be available unless Med Select is redlined. Contact the pharmacy if unable to obtain from the Diebold.

3. The MAK system’s safety feature will check for any clinical conflicts regarding that medication. If during the chart pharmacy review pending process a clinical conflict occurs, the nurse shall review the clinical conflict, determine a clinical intervention and then document the clinical intervention.

4. When a STAT order is entered, the physician order form with the STAT order still must be sent to pharmacy. The nurse needs to write on the yellow physician order form that the STAT med was already administered so pharmacy will not enter the order into MAK. If Pharmacy still enters the order, the nurse does not verify
the new order and sends a message to Pharmacy to remove the order and not admin the med on the active work list.

Q. Downtime Procedure for Outage on Invision/Pharmacy/MAK Systems

1. Invision Outage
   a. Planned Invision outages
      1) Will be scheduled at convenient times for Pharmacy and Nursing and a documented outage plan will be communicated to all parties. Charting during Invision downtime:
         a) Orders that were written prior to downtime may be given and documented by the normal procedure.
         b) New or revised orders entered by pharmacy during downtime will not be accessible for documentation in MAK (ancillary number isn't assigned, so medication can not be verified).
         c) If the new or revised order is not a STAT or now order, is not a PRN order that needs to be given now, or is an order for scheduled times that does not need to be given until after downtime is over, wait until down-time is over and then the order can be verified. Then the medication can be administered and charted.
         d) If the new or revised order is STAT or needs to be administered before down time is over, the nurse will enter the order into MAK as a one time order pending pharmacy review (chart-pending pharmacy review).
         e) When Invision comes back up the nurse
            i. Will verify all new or revised orders that pharmacy entered during downtime (medication will have a pencil next to it).
            ii. For new or revised orders that were given during downtime using pending pharmacy review chart these medications as “Not Admin”, reason - given during downtime.

   b. Unplanned Invision Outage
      1) Procedure for unplanned outages on Invision that will be down less than two hours and will not cross shifts:
         a) Computer services will notify staff by a broadcast message and overhead page on how long the downtime is expected to last.
b) Follow the procedure for planned downtime.

2. **Pharmacy or MAK Outage (Planned or Unplanned)**
   a. Refer to Hospital Policy 8.13 (Control of Medications) for information on communications and the impact on Med Select.
   b. Staff will be notified by an overhead page about the expected length of the outage.

   1) **For an outage that is expected to last longer than 2 hours or will cross shifts**
      a) Using the last 10 PM Invision MAR, the nurse will verify and update all orders against the physician orders.
      b) Any medications given during downtime will be documented manually on the Downtime MAR (S/N 1287). When MAK comes back on-line, the nurse will place the white copy of the Downtime MAR in the medical record, which becomes a permanent part of the record.
      c) When MAK comes back up, the nurse will address every medication on the active work list that was due during downtime as “Non-Admin” with the reason, refer to Downtime MAR.

   2) **If the outage is less than 2 hours and does not cross a shift.**
      a) The nurse will verify and update the last 10 PM Invision MAR with the original MD written order before giving medications.
      b) Any medications given will be documented on a Downtime MAR (S/N 1287). When pharmacy/MAK comes back on-line, the nurse will “Admin” meds given during downtime on MAK and then will revise the time to reflect the accurate time of administration with the reason “Given during downtime”.
      c) Once the medications have been documented in MAK, the Downtime MAR can be shredded.

R. **PRN Work list**

1. The PRN Work list on the Active Work list will be used for a variety of medications. These include PRN medications and some unscheduled medications. Unscheduled medications will include IV pitocin and magnesium sulfate in the Labor Unit, and IV magnesium sulfate on 4G/J.
2. Medications that have the option of administration as IV or IM will be available on one line in the PRN Work List. The nurse will document the site location, which will denote if the medication was given IV or IM.

3. Medications that have the option of administering by injection or PO, will be listed on two separate lines in the PRN work list. Last charted date and time must be checked on both orders before administering the medication.

S. IV fluids:

1. To change a rate on IV drips that are currently hanging or on a PCA from the Charted List tab, expand the list to show the current IV or PCA information. Choose that medication and select “Revise”. Change the administered dose to reflect the new infusion rate and put the “revise reason” as “Refer to unit documentation for rate changes”. The nurse will not have to document revised rates after the initial revision.

2. All continuous IV fluids that have an additive (i.e. – KCL) will be on a routine schedule in the active work list.

3. Labor unit: All pitocin and magnesium sulfate IV fluids will appear in the PRN list at the bottom of the active work list as unscheduled medications. These medications will not show up on the active work list as a routine medication. The nurse will monitor the last time the dose was given on the active work list or charted work list and give the medication according to physician order.

4. For IV fluids mixed for the Oncology/BMT unit, the chemotherapy drug should be seen on MAK, if it isn’t, the pharmacy has entered the IV fluid as the first ingredient on the order detail. When this occurs, send a message to the pharmacy to get this changed. The chemotherapy drug always needs to be the first drug written in the order detail.

T. User Access:

1. Only individuals authorized to administer medications will be given access to the system.

2. On hire, the nurse recruiter will assign the new user access to the system. A password is selected by the user at the time of initial system entry. The logon id and password along with the employee ID Badge are used to gain system access. No other person, including pharmacy personnel, shall have knowledge of a user PIN.

3. Nursing instructors may attend a MAK class to become familiar with how it works. Students and/or instructors may administer medications with MAK. The nursing instructor or nursing staff that signed unto MAK:
   a. Will be accountable for ensuring that the charting of the medication is correct.
b. When a student nurse administers a medication, the nursing instructor or nursing staff will ensure that the student's name that administered the medicine is typed under reason, for example: “Adm. by Jane Doe”. This indicates who actually administered the medication.

4. The ultimate responsibility for ensuring that the patient receives their medications rests with the person signed onto MAK.

5. Security of each MAK user's password is the responsibility of the individual person. Administrators of the system do not have access to the password. If a password is forgotten on days, the user must contact their manager, if the manager is unavailable, the nurse recruiter at 56284. On the evening and night shifts the user may contact the Administrative House Manager in order to re-set their password. The password will be reset to today1. The user will then be prompted by the system to change the password. The new password must be at least 6 characters.

6. If an employee is hired and does not need a MAK ID on hire, but needs one at a later date, it will be the responsibility of the manager that will have the employee working on his/her unit to set up user access for the employee.

7. If the employee badge is lost, the employee will go to the cashier's cage to pay for the lost badge and then go to University Police Department with the receipt of payment to get the employee badge re-issued.
   a. UPD may give the employee a badge with the same ID number or a new ID number. If the employee gets a new ID number, the MAK User ID will have to be reset after badge replacement if the employee receives a new id number on the badge.
   b. The employee needs to ask the UPD if the ID number is new, if new, the employee needs to do the following:
      1) Report to pharmacy and have their profile reset by pharmacy for Diebold.
      2) Call the Help Desk, 55470, option 1 during the normal business hours to get their new badge ID entered into MAK.

8. Sharing password information with anyone else is strictly forbidden.

9. Nurses that are using MAK can access patient information anywhere in the hospital. Nurses will only access patient information as needed to perform their job duties.

U. Equipment malfunction:

1. If a mouse, keyboard, or scanner stops working, unplug it, wait a few seconds and then plug it back in. Document on the log sheet and include the number of the MAK cart. Managers will let
computer services know if an ongoing problem occurs with a mouse, keyboard, or scanner.

2. After trying above, and for any other MAK cart malfunction call the Computer Services HELPDESK (55470, option 1) at any time and computer services will work to get the problem corrected.
   a. **During normal business hours:**
      1) If the problem can’t be worked out over the phone, Computer Services will send someone to look at the cart. If Computer Services determines that the issue needs to be handled by Biomedical Engineering, the nurse will be asked by Computer Services to key in a work order and take the cart down to Biomedical Engineering. Biomedical Engineering will give the nurse a loaner cart, if available.
      2) Biomedical Engineering will notify the Manager or Charge Nurse when the cart is ready to be picked up.
   b. **During non-business working hours:**
      1) If the problem can’t be worked out over the phone, Computer Services will provide a loaner cart if available to be picked up in room G-309 on the Ground Floor of the Medical School, near the Safety Office, and tell the nurse what to do with the broken cart the next morning (keep on floor or take to Biomedical Engineering).
      2) The nurse needs to communicate with the day shift about what is to be done in the morning (leave the cart on the floor for Computer Services or key in a work order to Biomedical Engineering and take the cart down to Biomedical Engineering). This communication should occur in report and a note should be left on the broken cart.
      3) If Computer Services comes to the floor the next morning to look at the cart, they will determine if it is a problem that they will fix or tell the nurse to key in a work order for Biomedical Engineering and follow the process listed above in normal business hours.

V. **Medication Administration Record:**

1. A medication administration record (MAR) will print each night at 10 PM from Invision, which shows documentation of medication for the last five days. Each night the printed MAR shall be placed in the medication folder that is used by the nurse. Because the 10 PM MAR is a cumulative record of medication administration for five days, the MAR printed the night before can be shredded when the new MAR is placed in the nurse’s medication folder.
2. The electronic printed MAR is not a permanent part of the record; it is a tool that nurses can use to assess what medications have been given in the past 24 hours. In addition, it can be used as a reference in the event of downtime. A MAR can be printed from Invision if needed.

3. After discharge, a Medication Administration Record (MAR) will print in Medical Records. Medical Records will place this permanent MAR on the medical record.

4. A demand MAR can be printed from Invision or MAK if needed.

W. Training:
1. Each user shall attend a medication administration check training class offered by the Hospital Education Department. Upon completion of the MAK class, the user will receive a memo stating they have completed the class. Once training is completed, each user will need to be checked off by a qualified observer on the patient care unit – someone that has completed class, been checked off and has been using the system.

2. Nursing instructors shall attend a MAK class prior to getting MAK access. The nursing instructor shall call Hospital Education at 56285 to register for a MAK class. The manager will be responsible for ensuring that a competency checklist is completed on the instructor. A qualified observer on the floor can do this.

3. Competency checklists shall be kept in the employees file. Nursing instructor competency checklists shall be sent to Hospital Education.

4. Hospital Education will provide MAK classes routinely starting January 2005. A schedule of those classes will be given to managers.

X. A trouble-shooting guide is available on each MAK unit on the MAK cart. Please refer to this guide for assistance in responding to problems that may occur with your MAK system.

Y. Information may at times be delayed interfacing all systems. To ensure that new information recently entered into one of the systems has interfaced with MAK, the screen should be refreshed frequently.

Z. Reports:

1. Unit managers will review and respond to reports on an ongoing basis.

2. Pharmacy will review and respond to reports on an ongoing basis.

3. The Medication Quality Council will establish PI indicators each year to ensure an oversight review of MAK reports.
4. The pharmacy will establish PI indicators each year to ensure oversight reviews of key pharmacy issues.

5. Medical Records shall print a discharge MAR for each patient and place it on the patient's medical record.

Reference: Hospital Policy 8.6.1 - Standard Administration Times

Approved by Clinical Board: 8/16/05, 1/16/07
Written: 7/05
Reviewed: 10/06
Revised: 10/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

PRESCRIPTION PADS

Purpose:
To define the process for issuing and controlling prescription pads at LSUHSC-S.

Procedure:
1. Only the standardized prescription pad approved by the Pharmacy and Therapeutics Committee & the Clinical Board shall be used at LSUHSC-S. All orders for prescription pads shall initially be placed through Medical Communications in order to type set the required information, and then the template forwarded to the Print Shop. The following information is required by Medical Communications:
   a. Prescriber’s Name and Licensure Designation (MD, DDS, NP, PA)
      Note: If the prescriber has limited prescriptive authority (NP, PA), the prescription form shall also indicate the supervising physician’s name, licensure designation, address, and telephone number.
   b. Department
   c. Address
   d. Telephone Number
   e. Emergency Telephone Number
   f. Medicaid ID Number
   g. National Provider Identification (NPI) Number

Screen paper shall be used by the Print Shop to help deter forgery potential. Individuals shall not use prescription pads other than their own; a limited number of generic forms may be obtained through the Pharmacy department on an emergency basis. When a generic form is used, the prescriber must print their name legibly on the form in addition to signing.
2. Staff Physicians, Fellows, Dentists, Physicians Assistants and Nurse Practitioners

Generic prescription pads shall not be utilized. All staff physicians, fellows, dentists, physician assistants and nurse practitioners, either independently or through their department, are responsible for the purchase and control of the hospital approved personalized prescription pads.

3. House Officers

House Officers will be issued personalized prescription pads at the time of employment through the Office of Medical Education. At any time the House Officer may request additional pads through this office.

4. Prescription forms containing multiple practitioner names

If multiple physician names are identified on the prescription, the authorizing prescriber must mark the check box next to his/her name.

5. No prescriptions shall contain more than four (4) prescription drug orders per form. Each drug order on the form shall provide for the following:

a. check box labeled “Dispense as Written”

b. the number of refills, if any

6. Equivalent Drug Product Interchange

a. A pharmacist may select an equivalent drug product, provided the patient has been informed of and has consented to the proposed cost saving interchange. If the prescriber does not want a generic substitution, he/she must handwrite a mark in the check box labeled “Dispense as Written,” and personally handwrite his/her signature.

b. For prescriptions reimbursable by Medicaid or Medicare, the prescriber may only prohibit generic substitution by handwriting the words “brand necessary” or “brand medically necessary” on the face of the prescription order or on a sheet attached to the prescription.
Hospital Policy Manual
Hospital Policy Number: 8.2
Effective Date: 12/01/08

Administrator

11/19/08

Date

Approved by Clinical Board: 11/20/01, 10/18/05, 11/18/08
Written: 11/01
Reviewed: 10/05, 10/08
Revised: 10/05, 10/08
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

MEDICATIONS ADMINISTRATION VIA THE INTRATHECAL ROUTE

Purpose:

To establish guidelines for the use of the intrathecal route for administration of medications including measures to prevent medication errors when using this route of administration.

Inadvertent intrathecal (spinal route via lumbar puncture or Ommaya reservoir) administration of some medications can be fatal; therefore every effort to prevent this type of medication error should be employed.

Procedure:

1. The hospital, through the P&T Committee, shall establish a list of drugs that can be administered intrathecally.

2. When intrathecal drugs are being administered, there will not be any other injectable drugs present in the patient room or procedure area.

3. Only the person administering the medication may remove wraps or packages immediately prior to injection.

4. A “TIME OUT” with the MD and chemotherapy certified or credentialed nurse must be done prior to administration of any intrathecal medication. Documentation of the “time out” must include:
   a. the name of the DRUG
   b. DOSE
   c. ROUTE given and
   d. TIME of administration

   as well as names of those health care workers conducting the “time out”.
References:

1. Joint Commission International Center for Patient Safety, 
   www.jcipatientsafety.org
3. LSUHSC, Pharmacy and Nursing Dept. 2005

Approved by Clinical Board: 10/18/05, 11/18/08, 3/17/09
Written: 9/05
Reviewed: 10/08, 2/09
Revised: 10/08
PT revised: 1/09
MEDICATION RECONCILIATION

Purpose:

To ensure timely and accurate capture and documentation of a comprehensive list of a patient’s medications.

- communication of this information across the continuum of care
- to reduce medication-related errors
- improve patient safety and outcomes.

Policy:

The medication reconciliation process includes these steps:

1. Obtaining and documenting the most complete and accurate list possible of all current medications for each patient.

   For the purposes of reconciliation, the term “medication” includes:

   - prescription medications
   - over-the-counter (OTC) medications
   - sample medications
   - investigational/study medications
   - vitamins and other supplements
   - herbal remedies
   - eye, ear, skin preparations or patches
   - dietary or nutritional supplements
   - parenteral nutrition
   - inhaled medications and respiratory treatments
   - diagnostic, contrast, and radioactive agents
   - vaccines
   - blood derivatives
   - intravenous solutions (plain, with electrolytes or drugs)

2. Comparing the list against admissions, transfer, and discharge orders.

3. Resolving any discrepancies.
4. Making necessary and appropriate medication changes based on the patient’s clinical condition.

5. Communicating the complete and updated list to the next provider of service whenever the patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the hospital.

The medication reconciliation process shall be initiated at each of the following points-of-care:

- Outpatient Clinic, Renal Unit or ECC visit
- Admission
- Intra-hospital transfer to another service or level of care (i.e. ICU to floor transfer) using the INVISION generated
- Discharge to home or transfer to another facility

a. Outpatient Clinic visit / Renal Unit visit/ECC visit / Admission

The Medication Assessment History Form (S/N 7266) shall be completed at each outpatient clinic visit, Renal Unit visit, ECC visit, or admission, by the nurse. The second page may be used for patients on multiple medications and for patients with multiple clinic visits. Patients from Outpatient Clinic, Renal Unit or ECC visits shall be given a copy of the Medication Assessment History Form for their records at the conclusion of their visit.

The Medication Assessment History Form is not required for patients scheduled for lab, medication, or diagnostic testing only.

The Pediatric Hematology/Oncology Clinic shall complete the Outpatient Clinic Record Pediatric Hematology/Oncology /Sickle Cell (S/N 7066) and Pediatric Hematology/Oncology /Sickle Cell Patient Education Record (S/N 7133) at each clinic visit in lieu of the Medication Assessment History Form. The patient shall receive a copy on the Pediatric Hematology/Oncology/Sickle Cell Patient Education Record at each clinic visit.

The Medication Assessment History Form shall be completed for all admitted patients.

Note: A physician’s signature is required only for patients being admitted to the hospital.
b. Intra-hospital transfer to another service or level of care
The nurse shall print the active medication list from
INVISION and place the list on the patient’s chart for the
physician’s review. The physician shall review and reconcile
the medication list prior to writing new orders.

Note: If the INVISION System is down, the transferring unit
shall provide a handwritten Medication Assessment History
Form.

c. Discharge to home or transfer to another facility
The nurse shall complete the Medication Assessment
History Form. A copy of the form shall be provided to the
patient.

Process:

1. Obtain information to complete the list of the patient’s current
medications and document this information on the Medication
Assessment History Form (S/N 7266). Information sources may
include:

- Prescription medications
- List provided by the patient or surrogate
- Patient/family recall
- Primary care physician or other medical service providers
- Medication Administration Record (MAR) from an outside
  facility or agency
- Discharge summary or discharge medication list from a
  previous hospitalization (providers are discouraged from
  using a recent discharge summary as the sole data source)
- Current hospitalization MAR
- Contacting patient’s pharmacy provider.

Reasonable efforts should be made and resources used to obtain
medication information in situations involving a poor historian;
literacy, language, cultural, or cognitive status barrier; or other
patient vulnerability.

A complete medication entry will include the elements listed below,
if unable to obtain this information, the nurse will document the
reason:

- Medication or product name
2. The physician writing admission orders shall sign the Medication Assessment History Form. The physician’s signature indicates that the medications have been reconciled. The discharging physician shall review the admission Medication Assessment History Form prior to writing discharge orders. Upon discharge the nurse shall transcribe the medications listed in the discharge orders on to the Medication Assessment History Form.

3. All individuals involved in documenting the Medication Assessment History Form, and the physician who completed the review and reconciliation will: sign, initial, date, and time the form used for this purpose.

4. After completion of the medication reconciliation process, the physician will write new orders (admission, transfer, or discharge) or enter them into the electronic order entry system.

5. The patient or surrogate should be given a copy of their current medication list at the time of discharge and encouraged to partner with medical providers in keeping the list current.

Administrator

11/21/07

Date
ALLERGY AND ADVERSE DRUG REACTIONS

Purpose:

To readily identify patients with known food, drug and environmental allergies/adverse drug reactions and to provide for documentation of such on the Patient Assessment, in order to prevent the possibility of reactions.

Definitions:

Allergy - a reaction caused by an immune response to a drug, resulting in tissue inflammation and/or organ dysfunction usually, but not always, characterized by angioedema, rash or anaphylaxis.

Adverse Drug Event (ADE) - any response to a drug which is noxious and unintended and which occurs at doses normally used in man for prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.

Severity Scale
Level 1 – ADE occurred but required no change in treatment with suspected drug
Level 2 – Drug held, discontinued or changed but no antidote or additional treatment needed.
Level 3 – Drug held, discontinued or changed AND/OR antidote or other treatment required.
Level 4 – ADE required patient transfer to an intensive care setting
Level 5 – ADE caused permanent harm to the patient
Level 6 – ADE either directly or indirectly led to the patient’s death

Policy:

1. A history of any allergies/ADEs shall be obtained during the admission nursing assessment before any medications are administered, except in emergencies. This history is documented in the space provided on the Patient History and Discharge Record.

2. An orange allergy/ADE bracelet shall be placed on any patient who has admitted by history to a specific allergy/ADE, or who has demonstrated allergic clinical manifestations.
3. An allergy alert sticker shall always be placed on the front of the patient's chart, and allergies/ADEs shall be documented on each unit dose Medication Administration Record (MAR), the first physician order sheet and electronically in the HIS (Invision). If the patient has no known allergies/ADEs, NKDA shall be documented in these areas.

4. Suspected Adverse Drug Reactions shall be identified and reported on the Hospital Variance Reporting website.

5. The physician must also document the ADE in the Progress Notes of the patient's medical record. If upon investigation a physician deems the patient does not have the noted allergy/ADE, the physician shall write an order to remove the noted allergy and document such in the progress notes of the medical record.

6. The Pharmacy Department will be responsible for monitoring and grading of reported adverse reactions:
   a. All suspected ADEs shall be reported to the pharmacy for investigation and entered into the pharmacy department’s intervention database.
   b. All severity level 5 and 6 reports shall be forwarded to the Quality Management Department for Peer Review.
   c. All severity level 2, 3, and 4 reports will be forwarded to the Quality Management Department for Peer Review if the reaction has not been previously reported by the manufacturer as a side effect or adverse effect.
   d. Any ADE occurring prior to the patient entering the LSUHSC-S system will not be subject to the Peer Review process unless the medication was prescribed by an LSUHSC-S physician.

7. The reaction will be reported to the manufacturer or the Food and Drug Administration if:
   a. The ADE is classified probable or definite and is a severe reaction.
   b. The ADE is probable or definite and is not listed in the manufacturer’s package insert.
c. The ADE involved is a new drug (released in the last three years) and exhibits a temporal relationship to the administration of the new drug.

Administrator

3/27/07

Date

Approved by Clinical Board: 1/16/01, 9/17/02, 2/17/04, 3/20/07
Written: 3/95
Revised: 11/97, 8/03, 8/03, 1/04, 1/07
Reviewed: 1/01, 9/02, 8/03, 8/03, 1/04, 1/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

DRUG SAMPLES

PURPOSE:

To regulate the handling of sample medications

POLICY:

Sample medications are stored, controlled and distributed in accordance with federal and state guidelines and medical center policies and procedures. All drug samples kept in ambulatory care clinics, emergency rooms or other areas must be maintained in an automated dispensing machine and adhere to the procedure that follows:

SCOPE:

This policy applies to all employees permitted to prescribe and dispense under the hospital bylaws. The department Chairman, Section Chief, or Medical director will determine which drug samples are to be used in their respective areas. If drug samples are to be kept:

1. All drug samples that are received will be recorded on a sample medication receipt form. The Department Chairman/Section Chief/Medical Director will sign the form, indicating the medications are appropriate for dispensing in that clinic. The Department Chairman/Section Chief/Medical Director shall designate one or two persons responsible for stocking the sample medications in the automated dispensing machine (ADS), and verifying compliance with the sample drug policy. Those chosen to be responsible for stocking the sample medications must possess a professional license which enables them to handle prescription medications.

2. The sample medication receipt form will be FAXed to the pharmacy, (5181) so that the sample medications, and lot numbers can be added into the automated dispensing machine database.

3. The sample medications will be locked in a secure area until the medications have been entered into the automated dispensing machine. Sample medications may not be distributed from this area.
4. After the pharmacy has entered the sample drug information into the ADS database, the designated person will stock the samples in the appropriate cabinet of the automated dispensing machine.

5. Each employee permitted to distribute sample medications will be given access to dispense those medications from the automated dispensing machine by Pharmacy personnel. Employees will be granted access by the Department Chairman/Section Chief/Medical Director of the clinic.

6. Any expired drug samples will be removed by the Pharmacy Department for proper disposal.

7. Any drug samples that are not stored according to hospital policy will be removed by the Pharmacy Department for proper disposal.

8. Pharmacy will be responsible for removing any recalled sample medications in the automated dispensing machines. Pharmacy will also generate a list of patients who have been issued recalled sample medications. This list will be given to the Department Chairman/Section Chief/Medical Director who will decide on action to be taken.

9. Sample medications must be labeled prior to distribution. Sample boxes may be taped together with label attached or doses may be placed in plastic bags and the label attached to the bag. The sample labels may be obtained from the general service store (#1340) or the directions may be written on the label generated by the automated dispensing machine.

10. Controlled substance samples are not allowed. Any controlled substances discovered by Pharmacy will be confiscated and destroyed according to state and federal laws.

Administrator

7/24/06

Date

Approved by Clinical Board: 1/16/01, 2/18/03, 7/18/06
Revised 2/98, 2/03, 6/06
Reviewed: 1/01, 2/03
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

MEDICATION ADMINISTRATION

Policy:

Medications shall be administered only by persons authorized by and within the guidelines of the respective licensing agencies of the State of Louisiana and who are on the staff of LSUHSC-Shreveport.

Procedure:

1. Nurses
   
   a. Registered nurses currently licensed by the Louisiana State Board of Nursing and licensed practical nurses licensed by the Louisiana State Board of Practical Nurse Examiners or possessing current permits are permitted to administer medications. Parameters are further defined in Nursing Policies, Pharmacy and Therapeutics Committee Policies and other Departmental Policies (such as Anesthesiology, etc.).
   
   b. Nursing students are permitted to administer medications under the supervision of an instructor/staff nurse as part of their educational experience. (See Nursing Policy N-60)

2. Medical Staff
   
   a. Medications may be administered by licensed practitioners of medicine and dentistry that have been granted clinical privileges by LSUHSC-Shreveport. This includes physician house staff and foreign graduates with permits for institutional practice approved by LSUHSC-Shreveport.
   
   b. Medical students may administer medications under supervision of a licensed physician. Administration is documented in the patient’s medical record in the appropriate section; i.e.: progress notes, treatment record.
   
   c. Physician’s Assistants may administer medications delegated to them by their supervising physicians and defined in the Practice Act.
   
   d. Nurse practitioners may administer medications as established by LSUHSC-Shreveport protocols.

3. Other staff
Medications may be administered only by persons authorized by their respective licensing agency within the State of Louisiana and approved departmental policy. These persons include:

a. Respiratory therapists and technicians,
b. Radiology technologist,
c. Physical therapist,
d. EEG technicians

4. The following information shall be available to all clinical staff involved in the medication management process:

a. Patient’s age,
b. Patient’s sex,
c. Patient’s current medications,
d. Patient’s diagnosis, co-morbidities and concurrently occurring conditions,
e. Patient’s relevant laboratory values, and
f. Patient’s allergies and past sensitivities.

As appropriate to the patient, the following information should also be accessible:

g. Weight and height,
h. Pregnancy and lactation status, and
i. Any other information required by the hospital for safe medication administration.

5. Before administering a medication staff shall:

a. Verify that the medication selected is the correct one based on the medication order and product label,
b. Verifies that the medication is stable based on visual exam for particulates or discoloration and that the medication has not expired,
c. Verifies that there is no contraindication,

d. Verifies that the medication is being given at the proper time, in the prescribed dose and by the correct route,

e. Educates the patient, or if appropriate, the patient's family about any potential significant adverse reaction and other concerns about administering a new medication, and documents the same,

f. Discusses unresolved significant concerns about the medication with the patient's physician, prescriber, and/or relevant staff, and

g. Verifies patient name and medical record number or birth date.

6. Medication labeling

Medications shall be labeled according to the following guidelines.

a. Any time one or more medications are prepared but are not administered immediately, the medication container must be appropriately labeled. The medication container can be any storage device such as a plastic bag, syringe, bottle, or box which can be labeled and secured in such a way that it can be readily determined that the contents are intact and have not expired.

b. All medications, medication containers (e.g. syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings must be labeled. Labeling occurs when any medication or solution is transferred from the original packaging to another container.

c. Department specific procedures are instituted ensuring compliance with the following:

1) Labels include the name and strength of the medication or solution, the date, and the initials of the person preparing the label.

2) All labels are verified both verbally and visually by two qualified individuals. No more than one medication or solution is labeled at one time.

3) Any medication or solution found unlabeled is immediately discarded.
4) Original containers from medications or solutions remain available for reference in the perioperative or procedure area until the conclusion of the procedure. All labeled containers on the sterile field are discarded at the conclusion of the procedure.

5) At shift change or break relief, all medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting personnel.

d. At a minimum, all medications are labeled with:

1) Drug name, strength and amount (if not apparent from the container),

2) Expiration date when not used in 24 hours,

3) Expiration time when expiration occurs in less than 24 hours

4) For all compounded IV admixtures and parenteral nutrition solutions, the date prepared and the diluents

7. Qualified staff member documents medication administration in the medical record including, but not limited to:

a. Date of time of administration

b. Medication name, dose, and route of administration,

c. Legal signature and title of person administering the medication.

______________________
Administrator

_3/19/09 __________________
Date

Approved by Clinical Board: June 2000, 2/17/04, 1/17/06, 3/17/09
Written: 3/95
Reviewed: 5/98, 2/04, 2/09
Revised: 2/04, 12/05, 2/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

STANDARD ADMINISTRATION TIMES

Policy:
Schedules to be observed in administering medications ordered by medical staff unless otherwise specified:

Procedure:

1. Adult Units (see exceptions below)

<table>
<thead>
<tr>
<th>Time</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>QAM</td>
<td>Once per day AM</td>
</tr>
<tr>
<td>QPM</td>
<td>Once per day PM</td>
</tr>
<tr>
<td>QDay</td>
<td>Once per day</td>
</tr>
<tr>
<td>QHS #</td>
<td>Once per day at specified time</td>
</tr>
<tr>
<td>BID</td>
<td>Twice per day</td>
</tr>
</tbody>
</table>

   a. QAM or QDay 0900 (with 1 hour administration window) Colony Stimulating Factors recommended to be given after AM lab results
   b. QAM Insulin 0630
   c. QDay Warfarin 1600
   d. QPM Insulin 1630
   e. QHS 2200
   f. BID or Q12H 0900 – 2100 (with 1 hour administration window)
   g. TID or Q8H 0600 – 1400 – 2200
   h. TID with meals* 0800 – 1200 – 1700
   i. QID or Q6H 1200 – 1800 – 2400 – 0600
   j. QID during waking hours 0800 – 1200 – 1700 – 2200
   l. Q18H Notify Pharmacy of first dose time

2. Psychiatry Unit Exceptions

   a. QAM or QDAY 0900 (with 1 hour administration window)
   b. BID or Q12H 0900 – 2100 (with 1 hour administration window)
   c. TID or Q8H 0800 – 1400 – 2100
   d. QID or Q6H 0800 – 1200 – 1600 – 2100
e. QID during waking hours 0800 – 1200 – 1600 – 2100
f. QHS 2100

3. Neonatal ICU Exceptions

a. QAM – 1000 (including all maintenance IV solutions, with 1 hour administration window)
b. QDAY – All once daily doses – 1300 (exception – antibiotics)
c. BID – 1000 – 2200
d. TID – 0700 – 1600 – 0100
e. QID – 0700 – 1300 – 1900 – 0100
g. Antibiotics will be administered at the nearest feeding time and scheduled at hourly intervals from that time. Any time changes in antibiotics should only be made if associated with a variance.

4. Respiratory Therapy Exceptions

a. TID – 0800 – 1400 – 2000

5. Medicine schedules are to be altered as needed for any emergency situations.

* These times will print on Medication Administration Records; however, nursing units will have to make adjustments on actual dosing times depending on meal service.
DURATION OF DRUG ADMINISTRATION

Policy: To establish policy regarding the duration of drug administration

1. It is advisable, but not mandatory, that drug orders indicate the number of doses and/or days to be administered.

2. Orders for narcotic analgesia shall be rewritten every 72 hours. The patient's nurse is responsible for notifying the prescribing physician of an order, which is about to expire. This may be done verbally or in writing on the chart.

3. Orders for adult total parenteral nutrition solutions and pediatric parenteral nutrition solutions are rewritten daily.

4. A physician shall indicate any medications to be administered orally after a patient has been placed on a “NPO” status.

5. All drug orders are cancelled when patients go to surgery or the delivery room, when a general anesthetic is administered, or when the patient is transferred to another service or an intensive care unit. All orders will be re-written as part of new admission orders, dated and timed.

6. Outpatient standing orders are limited to six (6) months in duration.

7. The following medications have specific automatic stop orders:
   - 5HT3 receptor agonists (Zofran, Anzemet, Kytril, etc.) – five (5) days
   - THC (Marinol) – ten (10) days
   - Fentanyl (Duragesic) patches, benzodiazepines and Zolpidem (Ambien) – fourteen (14) days
   - Ketorolac therapy – five (5) days
8. All other inpatient drugs shall be stopped after thirty (30) days. Continuation of the medication shall require a new physician order.

_____________________
Administrator

4/23/07
Date

Approved by Clinical Board: 6/17/03, 1/17/06, 1/16/07, 4/17/07
Written: 3/97
Transferred to Hospital Policy Manual – March 2001
Reviewed: 3/01, 6/03, 10/06
Revised: 6/03, 12/05, 10/06, 3/07
HIGH-RISK MEDICATION PROTOCOLS

Purpose:

To standardize and limit the number of drug concentrations of high-risk medications and to assure concentrated electrolytes (including, but not limited to: potassium chloride, potassium phosphate, sodium chloride >0.9%) are provided in a safe and effective manner.

Medications included:

- Aminophyllin
- Antineoplastic Agents
- Colchincine injection
- Heparin
- Iron Dextran
- Magnesium sulfate
- Morphine
- Potassium chloride
- Phenytoin and Fosphenytoin
- Promethazine
- Vincristine

Policy:

To establish guidelines for safe administration of high-risk medications in general care areas.

AMINOPHYLLIN

1. Standard aminophylline IV infusion: 1 gram aminophylline in 250ml of diluent.

2. The aminophylline solution must be infused via an infusion device.

ANTINEOPLASTIC AGENTS

1. All antineoplastic orders must be signed or co-signed by an Attending (Faculty) hematologist or oncologist prior to processing.

2. Verbal orders for initial antineoplastic chemotherapy will not be accepted.
3. A verbal order can be taken to clarify an existing antineoplastic chemotherapy order.

4. Physician orders should be sent via pneumatic tube system to Pharmacy. If necessary, a computer print out of the physician’s orders may be faxed but at no time shall a physician’s handwritten orders be faxed.

5. Physician orders must include the following information:
   a. Medication ordered
   b. Dose of medication ordered in units (i.e., mg/m2, mg/kg)
   c. Total dose of medication
   d. Administration route
   e. Administration rate
   f. Administration frequency
   g. Total course of therapy (i.e., number of doses, number of days)

**Colchicine Injection** - Can only be prescribed by Rheumatology physicians.

**HEPARIN - Weight-Based Heparin Protocol for Adults**

*(All blanks must be filled in by prescriber)*

1. Patient weight (total body weight) ______________ kg.

2. Laboratory: Baseline PTT, PT/INR
   Baseline CBC with platelets
   Daily PT/INR when initiating warfarin
   Daily PTT after therapeutic range reached

3. Initial Heparin Therapy: (Heparin 25,000 units in 250ml of 0.45%
   NaCl = 100 units/ml)
   a. Loading Dose = 80 units/kg = __________ units
   b. Initial Maintenance Dose = 18 units/kg/hour = __________ units/hr = __________ ml/hr
4. PTT (6) six hours after heparin bolus and per sliding scale below.

5. Sliding Scale Heparin Adjustment: (Adjust heparin by sliding scale below until therapeutic range is maintained (PTT = 46-70 sec. or ______ - ______ sec.)

<table>
<thead>
<tr>
<th>PTT</th>
<th>Repeat Bolus</th>
<th>Hold Infusion</th>
<th>Rate Change</th>
<th>Repeat PTT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 35</td>
<td>Fullbolus</td>
<td>No</td>
<td>+ 2.5ml/hr (250 units/hr)</td>
<td>6 hours</td>
</tr>
<tr>
<td>35-45</td>
<td>Half Bolus</td>
<td>No</td>
<td>+ 1.0ml/hr (100 units/hr)</td>
<td>6 hours</td>
</tr>
<tr>
<td>46-70</td>
<td>None</td>
<td>No</td>
<td>No Change</td>
<td>Next Day</td>
</tr>
<tr>
<td>71-90</td>
<td>None</td>
<td>No</td>
<td>- 1.0ml/hr (100 units/hr)</td>
<td>6 hours</td>
</tr>
<tr>
<td>&gt; 90</td>
<td>None</td>
<td>60 minutes</td>
<td>- 2.0ml/hr (200 units/hr)</td>
<td>6 hours</td>
</tr>
</tbody>
</table>

6. Call Prescriber for 2 consecutive PTT’s > 90 sec. or < 35 sec., or for 2 Gm decrease in Hgb, or platelets less than 100,000/dl.

7. Begin warfarin _____ mg po daily with initiation of heparin therapy. (Recommended starting dose is 5mg per day.)

8. Discontinue heparin after a minimum of 4 days of concomitant warfarin therapy and therapeutic INR level is reached. (Separate order required)

IRON DEXTRAN

1. Adverse reactions to intravenously administered iron dextran may be immediate or delayed. Anaphylactoid reactions can occur; therefore epinephrine must be readily available. Other adverse reactions may include flushing, joint pain, nausea, fever, bronchial constriction, headache and urticaria.

2. Each time a new course of therapy is begun, another test dose must be given and the following guidelines will be followed depending upon the infusion technique utilized.

3. Total dose infusion technique guidelines:
   a. Epinephrine must be readily available and the physician must remain on the unit for one-hour post-test dose.
b. A test dose of 0.5ml (25mg) must be given intravenously prior to administration of the total dose. This test dose may be given by slow IVP or given in a separate mini bag.

c. Within 15 minutes of completion of the test dose, vital signs should be taken and recorded.

d. The total dose infusion may be given 30 minutes after the test dose is completed if no reactions occur. It should be administered per an infusion device over 4 to 6 hours at a rate of 10-15 milligrams per minute.

4. Divided daily dosage guidelines:

   a. Epinephrine must be readily available and the physician must remain on the unit for one-hour post-test dose.

   b. A test dose of 0.5ml (25mg) must be given intravenously prior to administration of the total dose.

   c. Within 15 minutes of completion of the test dose, vital signs should be taken and recorded.

   d. The first day’s dose may be given 30 minutes after the test dose is completed provided no adverse reactions occur. No more than 100mg may be infused daily with this method.

MAGNESIUM SULFATE

1. Not more than 2 grams (4ml of a 50 percent solution) of magnesium sulfate may be diluted in 250ml of diluent.

2. The solution should be infused at a rate of not under two hours.

3. An infusion device should be utilized.

4. Monitor blood pressure at least every two hours while drug is infusing.

5. If a larger dose or more concentrated solution is needed, the patient should either be moved to an intensive care unit or the attending physician contacted.

6. Exceptions: Total Parenteral Nutrition Solutions and Code situations, and obstetrics. The labor unit may utilize a 20-gram/
500ml dilution of magnesium sulfate. Other perinatal care areas may utilize a 4-gram/100ml dilution of magnesium sulfate.

**MORPHINE**

1. Continuous Patient Controlled Anesthesia (PCA) is the route for morphine administration.

See Nursing Policy P-15 for eligible patients, physician documentation as to necessity of IV administration and monitoring of therapy.

**POTASSIUM CHLORIDE**

1. 20mEq potassium ion shall be admixed with *not less than 50ml of diluent*.

2. 40mEq potassium ion shall be admixed with *not less than 100ml of diluent*.

3. 60mEq potassium ion shall be admixed *in 250ml – 1000ml of diluent*.

4. No more than 60mEq per liter shall be admixed in a Parenteral Nutrition Solution.

5. The maximum rate of infusion shall be *10mEq per hour* for General Care Areas.

6. The maximum rate of infusion for all other areas shall be *20mEq per hour*.

7. Patients requiring greater than *10mEq per hour* shall be continuously monitored.

8. Potassium containing solutions must be administered via an infusion device.

9. Doses shall not be repeated until the physician has checked the patient’s serum potassium.

10. Staff physician approval must be obtained to exceed the limits of the established guidelines via a non-formulary request.

11. Undiluted potassium ion solutions shall not be floor-stocked.
PHENYTOIN & FOSPHENYTOIN

1. Phenytoin & Fosphytoin have cardiovascular effects that can be more pronounced when given parenterally.

2. Administration is restricted on general patient care units and can only be administered parenterally by a physician.

3. A physician must monitor the patient’s EKG continuously for the first hour after each administration.

4. Special care units may use these agents as detailed in their approved unit specific policy.

PROMETHAZINE

1. Promethazine must be diluted to a concentration of 25mg/10ml with normal saline or other compatible diluent to reduce vesicant effects and allow for slow IV administration.

VINCIRISTINE AND VINBLASTINE

1. Vinca alkaloids (vincristine and vinblastine) are administered by the IV route only.

2. The major toxicity associated with these agents is neurotoxicity that is dose limiting and tissue necrosis if the drug extravasates. Neurotoxicity usually is reversible with discontinuation of the drug.

3. Vinca alkaloid overdoses cause sensory impairment and motor nerve involvement that can be debilitating and even fatal.

4. Inadvertent intrathecal (spinal route via lumbar puncture or Ommaya reservoir) vinca alkaloid administration is usually fatal and every effort to prevent this type of medication error should be employed.

PREPARING, DISPENSING, AND ADMINISTERING VINCIRISTINE OR VINBLASTINE FOR INJECTION

PHARMACIST:

1. All doses of vinca alkaloids shall be prepared in the hospital pharmacy only as an IVPB in 25ml NS at the time it is to be
administered. Vinblastine doses greater than 10mg may be placed in 50ml of fluid.

2. All doses of vinca alkaloids shall be clearly labeled. “Infuse as IVPB over 15 minutes” shall be printed on the label.

3. All doses of vinca alkaloids shall be labeled that it is for intravenous use only, and may be fatal if administered by any other route.

4. All doses of vinca alkaloids shall be dispensed in a separate Ziploc container.

NURSING:

1. Conduct and document a "TIME OUT" with at least two qualified healthcare professionals to independently verify the drug, dose, route and time. This should be done prior to scanning the patient and documenting the administration in MAK. (Refer to Hospital Policy 8.20)

_______________________
Administrator

7/19/07
Date

Approved by Clinical Board: 3/20/01, 9/18/01, 1/21/03, 7/20/04, 4/19/05, 10/18/05, 1/16/07, 7/17/07
Reviewed: 6/04, 3/05, 11/06, 5/07, 6/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

INTRAVENOUS MEDICATIONS

Policy:
To specify which medications may be administered via IV push on General Care Units.

Procedures:

1. The following medications may be administered IV Push by RNs on General Care Units:

- Bumetanide – (Bumex)
- Cimetidine – (Tagamet)
- D25W – (Dextrose 25% in water)
- D50W – (Dextrose 50% in water)
- Dexamethasone Sod. Phosphate
- Diazepam - (Valium)
- Diphenhydramine – (Benadryl)
- Dolasetron – (Anzamet)
- Droperidol – (Inapsine)
- Enalapril – (Vasotec)
- Factors 8 and 9 -
- Famotidine – (Pepcid)
- Furosemide - (Lasix)
- Granisetron - (Kytril)
- Heparin – (Liquaemin)
- Hydrocortisone Sod. Succinate – (Solu-Cortef)
- Hydromorphone Hydrochloride – (Dilaudid)
- Methylprednisolone Sodium Succinate – (Solu-Medrol)

- Ketoralac – (Toradol)
- Lorazepam – (Ativan)
- Meperidine – (Demerol)
- Meoclopramide – (Reglan)
- Morphine – (Morphine)
- Naloxone – (Narcan)
- Ondansetron – (Zofra)
- Prochlorperazine – (Compazine)
- Rho(D) Immune Globulin for ITP – (WinRho SD)
- Saline/Heparin Lock Flush-
- Warfarin – (Coumadin)

Atropine and epinephrine may be administered provided the RN is competent in Arrhythmia recognition and the patient is cardiac monitored. (Refer to Nursing Policy)

Registered nurses may administer unit specific medications IV Push if the medications are approved by the P&T Committee. Administration of these medications shall be covered in Unit Specific Policies.

2. IV Flushes
Unless otherwise ordered by the physician, 1-3ml of normal saline shall be used as the flush for locks on adult nursing units. Heparin
flush should continue to be utilized with pediatric patients unless otherwise ordered by the physician.

3. For IV Catheter Clearance
Recommend dose 2mgs of alteplase; Dosing ranges of 2-5mg are acceptable.

_______________________
Administrator

____11/19/08___________
Date

Approved by Clinical Board: 3/20/01, 6/18/02, 7/19/05, 11/18/08
Revised: 8/94, 5/95, 3/96, 4/96, 3/98, 11/00, 5/02, 5/05, 10/08
FORMULARY SYSTEM

Purpose:

To denote the type of formulary system in use at LSUHSC-S.

Policy:

LSUHSC-S operates under a closed formulary system, which helps assure the quality of drug use and controls cost. The hospital formulary is continually revised to compile a catalog of pharmaceuticals, which reflect the current clinical judgment of the Pharmacy and Therapeutics Committee with approval by the Clinical Board. The formulary is reviewed annually to assess medications for continued safety, including look-alike/sound-alike drugs, and efficiency. The P&T Committee endorses in principle the policy of prescribing, dispensing and administering drugs by their generic names. Only one brand of drug dosage form is stocked. Orders for drugs written for brands other than those stocked will be filled with the generically equivalent brands that are available. There are two classifications of drugs under the formulary system and they are defined as follows:

A. Formulary Drugs

A formulary drug is one that has been reviewed and accepted by the Pharmacy and Therapeutics Committee and which, in the opinion of the clinicians from various departments knowledgeable and experienced in the use of the drug is:

1. conducive to rational drug therapy
2. considered essential for patient care
3. not duplicated by another agent in the formulary
4. cost effective and whose therapeutic efficacy is well established.
Formulary drugs are listed in the Hospital Formulary, which is posted on the pharmacy website, and are stocked in the hospital pharmacy. The procedure for requesting that a drug be added to formulary is:

1. Any medical staff member or house staff may initiate a request for addition of a drug to the formulary. Requests must be endorsed by the Chairman of the Department or the Service Chief.

2. Formulary request forms are obtained from the pharmacy department. Forms will not be given to pharmaceutical company representatives.

3. The form must be completed in entirety and returned to Pharmacy.

4. Pharmacy shall forward a copy of the form to the Compliance Office for review of Conflict of Interest Information prior to being reviewed by the P&T Committee.

5. The request will be placed on the Pharmacy and Therapeutics Committee meeting agenda.

6. The requesting physician must present the request to the P&T Committee and answer any questions that arise.

7. The requesting physician is informed of the Committee’s decision.

8. The following changes in formulary may be made without committee approval:
   a. Deletion of products no longer commercially available.
   b. Drugs recalled or withdrawn from the market.
   c. Change in commercial size.
   d. Addition of a new strength of a drug if the drug’s indication, side effects, etc., do not differ from that of the formulary dosage form.
   e. Addition of a new dosage form of a drug if the drug’s indication, side effects, etc., do not differ from that of the formulary dosage form.
B. Non-Formulary Drugs

A non-formulary drug is one other than those classified as formulary drugs, or a special brand of any formulary drug, which is not stocked by Pharmacy. Non-formulary drugs will generally not be stocked by Pharmacy, but can be obtained for treatment of an individual patient as follows:

1. Requests for drugs, which have not been approved, by the Pharmacy and Therapeutics Committee will be referred back to the prescriber. If it is the opinion of the prescribing physician that the agents available on formulary would not meet the needs of the patient, the prescribing physician must obtain approval from the Attending Physician to use the drug by having the Non-formulary Drug Request Form (SN 1066) completed and forwarded to the Pharmacy.

   a. If the Attending is not available to sign the request, the ordering physician must obtain and document on the form verbal approval from the attending. After this consultation, the Attending can approve the ordering physician to sign his/her name to the form.

   b. Signature must be legible.

2. The request is valid only for that particular patient and only for that admission.

3. The completed form should be sent to Pharmacy where the request will be noted and the drug obtained unless the drug has been previously listed on the “will not buy” list.

4. The Pharmacy will compile all non-formulary drug requests and report utilization data to the P&T Committee on at least a quarterly basis.

5. If the patient’s own supply of medication brought into the hospital is to be administered, the physician must write an order for such administration in accordance with policy.

6. Non-formulary drugs will be obtained from sources outside the hospital when they are requested. Pharmacy will purchase the most appropriate package size available based on intended duration of therapy.

7. First-time use of a Non-Formulary drug in the institution or first-time use of a formulary drug in a special patient
population, e.g. pediatrics, for which safety and efficiency data is not available must be approved by the Chairperson of the Pharmacy and Therapeutics Committee, Associate Dean for Medical Affairs, or Assistant Dean for Medical Affairs.

Administrator

5/22/06
Date

Written: 2/80
Revised: 3/95, 11/97, 11/03, 6/04, 5/06
Reviewed: 1/01, 11/03, 6/04, 5/06
Clinical Board Approved: 1/16/01, 1/20/04, 7/20/04, 5/16/06
HOSPITAL DRUG STORAGE AND CONTROL

Policy:

All policies and procedures pertaining to drug distribution, administration and control by hospital personnel shall be submitted by the respective departments to the P&T Committee for review before such policies and procedures are initiated. Should such policies and procedures need to be initiated before the next scheduled meeting of the P&T Committee they shall be reviewed by the Committee chairman, secretary and nursing service representatives.

A. Emergency Drugs

1. Pharmacy shall be responsible for maintaining medications on crash carts. Emergency medications stocked on crash carts are reviewed annually by the Special Care Committee.

Procedure: Pharmacy will provide crash cart medications in sealed drawers to Central Medical Supply (CMS) to be placed in cleaned, refilled crash carts immediately prior to locking. Refer to Hospital Policy 5.12.1 for details.

2. Pharmacy shall be responsible for maintaining emergency drugs in the radiologic procedures areas for treatment of immediate IV contrast reaction.

Procedure: Pharmacy will provide a sealed bag containing medications as determined by a faculty radiologist and the director of pharmacy to be stored in designated procedure areas. The expiration date of the contents will be listed on the container and inspected daily by department of radiology personnel. Inspection and replacement of used/outdated contents will be accomplished per department of radiology procedures 4.14.1.

B. Inspection of Drug Storage Facilities

The proper storage of pharmaceuticals throughout the hospital shall be a responsibility of the Pharmacy Department. Monthly inspections of drug supplies throughout the hospital shall be conducted by pharmacy personnel in cooperation with the appropriate nursing personnel.
C. Medication Storage

Medications shall be stored according to the following guidelines.

1. Medications are stored under conditions to ensure stability.

2. All medications including nonprescription medications are in locked containers in a room or are under constant surveillance by appropriate personnel.

3. Medications that are easy to confuse (sound alike and look alike drugs or reagents or chemicals that may be mistaken for medications) are segregated.

4. All medication storage areas are periodically inspected according to policy to ensure medications are stored properly.

5. Medications and chemicals used to prepare medications are accurately labeled with:
   a. Contents
   b. Expiration dates
   c. Appropriate warnings

Administrator

3/1909
Date

Approved by Clinical Board: June 2000, 3/16/04, 4/17/07, 3/17/09
Written: 6/00
Combined 8.7.1, 8.1.5, 8.1.2 and 1 new (1/29/04)
Reviewed: 3/01, 1/04, 3/07, 2/09
Revised: 2/04, 3/07, 2/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

RESTRICTIONS IN THE USE OF SPECIAL DRUGS

Policy:

The Administration of the Hospital, in consultation with the Director of Pharmacy, the Chairman of Pharmacy and Therapeutics (P&T) Committee or the Antibiotic Review Committee, and the Hospital Medical Director, reserves the right to restrict or regulate the use of medications when deemed necessary. Any restrictive action will be reviewed at the P&T Committee or Antibiotic Review Committee for future formulary consideration. Recommendations shall be sent to the Clinical Board.

[Signature]

Administrator

6/21/07
Date

Approved by Clinical Board: 6/00, 6/15/04, 6/19/07
Written: 4/94
Rewritten: 5/04
Reviewed: 3/01, 5/04, 5/07
USE OF INVESTIGATIONAL DRUGS

Policy:

Investigational Drugs (INDs) will refer to those drugs, which have not yet been released by the Federal Food and Drug Administration for general use or are commercially available drugs used as part of an investigational protocol. Therefore, they will include drugs bearing the following cautionary labeling: “CAUTION – NEW DRUG – Limited by Federal Law to Investigational Use.” INDs are also used under provisions of an investigational drug, as authorized by the Food and Drug Administration to a physician investigator. Principal Investigator will refer to the physician signing the FDA release for obtaining the drug(s). Co-investigator(s) may be designated by the principal investigator.

Procedure:

1. All protocols involving investigational drugs must be approved by the Institutional Review Board (IRB) before they may be initiated.

2. All investigational drugs for inpatient use shall be stored and dispensed from the Pharmacy, according to guidelines established by the P&T Committee.

3. It shall be the responsibility of the pharmacy director to establish suitable procedures for the proper labeling and dispensing of these drugs in accordance with the principal investigator’s orders.

4. The signed informed consent form as required by the institution’s IRB must be obtained prior to commencing therapy. It is the principal investigator’s responsibility to ensure the consent form is complete before initiation of the protocol.

5. It is the responsibility of the principal investigator to provide the Pharmacy Director with the signature and legible written names of all co-investigators authorized to release investigational drugs from the Pharmacy. No drugs can be released from the Pharmacy until such time as the physician’s order is received in the Pharmacy with the authorized signature and LSU protocol number of pre-approved
nomenclature. The pharmacy director or designee implements a procedure to be followed for dispensing each IND. Pharmacy will maintain an inventory log of drugs dispensed.

6. Study drugs may be dispensed by the physician investigator when research is performed on outpatients. It is expected that the principal investigator will take appropriate and adequate steps to ensure proper security of all investigational drugs. In this case, the investigator will maintain all records.

7. A pharmacist may initiate or adjust drug therapy and/or order laboratory tests associated with a drug study protocol when requested to do so by the principal investigator. Any pharmacist participating in such a protocol must be trained and deemed competent to participate by the principal investigator or his/her designee.

8. The form “Investigational Drug Information Record” is a portion of the Request for Approval of Investigational Drugs Involving Use of Human Subjects, which is submitted to the IRB for review. It is the responsibility of the principal investigator to place a copy of each form in the patient’s medical record so that it is available for all staff. A completed form containing this information shall be on file in the Pharmacy Department. It is expected that the principal investigator or a designated person familiar with the research will be available to answer questions that may arise and are not covered in this data. It shall be the responsibility of the principal investigator to collaborate with pharmacy and nursing to make any necessary arrangements for the administration and control of these drugs on the individual nursing units.

9. All health care professionals, prior to administering an investigational drug, must complete a competency assessment form to be filed within their respective departments. Competency assessment forms (S/N 1146 may be obtained on each nursing unit or from the department director.)

10. All adverse reactions must be reported to the investigator, hospital pharmacy, the IRB and the sponsor. Adverse reactions must also be reported on the hospital variance website. The investigator is ultimately responsible for completing the necessary paperwork in reporting adverse reactions to appropriate local, state and federal agencies.
Hospital Policy Manual
Policy Number: 8.8
Effective Date: 4/01/07

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Administrator

3/27/07
Date

Approved by Clinical Board: 1/16/01, 2/17/04, 3/20/07
Reviewed: 9/98, 3/99, 1/01, 11/03, 1/07
Revised: 11/03, 1/07
PERSONNEL AUTHORIZED TO PRESCRIBE MEDICATIONS

Purpose:

To establish to whom medication prescribing privileges are given at LSU Health Sciences Center.

Policy:

1. The prescribing of medications for patients shall be limited to licensed (granted by the Louisiana State Board of Medical Examiners) practitioners of medicine and dentistry who are members of the medical staff (including Clinical Fellows in training) or house staff (including international physicians practicing under the Graduate Education Temporary Permit) as approved by LSUHSC-S.

2. All medication orders written by medical students must be countersigned by the above before such orders may be executed. It is the responsibility of the medical student to have orders countersigned by a licensed individual.

Administrator

3/27/07

Date

Approved by Clinical Board: 1/16/01, 2/17/04, 3/20/07
Written: 1/85
Revised: 7/90, 3/95, 10/97, 11/98, 12/03, 12/06
Reviewed: 2/01, 12/03, 12/06
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

MEDICATION ORDER INFORMATION

Policy:

Physicians shall record legibly all medications to be administered during the patient’s hospitalization. Unapproved abbreviations shall not be used on medication orders. Allergies must be documented in the medical record and pharmacy information system prior to dispensing of medications unless the information is unavailable.

1. Orders must include the following information:
   a. Date and time written
   b. Name of the medication, preferably by generic name. Specifications of appropriate salts (i.e. potassium chloride or potassium phosphate) must be written on ALL orders.
   c. Drug strength and dosage units (dose ranges are unacceptable)
      1.) Metric units only (except for standard “unit-based” dosing (i.e. insulin)
      2.) If dosing is specified as a volume, specify the concentration as well (i.e. mg/ml) or refer to standard concentration.
   d. Route of administration
   e. Frequency of interval of administration – All orders for PRN medication must include a specific time interval and an indication (time ranges are unacceptable)
   f. Physician’s signature, including credentials and Pager Number

2. Requirements for specific types of orders:
   a. Weight (kg or gm) – Needed only for those drugs that are dosed based on weight (i.e. chemotherapy)
b. Diluent – Specify if requiring diluent OTHER THAN the standards (5% Dextrose or 0.9% NaCl)

3. Tapering/titrating orders shall include the above listed information parameters for administration based upon laboratory results or physical exam criteria. (Example: blood glucose level for insulin administration)

4. Order requirements for pediatric patients (less than or equal to 17 years of age except for obstetrics) include the following:
   a. Weights (kg or gm) are required for ALL pediatric patients
   b. Dose
      1.) Dose/kg/interval for all patients less than 40 kilograms (i.e. mg/kg/dose or mg/kg/day)
      2.) For medications given in combination the dose/kg interval should be specified for one of the medications in the combination
      3.) Elemental preparations (i.e. iron and zinc) should be ordered based on the desired dose of the element (not the salt)

5. There is a documented diagnosis, condition, or indication-for-use for each medication ordered in the medical record.

6. All drug orders are cancelled when the patient undergoes a surgical procedure in the OR, delivers a baby, receives a general anesthetic, or is transferred to a different level of care (i.e. from an ICU to a general care area and vice versa). Drug orders are not required to be rewritten when patients are transferred from one general care unit to another general care unit.

7. Blanket re-instatement of previous medication orders are not acceptable.

8. Pharmacy automatically discontinues medications after specified time frames:
   a. After 72 hours – narcotic analgesics
b. After 14 days – benzodiazepines (sedatives) and azithromycin

c. After 5 days - Ketorolac

d. After 30 days – all other medications

9. Actions to be taken if medication orders are incomplete, illegible or unclear include, but are not limited to:

a. Contact prescriber for clarification

b. If prescriber is unavailable, contact another physician on the same service and team

c. If the above are unavailable, contact the on-call physician.

Administrator

1/28/08
Date

Approved by Clinical Board: 6/00, 4/20/04, 4/21/05, 11/21/06, 1/15/08
Written: 4/00
Reviewed: 12/03, 10/06, 12/07
Revised: 2/04, 3/05, 10/06, 12/07
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT

DISCARDING MEDICATIONS

Purpose:

To assure proper administration of sterile medications and reduce the risk of nosocomial infection.

Policy:

1. All vials or ampules that state “contains no preservative” and/or “single use” shall be discarded after each use regardless of the amount not used.

2. All medications shall be discarded according to manufacturer recommendations. Medications that require reconstitution must be timed, dated, and initialed when reconstituted; must be used within one hour of reconstitution; and discarded immediately after use.

3. Multi-dose vials (those that contain a preservative) are timed, dated and initialed upon initial needle puncture. All multi-dose vials shall be discarded within 28 days of needle puncture or immediately upon expiration if sooner than 28 days, possible contamination or improper storage, i.e. not refrigerating or exposure to light.

4. All outdated drugs, overstocked medications, and those with worn containers or illegible labels shall be returned to Pharmacy for disposition.

_____________________

Administrator

2/19/09

Date

Clinical Board Approved: 1/16/01; 9/17/02, 11/15/05, 2/17/09
Written: 10/83
Revised: 8/91, 3/95, 11/97, 9/02, 4/04 typo correction only, 10/05, 1/09
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER - SHREVEPORT

MEDICATIONS REQUESTED ON INTERNAL TRANSACTIONS

Policy:

To establish guidelines for obtaining medications via Internal Transactions.

1. Medications requested on Internal Transactions shall be authorized and signed by a physician.

2. Non-formulary medications will be provided only if a Non-formulary Drug Request is completed by a physician and signed by the Department Chairman.

3. Controlled substances shall not be issued via an Internal Transaction.

4. Medications can only be obtained on an internal transaction for IRB approved outpatient research that has been pre-approved by Hospital Administration and the Director of Pharmacy. Internal transactions shall not be used to obtain medications for inpatient use.

[Signature]
Administrator

6/21/07
Date

Approved by Clinical Board: 3/20/01, 6/15/04, 6/19/07
Written: 3/01
Reviewed: 5/04/07
Revised: 5/04, 5/07
Oral Care
Purpose: To provide guidelines for the critical care nurse.cardiopulmonary therapist in providing effective oral care for the critically ill patient. To aid in the prevention of ventilator associated pneumonia.

I. Expected Practice:

A. Ventilated patients shall have routine oral care preformed at least every 12 hours.
B. Ventilated patients at high risk for ventilated associated pneumonia shall have oral care performed every 4 hours. This includes neurosurgery and trauma patients and/or any patient deemed high risk by the Nurse or Physician.
C. Assessment of the endotracheal tape job will be done every 12 hours by the respiratory therapist.
D. The endotracheal tube shall be re-taped according to cardiopulmonary policy.
E. The healthcare team will initiate a nutritional consult upon admit and assess for initiation of enteral nutrition.
F. The use of undiluted sodium bicarbonate, hydrogen peroxide and lemon glycerin swabs shall be avoided.

II. Guidelines:

Routine Oral Care
Routine oral care shall be done on all intubated patients.
1. The critical care nurse shall initiate oral care on a routine bases on all patients who are intubated.
2. The physician shall place order on chart if special considerations are to be made.
3. Teeth shall be brushed at least every 12 hours with preferably a small headed soft toothbrush or foam stick.
   a. Patients with low platelet counts, DIC or coagulopathies shall have teeth cleaned with soft foam sticks.
   b. With extreme coagulopathies the nurse/therapist may forgo oral care during the acute phase of bleeding. Documentation of reasoning shall be done.
4. Oral moistening shall be done every 8 hours with moisturizer or saline.
5. Lip Care shall be done every 8 hours with soft moist cloth and placement of a moisturizer.
6. The yankner oral suctioning device shall be changed every 24 hours.
7. Assessment of the endotracheal tape job will be done every 12 hours by the respiratory therapist.
**High Risk Patients**
High risk patients are defined as that group of patients who have developed an increased number of VAP via infection control surveillance.

1. Oral care shall be provided every 4 hours using the Toothette Oral Care Kit.
2. A 24 hour Oral Care Kit shall be placed at the beside at the start of the day.

**MD/RN**
Assess the patient for risk of acquiring ventilator associated pneumonia.

**RN/Cardiopulmonary Therapist**
1. Assess the oral cavity and endotracheal tape at least every shift and document findings.
2. Complete oral care routine at least every 8 hours for routine oral care and every 4 hours for high risk care.
   a. Wash hands
   b. Don gloves
   c. Suction oral cavity
   d. Rinse oral cavity with moisturizer/saline
   e. Suction oral cavity
   f. Wipe mouth with moist cloth
   g. Place lip moisturizer
   h. Use oral care kit per instructions on Kit.
   i. Remove gloves
   j. Wash hands
   k. Document procedure
3. Complete tooth brushing with small headed soft toothbrush/foam stick and cleanser at least every 12 hours.
4. Assist cardiopulmonary with re-taping as needed.
5. Enter nutritional consult once patient is intubated in hospital ordering system.

**Resources:**
1. AACN Practice Alert: Oral Care In the Critically Ill. (8/2006)
Sedation Monitoring

Purpose: To provide guidelines for appropriate monitoring of ventilated patient’s receiving continuous sedative agents.

Policy:
1. All patients on continuous sedative agents shall be monitored at least every 4 hours to assess sedation level.
2. A sedation scale that assesses both agitation as well as sedation shall be used to assess level of sedation/agitation.
3. The physician shall be responsible for determining appropriate sedation level.
4. The nurse will follow the physicians order to maintain the patient in the appropriate sedation level.
5. Daily Awakening Trials (DAT) shall be performed on appropriate patients.
6. The physician shall be responsible for determining which patients shall receive DATs.
7. During the ventilator weaning process patients shall receive active titration of sedatives to ensure appropriate levels of awakening.

Responsible Parties:

MD/MD student with MD supervision
1. assess the need for continuous sedation
2. Orders appropriate level of sedation.
3. Assess patient’s readiness for ventilator weaning.
4. Orders DATs for appropriate patients.

RN
1. Monitors level of sedation/agitation at least every 4 hours.
2. Documents sedation/agitation level at least every 4 hours.
3. Titrates continuous sedation per physician order.
4. Performs DATs per physician order.
5. Informs physician of changes in patient condition.
6. Assess patients need for Day/Night routine and promotes routine if possible.
7. Encourages patient’s family to bring pictures of familiar surroundings (family, friends, pet, etc.)
8. Encourages patient’s family to bring music from home and plays music as needed.
9. Monitors for tolerance of DAT.
10. If patient becomes restless or agitated during DAT, restarts continuous infusion at \( \frac{1}{2} \) the dose and titrates as necessary for appropriate level of sedation.

11. Informs physician of any signs of delirium.

12. Documents appropriately in nurses’ notes regarding sedation/agitation and delirium.

13. Educates family regarding sedation during ICU stay.

Contraindications for DAT:

- Increased ICP
- \( \text{FiO}_2 > 50\% \)
- Hemodynamic instability
- Paralytics
- Cardiogenic shock
- Active upward titration of sedation

Criteria for Day/Night Routine:

- Awake and Alert
- Hemodynamically stable
- Patients awaiting rehab placement with hemodynamic stability
- Overflow patients

Day/Night Routine:

1. Lights out and quiet environment from 2200 – 0600
2. Minimal vital signs while asleep.
3. Lab drawn at 0600
4. At 0600, lights on, out of bed, TV on.

References:


Preventing Ventilator Associated Pneumonia

Purpose: To provide guidelines for the critical care healthcare staff in preventing ventilator associated pneumonia (VAP)

Expected Practice:

1. Hand washing shall be performed before and after every patient or equipment contact.

2. Elevation of head of bed (HOB) 30 – 45 degrees. Patients with contraindications for elevated head of bed shall be placed in reverse Trendelenberg.
   a. Contraindications to elevated HOB
      i. Present or suspected spine injury
      ii. Prone positioning patients
   b. In the NICU patients shall be placed in reverse Trendelenberg if medically appropriate.

3. Daily Awakening Trials shall be performed on appropriate patients as per physician preference.
   a. If unable to wean sedation the physician shall document in the progress notes the patient's medical condition.

4. Patients shall be assessed for readiness to extubate daily. All attempts shall be made to wean. Once the patient is on minimal ventilator settings weaning parameters shall be performed and documented on the ventilator management flow sheet.
   a. If unable to wean ventilator the physician shall document in the progress notes the patient's medical condition.

5. Patients shall be placed on peptic ulcer prophylaxis (PUD) unless contraindicated.

6. Patients shall be placed on DVT prophylaxis unless contraindicated.
   a. Patients shall have both pharmacologic as well as non–pharmacologic prophylaxis provided if indicated by the physicians.
   b. If contraindication present the physician shall document in the progress notes the patient’s medical condition.

7. Early assessment of nutritional needs shall be completed and recommendations performed.

Resources:

1. Institute for Healthcare Improvement. www.ihi.org
5. Oral Care Guidelines. LSUHSC – Shreveport. Critical Care
Preventing Central Line Blood – Stream Infections

Purpose: To provide guidelines for the critical care healthcare staff in preventing central line blood – stream infections.

Expected Practice:
1. Hand washing shall be performed before and after every patient or equipment contact.
2. Physicians shall use maximum barrier precautions upon catheter insertion.
   a. Physicians shall use large body drape
   b. Physicians shall wear mask
   c. Physicians shall wear hat
   d. Physicians shall wear sterile gown
   e. Physicians shall wear sterile gloves
3. Chlorohexidine skin prep shall be used to prep patient skin. See Infection Control Policy 22.0 Skin Preparation for Invasive Procedures.
4. Physicians shall perform surgical hand scrub with chlorohexidine for 6 minutes. See Infection Control Policy 2.0 Hand Hygiene.
5. The physician shall place the catheter in the optimal site appropriate for that patient.
6. Dressings shall be changed at least every 96 hours.
   a. Please see unit specific policy for dressing changes.
   b. Chlorohexidine skin preparation shall be used with dressing changes.
7. The physician and nurse shall assess for need of central access every 24 hours.
   a. Central line access shall be removed as soon as possible.
8. Central lines shall be changed if any signs of line infection present and physician feels central line blood stream infection present.

Resources:
1. Institute for Healthcare Improvement. www.ihi.org
Continuous Narcotic and Sedative Usage in the ICU

**Purpose:**
To provide guidelines for nurses administering continuous narcotics and sedatives to critically ill patients in the ICU.

**Policy:**
1. The nurse shall note the physician’s order for continuous narcotics and/or sedation.
2. The nurse shall obtain sedative and/or narcotic from pharmacy’s automated dispensing system. The same nurse shall mix, hang, and document narcotic and/or sedative.
3. The nurse shall mix the continuous infusion using standard concentration. If the physician wants a different concentration other than the standardized form, an order shall be written as to how the concentration is to be made.
4. The nurse shall dispense the volume of the bag where the narcotic/sedative are mixed into a Buritrol ready for continuous infusion.
   a. If the patient is a child or infant a syringe can be used to mix the infusion. Once infusion mixed it shall be placed on an auto – syringe to administer.
5. The Buritrol is then placed on a controlled rate IV pump.
7. Nurse documents on flowsheet any change in rate or stoppage of continuous infusion.
8. Pain and sedation shall be assessed every 4 hours during infusion.
9. Upon completion of continuous infusion 2 nurses shall waste and document wastage in the automated dispensing system.
10. Also refer to Hospital Policy 8.13 Control of Medications and Nursing Policy P – 15 Patient Controlled Analgesia (PCA) Pump.

**Procedure:**

**RN**
1. Assess patient for need of continuous sedation or pain medication.
2. Discuss with physician regarding initiation of continuous infusion.
3. Notes and sends order for sedation and/or narcotic to pharmacy.
4. Mixes infusion according to standard concentration.
5. Documents name, drug, admixture volume, date, time and nurses initials on label and label placed on infusion.
7. Dispenses infusion volume into Buritrol in – line with controlled rate IV pump tubing.
8. Sets controlled IV pump to desired rate to give prescribed dosage.
   a. Nurses shall document in MAK in units where MAK is used.
   b. Nurses shall document on the ICU flow sheet in units where MAK is not used.
      i. An (up arrow) on the flow sheet is indicative of a new infusion bag being hung at documented time on flow sheet.
10. Nurse documents on flow sheet any change in rate or stoppage of continuous infusion.
11. Reassess sedation and pain level every 4 hours.
12. Performs daily awakening trials as per unit specific policy.
13. Upon completion of continuous infusion 2 nurses shall waste and document wastage in the automated dispensing system.

**MD**
1. Assesses need for continuous sedation and/or pain medication.

Continuous Narcotic Usage
2. Orders continuous sedation and or pain medication.
3. Orders any change in sedation or pain medication.

Pharmacist
1. Receives order for continuous sedation and/or narcotic.
2. Enters order into pharmacy computer system in a timely manner.

**See Standard Concentration Policy**

References:
Minimally Invasive Hemodynamic Monitoring

I. Purpose:
1. To assess cardiac flow.
2. To provide an indication of cardiac function and volume status.

II. Policy:
1. RN’s shall use the Flo Trac Transducer and Vigileo monitor to assess minimally invasive hemodynamics.
2. The Edward Vigileo Monitor allow for continuous cardiac output monitoring and continuous central venous oxygen saturation monitoring. Continuous cardiac output monitoring via the Edwards Vigileo Monitor using the FloTrac Sensor attached to any arterial line will allow less invasive cardiac output monitoring. Continuous central venous oxygen saturation monitoring using the Precept catheter will allow less invasive monitoring than mixed venous oxygen saturation.
3. RN’s shall abide by the arterial line policy when using minimally invasive hemodynamics.

III. EQUIPMENT – Continuous Cardiac Output Monitoring:

<table>
<thead>
<tr>
<th>Functional arterial line</th>
<th>IV Pole</th>
<th>Pressure Bag</th>
</tr>
</thead>
<tbody>
<tr>
<td>FloTrac Sensor</td>
<td>Transducer Holder</td>
<td></td>
</tr>
<tr>
<td>Vigileo Monitor (Edwards)</td>
<td>IV bag of 250cc or 500cc - 0.9% Saline</td>
<td></td>
</tr>
</tbody>
</table>

IV. PROCEDURE – FloTrac Sensor Set up

1. Gather equipment
2. Explain to patient and/or family reason for addition monitoring.
3. Open the FloTrac Sensor packaging. Replace all caps with non-vented caps and ensure that all connections are tight.
4. Remove the FloTrac Sensor from packaging and insert into a transducer holder that is secured to an IV pole.
5. Insert the IV bag into the pressure bag and hang on the IV pole. Do not inflate pressure bag.
6. Flush the FloTrac Sensor holding pressure on the IV bag and pulling the flush tab. Clear all air and bubbles from the tubing.
7. Connect the green FloTrac connecting cable from the Vigileo Monitor to the green capped connector on the FloTrac Sensor.
8. Connect the bedside monitor’s arterial pressure cable to the white cable connector.
9. Connect the FloTrac tubing to the arterial line, using sterile technique.

10. Turn on the Vigileo Monitor and Set-up according to the first part of this procedure.

11. Level the FloTrac Sensor to the phlebostatic axis. Open the FloTrac Sensor to atmospheric air, rotate the knob on the monitor to **Zero** and press the knob. Select **Return** to exit screen.

12. Close the FloTrac Sensor

13. Zero the arterial channel on the bedside monitor.

14. Inspect arterial pressure trace on bedside monitoring screen or the waveform confirmation screen on the Vigileo monitor.
IV. PROCEDURE – Vigileo Monitor Set up

1. Press the ∅ button on the front panel to turn the Vigileo monitor ON.

2. When the POST is complete, enter patient information (gender, age, height, weight).

3. Connect the cables as outlined in the FloTrac Sensor Set up part of the procedure.

4. Rotate the navigation knob until the CO frame is outline in yellow and then press the knob to open the CO menu.

5. From the CO Menu, rotate the navigation knob until Zero Arterial Pressure is highlighted and then press the knob. The Zero Arterial Pressure screen will appear.

6. Open the FloTrac Sensor to atmospheric air, rotate the knob on the monitor to Zero and press the knob. Select Return to exit screen. Close the FloTrac Sensor.

7. Cardiac output will be displayed within 40 seconds after arterial pressure is registered by the FloTrac sensor.

KEY POINTS

- The screen will display a message indicating that a Power On Self Test (POST) is being performed.

- Information must be entered before continuous cardiac output monitoring can occur. Use the navigate knob to select and enter values. Press Continue to confirm selection and open the Home screen.
### III. EQUIPMENT – Central Venous Oxygenation Saturation Monitoring:

- PreCept Central Venous Catheter
- IV Pole
- Transducer Holder
- Pressure Bag
- Vigileo Monitor (Edwards)
- IV bag of 250cc or 500cc - 0.9% Saline

### IV. Procedure – Central Venous Oxygenation Saturation Monitoring:

1. Gather equipment

2. Explain to patient and/or family reason for addition monitoring.

3. Connects the optical module to the oximetry (red to red) connector on the back of the Vigileo monitor. Allows 20 minutes for the optical module to warm up.

4. Opens the PreSep central venous catheter lid exposing only the optics connection (or entire tray if physician is inserting at that time). Removes optics connection being careful not to contaminate tray contents. Catheter tip must remain in the sheath for in vitro calibration.

5. Connects PreSep central venous catheter to optical module matching “TOP” on both optical module and optics connection.

6. Performs an In-Vitro calibration before inserting the catheter by:
   - Rotates the navigation knob to highlight the Oximetry Frame and presses to display the Oximetry Menu.
   - Rotates the knob to select “Parameter” and then presses the knob.
   - Rotates the knob and highlight the parameter to be used for oximetry (ScvO2 - when using the PreSep central venous catheter or SvO2 – Edwards PA CCO / Oximetry catheter).
   - Rotates the navigation knob to select “HGB” (hemoglobin) or “HCT” (hematocrit), then enters the lab values.


8. Performing an “In-Vivo” calibration (May be done as an alternative to “In-Vitro” calibration. Must be done every 24 hours thereafter.)
   - Rotates the navigation knob to highlight “In vivo Calibration”.
   - Selects “Continue” unless a “Wall Artifact
or Sedge Detected or Unstable Signal” message appears. Attempts to troubleshoot per manual.

- Presses the navigation knob and then:
- Draws waste sample first – slowly from the distal lumen of PreCep Catheter.
- Vigileo Monitor will remain in this mode until blood sample results are entered.
- Draws lab blood gas sample slowly (2 ml over 30 seconds). Labels sample central venous blood gas sample.
- Sends sample to Blood Gas Lab. Upon receipt of lab values from drawn sample, uses the navigation knob to enter the oximetry value and either HGB or HCT value.
- After values are entered, rotates navigation knob to select “Calibrate”. (At end of 25 second countdown, the Calibration Menu is removed from the screen and the Oximetry Menu is displayed.)

9. Vigileo Oximetry Monitor Recall Optical Module Data

- When transporting patients disconnect the optical module cable from the back of the Vigileo monitor.
- Do not disconnect the optical module from the connector or data will be lost.
- After transfer back to unit, reconnects optical module cable to the Vigileo monitor.
- If optical module is being connected to another Vigileo monitor, makes sure that previous patient data is cleared from the monitor.
- Rotates the navigation knob to highlight the “Oximetry Frame”. Presses the knob.
- Under the Oximetry Frame, selects “Recall OM Data.” The calibration data in the optical module will be displayed.
- If optical module data is less than 24 hours old, confirms instructions and a Yes/No confirmation is displayed. Selects “Yes” to start oximetry monitoring using the recalled calibration information OR selects “No” and performs an in vivo calibration.

III. DOCUMENTATION:
Cardiac output or ScvO2 will be documented on the ICU Flowsheet with each set of vital signs and with each titration of vasoactive drugs.
Reference:

6. Foraida MI, DeVita MA, Braithwaite RS, Stuart SA, Brooks MM, Simmons RL, Improving the Utilization of Medical Crisis Teams at an Urban Tertiary Care Hospital. Journal of Critical Care, 18:87-94
8. Goldhill DR, White SA, Sumner A: Physiologic values and procedures in the 24 hours before admission to the Intensive Care Unit. Anesthesia. 54:529-534
Neuromuscular Blockade

Purpose:
1. To provide guidelines for the care and monitoring of patients requiring paralyzation with neuromuscular blocking agents.
2. To provide guidelines for the safe use of a peripheral nerve stimulator.
3. Whenever the use of vecuronium or any other neuromuscular blocking agent is contemplated in the ICU, it is recommended that neuromuscular transmission be monitored during administration and recovery with the assistance of a nerve stimulator. Additional doses of any neuromuscular blocking agent should not be given before there is a definite response to the first twitch. If no response is elicited, infusion administration should be discontinued until a response returns.
   a. If bolus paralytic being given, nerve stimulation may not be done if bolus doses occur only for ventilator dyssynchrony and hypoxia.
4. The goal is to not have ventilator dyssynchrony or no spontaneous movements at the same time not giving more than necessary the amount of paralytic needed.

Policy:
1. The physician shall document the type of neuromuscular blockade. Physician's orders will include the drug, IV route, and administration schedule (bolus injection, continuous infusion or PRN movement).
2. Any change in infusion rate shall be ordered by the physician. In an emergency, the RN may decrease or stop the infusion before calling the physician.
3. The physician shall order eye lubricant on a regular scheduled basis.
4. The nurse shall assess for proper eye closure. (Eyelids may need to be taped if proper eye closure not present.)
5. **ALL patients who are paralyzed will receive adequate sedation.**
6. Assessment of appropriate muscle firing shall be done.
   a. A peripheral nerve stimulator can be used to assess muscle firing adequacy of neuromuscular blockade for patients on continuous infusions.
   b. Visual assessment of muscle firing can be performed with patients receiving intermittent dosages of paralytics.
   c. The goal is to have the patient receive the least amount of paralytic for the desired response.
7. The drug can be withheld every 24 hours so that a neurological assessment may be performed if ordered.
8. Tight Glycemic Control may be ordered to assist in the prevention of myopathy of critical illness.
**Procedure:**

<table>
<thead>
<tr>
<th>Responsible Party</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>1. Determines the need for neuromuscular paralysis.</td>
</tr>
<tr>
<td></td>
<td>2. Assures that the patient is properly mechanically ventilated with a secure airway and ventilatory rate.</td>
</tr>
<tr>
<td></td>
<td>3. Order appropriate amount of sedation. It is highly recommended that orders are written for a continuous infusion of analgesic and sedation/amnesic. Both are needed for patient comfort and loss of recall.</td>
</tr>
<tr>
<td></td>
<td>4. Order desired neuromuscular paralytic.</td>
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<td>5. Order the peripheral nerve stimulator as “Train of Four” with parameters if on continuous infusion.</td>
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<tr>
<td></td>
<td>6. Orders sedation monitor if desired.</td>
</tr>
<tr>
<td>RN</td>
<td>7. Assess the adequacy of mechanical ventilation with ventilatory rate and ensure that the airway is secure. Any patient undergoing paralysis will lose all voluntary neuromuscular function, including use of the muscles of respiration.</td>
</tr>
<tr>
<td></td>
<td>8. Verify order for sedation, paralysis, and eye lubricant.</td>
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<tr>
<td></td>
<td>9. Administer sedation. A patient who is paralyzed will remain awake and aware of being unable to move, unless properly sedated.</td>
</tr>
<tr>
<td></td>
<td>10. Administer bolus dose of paralyzing agent. Observe for cessation of muscular activity. Most drugs, such as Atracurium and Vecuronium are effective in 2 - 3 minutes.</td>
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<tr>
<td></td>
<td>11. Uses the peripheral nerve stimulator according to AACN Procedure Manual.</td>
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<tr>
<td></td>
<td>12. Notify MD for increased or decreased response and obtain order to change rate of infusion to produce appropriate level of neuromuscular blockade. In ICUs, the appropriate level of blockade is judged by two twitches, of decreasing strength, out of a train of four or spontaneous movement or breathing.</td>
</tr>
<tr>
<td></td>
<td>13. Observe for subtle changes in vital signs and notify MD if more sedation (analgesic and amnesic) is needed. Subtle increases in heart rate or blood pressure may be the only way for a patient to indicate that he is not receiving enough sedation.</td>
</tr>
</tbody>
</table>
Resources:


