

Greater New Orleans Surgery Center

INTERNAL RISK MANAGEMENT PROGRAM

Page 1 of 3

Reviewed: August 1, 2001
08/01/03, 06/24/08,
05/01/09
Implemented: August 1, 2001

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SUBJECT: Internal Risk Management Program.

PURPOSE: Minimize the risk of injuries, incident and unplanned occurrences to patients and staff.

COMPONENTS: Internal Risk Management Program.

Minimize the risk of injuries, incident and unplanned occurrences to patients and staff.

- A. Investigation and analysis of the frequency and causes of general categories and specific type of incidents.
- B. Procedures to minimize the risk of injuries and incidents to patients and staff including at least annual Risk Management and Risk Prevention education and training of all personnel.
- C. Analysis of patient grievances, which relate to patient care and quality of medical services.

STAFF EDUCATION:

- A. Procedures detailed in writing and disseminated to all employees.
- B. Instructions for all new employees within 30 days of employment in the procedures of the incident reporting system and their responsibilities of carrying out the program.

REPORTING SYSTEM:

- A. Incident Reports - to be reported to Internal and Corporate Risk Manager within 24 hours on risk identification form via the Incident Report Database.

DUTIES & RESPONSIBILITIES:

- A. Ensure a safe environment and improvement of quality of care through implementation of comprehensive risk management program designed to identify, analyze and evaluate potential risks and to select the best methods of preventing and reducing claim related losses.
- B. Assess necessity for and initiation of reporting incidents to the facilities malpractice carrier, through corporate when any incidence has or appears to have caused a complication or injury to a patient.
- C. Encourage staff involvement in all phases of the Risk Management Program.

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REVIEW AND ANALYSIS:

- A. Incident reports are immediately given to the Clinical Manager or Administrator then entered into the Incident Report Database. The Clinical Manager or Administrator reviews and analyzes all reported incidents as to content, cause, action, follow-up and any trends. A quarterly report is reported completed for quarterly presentation to the Medical Advisory Board.
- B. The Administrator in conjunction with the Corporate Risk Manager develop recommendations for appropriate corrective actions and Risk Management prevention education and training.
- C. Summary data to be maintained for at least 3 years.

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DEFINITIONS:

- Incident means any physical harm, bodily impairment, including infection, disfigurement, or delay in recovery
- Incident Report factual written statement about a particular incident detailing particulars as to time, location, and persons directly involved including titles and the event including description of injuries. The report should contain a listing of witnesses to the event.
- Patient Grievance any written complaint by a patient relating to patient care of the quality of medical service except for those matters pertaining to the cost of care.
- Serious Incident any untoward or adverse incident occurring in the facility or arising from health care received in the facility which:
- A. results in the death of a patient,
 - B. results in severe brain damage,
 - C. results in spinal damage to a patient,
 - D. is result of procedure performed on wrong patient.
 - E. is result of procedure performed unrelated to patient's diagnosis or medical needs.

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OTHER SOURCES OF INFORMATION TO BE EVALUATED BY ADMINISTRATOR AND REPORTED TO

1. Summary of any reported or suspected infection.
2. Summary of Performance Improvement Reports.
3. Summary of Peer Review.
4. Problems identified via Fire and Safety Program.
5. Summary of Patient Questionnaires.
6. Summary of Instrument Sterility Verification results.

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Greater New Orleans Surgery Center

MEDICAL ADVISORY BOARD/GOVERNING BODY

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Reviewed: August 1, 2001
2/27/2003, 1/2/08,
6/24/08, 1/22/09,
05/01/09

Implemented: August 1, 2001,
1/2/08, 1/22/09

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SUBJECT: Medical Advisory Board/Governing Body.

PURPOSE: To establish a board and committee of interested, concerned, qualified personnel to enhance the quality of care rendered at Greater New Orleans Surgery Center.

SCOPE: All Medical Advisory Board/Governing Body.

POLICY: The Medical Advisory Board/Governing Body will meet regularly on a quarterly basis and will have emergency meetings as needed.

Medical Advisory Board:

Jeffrey Sketchler, M. D. Medical Director

David Aiken, M. D.

Warren Bourgeois, M. D.

John Burvant, M. D.

William Junius, M. D.

Keith Larkin, M. D.

Governing Body:

Jeffrey Sketchler, M. D. Medical Director

John Burvant, M. D.

Melvin Parnell, M. D.

Dale Kennedy

Dan Beuerlein

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Greater New Orleans Surgery Center

MISSION

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Reviewed: August 1, 2001
08/01/03, 06/24/08,
05/01/09
Implemented: August 1, 2001

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Corporation Mission.

To provide a comprehensive quality of care approach for individuals (regardless of race, color religion, or creed) based on three vital factors:

The Worth and Dignity of the Individual
Excellence in Patient Care
Dedicated and unselfish Service

VALUE STATEMENT

The fundamental human relationships involved in the healthcare process are the foundation of our way of doing business. Therefore, we place primary value on our patients, their families and our employees.

We are dedicated to providing superior care to those individuals whose lives are entrusted to us. Our primary focus is to work with them and respond to their needs. Our dealings with them will be professional, courteous, helpful and cooperative.

Our employees are critical to our success as a corporation. We will respect their individuality, recognize and reward their good performance, provide opportunities for their growth and development and encourage their participation in the decision-making process.

We consider respect, trust and integrity to be essential in all of our dealings. We expect honest, ethical behavior from ourselves and encourage it in others.

Our employees live and work in the larger context of society. Therefore, we value and encourage responsible individual and corporate citizenship. We recognize our obligation to be a positive influence in the communities in which we maintain a corporate presence.

We are progressive in our response to the changing needs of our business and prudent in the management of our resources. We value superior, high-quality work at the individual unit and corporate levels.

Without apology, we are profit-oriented, for only profitable companies can adapt and survive to meet their long-term commitments to patients, employees and stockholders.

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Greater New Orleans Surgery Center

OPENING & CLOSING THE FACILITY

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Reviewed: August 1, 2001
08/01/03, 06/24/08,
05/01/09

Implemented: August 1, 2001

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SUBJECT: Opening and closing the facility.

PURPOSE: To ensure that the facility is secured when closed and prepared when open.

SCOPE: All assigned staff.

POLICY: The first person to arrive at the facility must use his/her key to enter the building.

PROCEDURE:

A. Opening - first person to arrive:

1. Enter your individual security code on security Panel.
2. Observe for "IN" light (green) to come on.
3. Unlock elevator.
4. Enter your individual security code on security Panel
5. Open surgery center door and turn on all of the lights

B. Closing:

When leaving your designated area the following should be completed

- Turn off all lights
- Shut down your computer
- Raise Thermostat of 74 degrees

If you are the last person in the office

- Turn off any remaining lights left on
- Double check the stairwell doors to ensure it is locked
- Lock suite doors
- Enter security code on security panel, look for "OUT" light (red) to appear on panel
- Lock elevator
- Set building alarm and lock building door if you are last

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ORGANIZATION OF ANESTHESIA DEPARTMENT

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Reviewed: August 1, 2001
08/01/03, 06/24/0
05/01/09

Implemented: August 1, 2001

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SUBJECT: Organization of Anesthesia Department.

PURPOSE: To establish an anesthesia department that is organized according to the basic recommendations of regulatory and accrediting bodies.

SCOPE: Anesthesiologists and CRNA's

POLICY: Responsibility for the direction of surgical services and the direction of anesthesia services provided by the organization is vested in physicians who are qualified to assume professional, organizational, and administrative responsibility for the quality of the respective services rendered.

PROCEDURE:

- A. The Anesthesia Department is comprised of Anesthesiologists and CRNA's.
- B. The Anesthesia Department shall be organized according to the basic recommendations of State, HICA and JCAHO. It shall be under the direction of the Director of Anesthesiology who shall have overall responsibility for the services provided. The Department of Anesthesiology renders service primarily to the operating room and PACU. Resuscitative assistance will be rendered throughout the Facility. The department is organized for the benefit of the patient with the patient's welfare being its primary concern.
- C. The Director's responsibilities include:
 - 1. Recommends privileges for those who provide anesthesia services.
 - 2. Assures that quality and appropriateness of anesthesia care provided are evaluated and that appropriate actions are taken when problems are identified.
 - 3. Recommends the type and amount of equipment necessary for administering anesthesia.
 - 4. Develops regulations for anesthesia safety.
 - 5. Participates in the development of policies relating to function of anesthesiologists.
- D. All members of the department of anesthesiology are responsible for complying with the provisions of the Medical Staff Bylaws, the policies established by the departments of anesthesia and surgery, and the regulations of the Facility.

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ORGANIZATIONAL PLAN AND CHART

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6/24/08,

1/2/08

Reviewed: August 1, 2001
8/1/2003, 1/2/08,

05/01/09
Implemented: August 1, 2001,

SUBJECT: Organizational plan.

The Organizational Plan for the Greater New Orleans Surgery Center is designed to ensure proper lines of authority to achieve optimal, safe and professional operation of the facility. The following chart will be revised and updated as necessary. (see attached)

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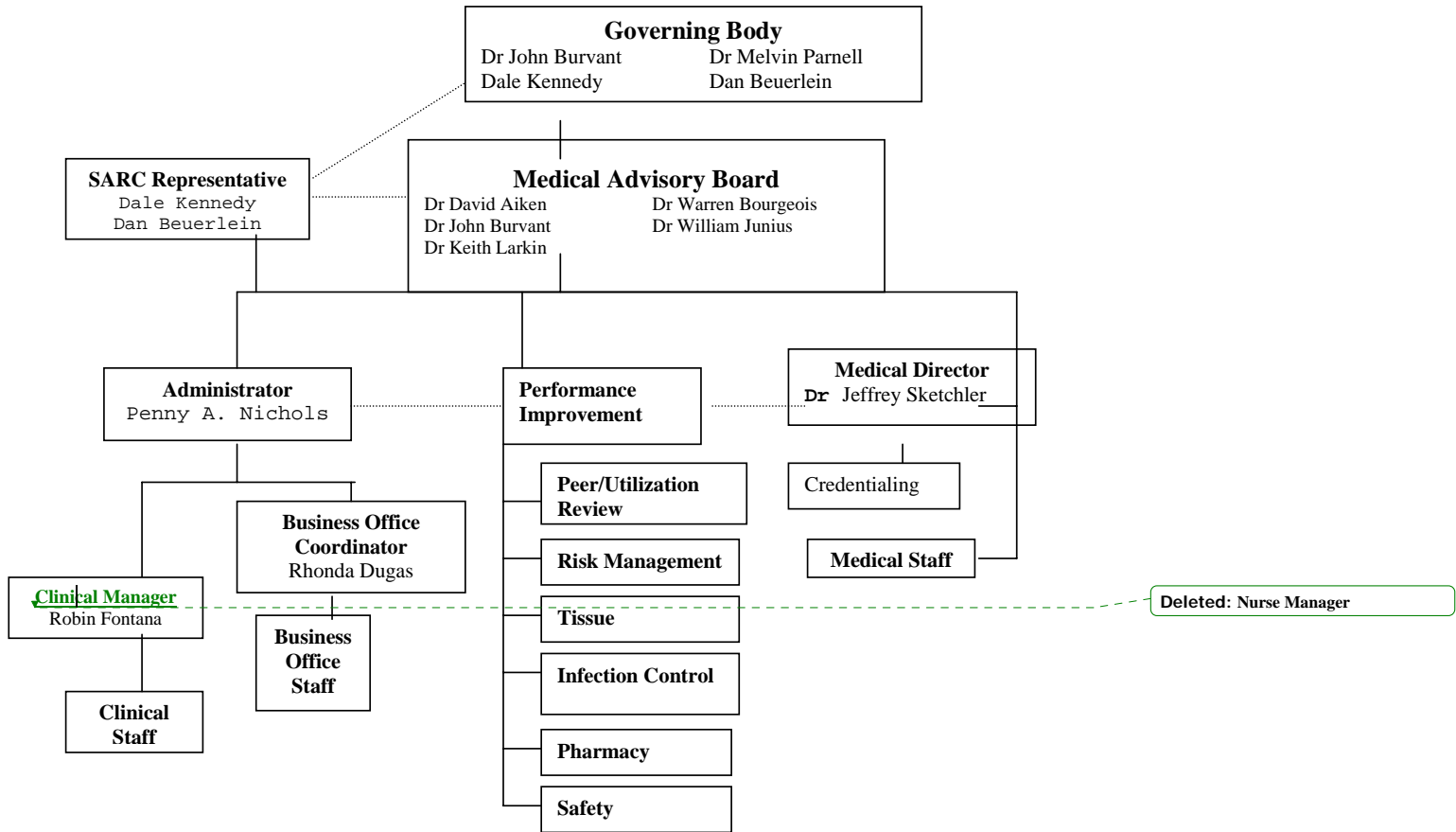
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Greater New Orleans Surgery Center Organizational Chart



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PHILOSOPHY AND OBJECTIVES OF PATIENT CARE

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Reviewed: August 1, 2001
08/01/03, 06/24/08,
05/01/09

Implemented: August 1, 2001

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SUBJECT: Philosophy and objectives of patient care.

PURPOSE: The Greater New Orleans Surgery Center is a specialty care facility designed to provide individual quality nursing care for patients requiring surgical intervention and related procedures as the preferred course of treatment to affect an expeditious return to restored health or comfort.

SCOPE: All personnel.

POLICY: Greater New Orleans Surgery Center nursing care is a dynamic professional service blending emotional maturity, mental and physical dexterity, team concepts, productivity, understanding and empathy to render patients the best possible care.

PROCEDURE:

A. It is directed toward:

1. Assisting the patients in accepting and participating in progressive surgical treatment in an environment other than a hospital and preparing them and their families for recuperation in the home environment.
2. Assisting the surgeon in accomplishing individual plans of treatment and creating a safe physical and mental environment to protect patients from the dangers that might befall them in preparation for, during and immediately following surgery with continuous awareness of human dignity and their physical, emotional and spiritual needs.

B. Scope of services:

1. The facility provides outpatient surgical services in the following specialties: General surgery, orthopedics, otorhinolaryngology, podiatry, pain management, hand surgery, and plastic and reconstructive surgery, wound care and urology.
2. If the facility cannot provide care due to a conflict with its mission philosophy or present scope of services, the patient will be informed and referral to another provider offered.

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PHILOSOPHY AND OBJECTIVES OF PATIENT CARE

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3. Designed to be a helping service which is planned and administered in combination with related services to render a safe, comfortable, effective environment for the patient and personnel, give adequate assistance to the medical staff in meeting the emergency, preventive and restorative health needs of the patient regardless of race, color, creed, national origin, social or economic status and to promote good relations within the community.

C. Policy manual:

The policy manual is meant to be a guide to the nursing personnel to promote quality patient care in the Greater New Orleans Surgery Center. They were developed to:

1. Guide the nurses and auxiliary personnel in performing specialty and routine care.
2. Foster good relations with:
 - a. Operating physicians, dentists, podiatrists and anesthesiologists.
 - b. Co-workers.
 - c. Other service units.
 - d. Other Center departments.
 - e. Community.
3. Simplify medical, medico-legal and administrative problems.

D. Objectives:

1. Provide experienced registered professional nurses for supervision of the ambulatory facility and trained paramedical groups to assist with patient care under supervision.
2. Assist the surgeon in performing surgical intervention or other related procedures, under optimum aseptic condition, with the skills necessary to give the most effective and efficient service possible.
3. Provide suitable equipment and supplies in good safe condition for all operations and any emergency that might occur.
4. Provide a safe, quiet, efficient environment with an atmosphere of compassion and understanding with minimal stress and anxiety for patients and staff.

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5. Provide a learning environment geared to stimulate, instruct and help all members of the staff in increasing their potential worth to perform at a high level of proficiency.

PHILOSOPHY AND OBJECTIVES OF PATIENT CARE

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6. Enhance the nursing service by contributing ideas to resolve problems and evaluate and revise nursing standards in accordance with medical and nursing concepts.
7. Be aware of and be involved in new research, new products and new ideas which may modify and improve present activities and procedures.
8. Recognize the diminishing sources of potential operating room nurses graduating from present schools of nursing and develop a plan to encourage new nurses to share in our rewarding work.
9. Help coordinate responsibilities of other service units with those of the nursing service.
10. Strive for the preservation of life, restoration of the patient to his maximum functional capacity or comfort and to decrease the overall morbidity.

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RESEARCH PROJECT PROCEDURE

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Reviewed: August 1, 2001
08/01/03, 06/24/08,
05/01/09

Implemented: August 1, 2001

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SUBJECT: Research project procedure.

PURPOSE: To assure that all research projects carried out within the facility are moral and ethical and meet the standards required of Greater New Orleans Surgery Center, relevant law, and community acceptance.

SCOPE: All staff physicians.

POLICY: The facility endorses the philosophy that research projects can be meaningful and supportive to patient care. All research project requests must be approved by the General Partner of the facility. The facility maintains the following "Statement of Principles" from the "Declaration of Helsinki" regarding the rights and welfare of human subjects.

- A. Clinical research must conform to the moral and scientific principles that justify medical research and should be based on laboratory and animal experiments or other scientifically established facts.
- B. Clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical person.
- C. Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.
- D. Every clinical research project should be preceded by careful assessment of inherent risks in comparison to foreseeable benefits to the subject or to others.
- E. Special caution should be exercised by the physician in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedure.
- F. Participation in a national IRB will be maintained for research projects. The Medical Advisory Board reviews all proposed clinical research projects to be carried out within the facility and contacts the National IRB affiliated with the study. It takes into consideration the nature of the research as well as the acceptability of the research in terms of the institutional regulations, relevant law, and community acceptance.

It includes broad considerations of the ethical and moral aspects of research on humans in addition to scientific justification.

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RESEARCH PROJECT PROCEDURE

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PROCEDURE:

A. REQUEST FOR A RESEARCH PROJECT.

An investigator must submit a summary of the research protocol and patient consent form to the IRB before the project is reviewed.

Once a research project has been approved by the IRB, the Medical Advisory/Governing Board and the facility continue the responsibility to properly and judiciously review the progress of the project. The principal investigator has continuing responsibility to the facility for both the proper administration and clinical aspects of an approved research project.

B. CRITERIA FOR RESEARCH PROTOCOLS

The Institutional Review Board (IRB) must adequately assess each project, including the ability to determine the acceptability of the proposal in terms of institutional commitments and regulations, applicable law, standards of professional conduct and practice, and community attitudes. This is particularly significant when research pertains to human subjects and the facility's correspondent responsibilities for protecting the rights and welfare of its patients. In the latter regard, the IRB will include broad considerations of the ethical and moral aspects of research in humans, in addition to the scientific justifications.

The following are to be included in the proposed protocol:

1. A detailed review of the research project to be undertaken. This must include:
 - a. The expected number of patients that might come under the project.
 - b. The expected benefits to be derived from the research.
 - c. A description of foreseeable risks to be involved.
2. A copy of the consent form to be used for the research project must be submitted with the application. Informed consent from each person involved in the project is to be obtained, as outlined in Section 812.310 Elements of Informed Consent, Federal Register Vol. 45, No. 13, January 18, 1980, Rules and Regulations:
 - a. Requirements: In seeking informed consent, an investigator shall provide to the subject, or to the subject's legal representative, information that includes:
 - b. An explanation of the procedures to be followed, including an explanation of each procedure that is experimental.

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RESEARCH PROJECT PROCEDURE

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- c. An explanation of the nature of the investigational device and an explanation of the expected duration and purpose of the use of the investigational device.
 - d. A description of any attendant discomforts and risks reasonable to be expected.
 - e. An explanation of likely result should the procedures fail.
 - f. A description of any benefits to the subject or others reasonably to be expected.
 - g. A disclosure of any appropriate alternative procedures that might be advantageous to the subject.
 - h. A description of the scope of the investigation, including the number of subjects involved.
 - i. An offer to answer any inquiries concerning the investigation.
 - j. A disclosure that the subject, or the subject's legal representative, is free to decline participation in the investigation or to withdraw consent and discontinue participation at any time without prejudice to the subject.
 - k. A disclosure that the investigation device is being used for research purposes. No application will receive IRB endorsement without submission of the proposed consent form.
3. In support of the protocol, the applicant is encouraged to attach pertinent articles which support the scientific basis for the research project.

The IRB does not allow participation in its review by an individual involved in the conduct of the research activity under review, except to provide information to the Committee.

C. CONTINUING REVIEW

Periodic reviews of approved research projects are conducted by the IRB at intervals appropriate to the degree of risk, but not exceeding one year, to assure that the research is being conducted in compliance with the IRBs understanding and recommendations. In this regard, the IRB requires written reports.

The investigator is required to report to the IRB any emergency problems, serious adverse reactions, any unexpected deaths, or any proposed procedural changes to the original approval, which may affect the status of the investigation. No changes are to be made to the approved protocol without IRB approval and that of the except when necessary to eliminate apparent immediate hazards. Following the action to eliminate the hazard, the investigator will immediately contact the Chairman of the Committed, and in his absence, the Vice-Chairman, relative to the matter.

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RESEARCH PROJECT PROCEDURE

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D. TERMINATION

Upon termination, a final report is required to be submitted to the IRB. Acceptance of the final report by the Medical Advisory/Governing Board terminates the project.

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SCOPE OF SERVICES

Page 1 of 1

Reviewed: August 1, 2001,
4/4/2003, 06/24/08, 05/01/09
Implemented: August 1, 2001

SUBJECT: Scope of Services

PURPOSE: To establish Greater New Orleans Surgery Center operational guidelines.

SCOPE: All personnel.

POLICY: All facility personnel will use operational guidelines and plan.

PROCEDURE:

- A. Days of operation - Monday through Friday.
- B. Hours of operation - 7:30 AM to 5:00 PM.
- C. Average patient age - 10 years to 90 years of age.
Children no younger than 6 months old
- D. Average length of procedure – 1 ½ hour.
- E. Average turnover time between cases - 15 minutes.
- F. Average patient stay in facility – 2 hours.
- G. Average number of procedures per operating room per day - six.
- H. Hours of surgery - 7:00 AM to 3:00 PM.
- I. Preoperative testing scheduled - 8:00 AM to 2:00 PM.
- J. Personnel policies provided per leadership.

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VOICING OF CONCERNS ETHICAL ISSUES INVOLVING PATIENT CARE

Page 1 of 2

Reviewed: August 1, 2001
08/01/03, 06/24/08,
05/01/09

Implemented: August 1, 2001

SUBJECT: Voicing of concerns - ethical issues involving patient care.

PURPOSE: To recognize the right of every patient and/or the patient's designated representative to participate in the consideration of ethical issues that arises in the care of the patient. In addition, the Facility recognizes that caregivers (including medical staff and employees of the Facility) may also participate in this process when it ultimately serves to benefit or improve the patient's care.

SCOPE: All personnel, patients, caregivers.

POLICY: Any concerns or issues regarding patient care should be reported to the Administrator or Clinical Manager. The mechanism(s) by which this participation evolves differs for (1) patients and/or the patient's designated representative and (2) caregivers (including the medical staff and employees of the facility) and are outlined below.

PROCEDURE:

A. PATIENT AND/OR PATIENT'S DESIGNATED REPRESENTATIVE

1. Patients and/or the designated representative are made aware of the patient's right to participate in consideration of ethical issues related to patient care in the "Statement for Patient's Rights and Responsibilities" which is posted in the lobby of the facility.
2. Should a patient voice concerns regarding this issue, the involved staff members should inform the Administrator or Clinical Manager immediately of the problem/concern. It may be necessary for the Administrator to contact the patient's attending physician, delay the start of the surgery, or take other steps in order to address the issue to the satisfaction of the patient and/or the designated representative. This may include involving the Medical Director and/or other facility staff members in order to assess the problem and initiate action.
3. Employees should always be cognizant of the patient's rights and be willing to assist in addressing the concerns or solving the problems at all times.

B. CAREGIVERS (INCLUDING MEDICAL STAFF AND EMPLOYEES OF THE FACILITY)

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STANDARDS OF PRACTICE FOR
THE USE OF LASERS IN SURGERY¶

¶
Page 1 of 2 Reviewed:
. August 1, 2001¶
. 08/01/03, 06/24/08¶
. Implemented: August 1,
2001¶

¶
SUBJECT: . Standards of practice for the
use of lasers in surgery.¶

¶
PURPOSE: To ensure that all
physicians that request to use the laser
have been trained in laser physics, safety
and have had practical experience with
the laser.¶

¶
SCOPE: . All physicians requesting use
of facility's laser.¶

¶
POLICY: . Physicians requesting the use
of the laser will be properly trained and
certified.¶

¶
PROCEDURE:¶

¶
A. . The following statement is proposed:¶

¶
. . Hospital privileges are and must remain
the responsibility of the hospital
governing body. Those requesting
privileges to use lasers shall meet all the
standards of the hospital with regard to
board certification, board eligibility,
special training, ethical character, good
standing, judgment, indications for
application, etc.¶

¶
B. . In addition, the following laser
training and experience is recommended:¶

¶
1. . The applicant shall review the
pertinent literature and audiovisual aids
and shall attend laser training course(s)
devoted to teaching of laser principles
and safety. These courses shall include
basic laser physics, laser tissue
interaction, discussions of the clinical
specialty field and hands-on experience
with lasers. Such courses should be a
minimum of 8-10 hours, although courses
ranging from 14-16 hours may be more
appropriate for first time attendees.
Approximately 50% of the course time
should involve hands-on training, with
the number of registrants assigned to each
laser small enough (3 or 4) to ensu... [1]

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Greater New Orleans Surgery Center

VOICING OF CONCERNS ETHICAL ISSUES INVOLVING PATIENT CARE

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Page 2 of 2

1. The caregivers (including medical staff and employees of the Facility) also possess the right and the responsibility to participate in the consideration of ethical issues that arise in the care of the patient. In the event that a caregiver may not provide care to a patient due to his/her moral, ethical, or religious beliefs, the caregiver must notify the Clinical Manager or the Administrator prior to the scheduled procedure so to allow for the approach changes to be made.
2. Issues may simply involve the need to improve a current policy/practice/procedure in order to improve patient care. In this instance, the individual should contact the Administrator or Clinical Manager at once to that the process can be initiated. Involvement of the Performance Improvement Committee may also be needed to resolve the issue.
3. At times this participation may involve situations in which an employee or medical staff member feels uncomfortable in addressing an issue which appears to place "blame" on another individual. To ease this process, a confidential form is utilized, allowing the person to address these concerns without fear of reprisal or reprimand. It should be noted, however, that the use of this form is for the sole purpose of resolving issues in regard to the patient care; the information submitted must be objective at all times, rather than subjective. (See attached.)
4. In utilizing the form, the medical staff member or Facility employee should submit the form directly to the Administrator, who will use the information in a confidential and positive manner.
5. The Administrator will inform the Medical Director of the situation and appropriate steps taken, which may include review of the issue at the Medical Advisory/Governing Board meeting. If necessary, a meeting of the Medical Advisory Committee/Governing Body will be called if the situation warrants immediate action.

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Greater New Orleans Surgery Center

ETHICAL ISSUES - PATIENT CARE CONCERNS

Note: The individual(s) completing this form should utilize objective data or observations in presenting concerns involving ethical issues in patient care. All information submitted will be reviewed and your concern is appreciated. It is not required that you sign this form, and the form may be typed if desired.

Patient Name: _____

Patient Number: _____ DOS: ____/____/____

Issue/Concerns:

(please continue on another sheet if necessary)

Signature (optional)

Form Received by: _____ Date: ____/____/____

Follow-Up Actions:

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Greater New Orleans Surgery Center

POLICY MANUAL

This Policy and Procedure Book of the Greater New Orleans Surgery Center has been read and approved by the following:

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Medical Advisory Board/
Governing Body

Date

Medical Director

Date

Administrator

Date

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Greater New Orleans Surgery Center

ENVIROMENT OF CARE POLICY AND PROCEDURE MANUAL

This Policy and Procedure Book of the Greater New Orleans Surgery Center has been read and approved by the following:

Medical Advisory Board/
Governing Body

Date

Medical Director

Date

Administrator

Date

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Greater New Orleans Surgery Center

SIGNATURES FOR POLICY AND PROCEDURE MANUALS

<u>SIGNATURE</u>	<u>INITIALS</u>
_____	_____
Medical Director	
_____	_____
Administrator	
_____	_____
Consultant Pharmacist	
_____	_____
Radiological Physicist	

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Greater New Orleans Surgery Center

INTIMIDATING AND DISRUPTIVE BEHAVIOR AMONG HEALTH CARE WORKERS

Page 1 of 3

Reviewed: December 23, 2008,
05/01/09

Implemented: January 30, 2009

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POLICY: It is the Center's policy, that all individuals, employees, physicians, and independent practitioners conduct themselves in a professional, collegial, and cooperative manner while in the Center. All individuals within its facility will be treated with courtesy, respect, and dignity. The Center will have "zero tolerance" for intimidating/disruptive behavior. If the behavior of members of the medical staff, allied medical staff (medical staff and allied medical staff collectively "Practitioners") or employees is intimidating/disruptive, the matter shall be addressed in accordance with this policy. For an employee who fails to conduct himself/herself as required by this policy, the matter shall be addressed in accordance with applicable Human Resources policies and/or Corporate Compliance Program.

Intimidating/disruptive behavior by a Practitioner or employee may include, but is not limited to, overt and passive behavior such as:

- Hostile, angry or aggressive confrontational voice or body language;
- Attacks, such as verbal or physical, that go beyond the bounds of reasonable conduct;
- Inappropriate expressions of anger such as destruction of property or throwing items;
- Inappropriate comments or illustrations made in the medical record;
- Criticism addressed to the recipient in such as way as to ridicule, humiliate, intimidate, undermine confidence, belittle or imply stupidity or incompetence;
- Derogatory comments that go beyond differences of opinion that are made to patients or patients' families about caregivers;
- "Passive" intimidating and disruptive behaviors are covered under this policy. As defined by the Joint Commission, "passive" intimidating and disruptive behaviors, without limitation would include "...refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities." or "... reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions."

PURPOSE: To ensure quality patient care and promote a safe, cooperative and professional health care environment and to the extent possible, prevent or eliminate disruptive behavior.

PROCEDURE:

1. Any Practitioner, employee, patient or visitor may report intimidating/disruptive behavior. Documentation of intimidating/disruptive behavior is critical because it is usually a pattern of behavior that leads to disciplinary action, rather than one incident. Reports shall become part of the peer review in the Practitioner's credentialing file or the employee's personnel file. It is recommended that documentation include:
 - a. The date and time of the incident;

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Greater New Orleans Surgery Center

INTIMIDATING AND DISRUPTIVE BEHAVIOR AMONG HEALTH CARE WORKERS

Page 2 of 3

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- b. If the conduct affected or involved a patient in any way, the medical record number of the patient;
- c. The circumstances that precipitated the incident;
- d. A description of the questionable behavior, limited to factual, objective language as much as possible;
- e. The consequences, if any, of the disruptive behavior as it relates to patient care or operations of the Center;
- f. Record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

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2. A complaint by a patient(s) or visitor(s) who witness or are involved with intimidating and/or disruptive behavior will be forwarded to the Administrator immediately. In the case were the complaint involves the Administrator, it will be forwarded to the Compliance Officer as provided for in the Corporate Compliance Program. The Administrator or Compliance Officer, as the case may be, will listen and acknowledge appreciation to the voicing of the complaint. The Administrator or Compliance Officer will assure the patient(s) or visitor(s) that the complaint will be processed according to the Center's policy.
3. A report involving a Practitioner will be submitted to the Administrator who after review, will forward the report to the Medical Director. If the report regarding intimidating and/or disruptive behavior involves the Medical Director, the Administrator will forward the report to the Chairman of the Medical Advisory Board (the "Chairman") and/or the Chairman of the Board of the Center if required. The Chairman will follow the criteria listed in this policy. A report involving the behavior of an employee will be submitted to the Administrator for review who will process the report in accordance with Human Resource policies and/or the Corporate Compliance Program. In the case were the complaint involves the Administrator it will be forwarded to the Compliance Officer as provided for in the Corporate Compliance Program. The reporter's identity may be kept from the individual being reported. The Administrator or Compliance Officer, as the case may be, will assure the reporter the Center does not allow retaliation or retribution based on the findings and outcomes of the report.
4. All conversations and meetings related to any report(s) shall be documented and placed in the applicable file.
5. The Medical Director or Chairman, as the case may be, may dismiss reports involving a Practitioner determined to be unfounded or not meeting the definition of intimidating/disruptive behavior. The Medical Director or Chairman, shall make the judgment as to whether a report is one of a minor nature or an isolated incident that does not need to be addressed. If a report involving a Practitioner is dismissed, the person who made the initial report will be advised of this decision.

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Greater New Orleans Surgery Center

INTIMIDATING AND DISRUPTIVE BEHAVIOR AMONG HEALTH CARE WORKERS

Page 3 of 3

6. Reports involving a Practitioner that are considered valid by the Medical Director or Chairman, as the case may be, will be addressed as follows:
 - a. For a single incident that the Medical Director or Chairman, has confirmed as one that warrants discussion but not suspension, the Medical Director or Chairman, shall investigate the observations and interview both the Practitioner and witness(es).
 - b. If intimidating/disruptive behavior is confirmed, the Medical Director or Chairman shall discuss the occurrence with the Practitioner. It should be emphasized that intimidating/disruptive behavior is inappropriate and must cease. The initial approach should be collegial and designed to be helpful. It will be emphasized to the Practitioner that retaliation or retribution will not be tolerated. The identity of the reporting person may be kept from the Practitioner.
7. If it appears that a pattern of intimidating/disruptive behavior is developing, it should be handled as outlined in 6(a) and (b). The Medical Director or Chairman, as the case may be, shall review the findings with the Practitioner and:
 - a. Emphasize that if such repeated intimidating/disruptive behavior continues, more formal action will be taken up to suspension of privileges. The Governing Board and the Medical Advisory Board will be notified if deemed necessary.
 - b. All meetings shall be documented.
 - c. A follow-up letter to the Practitioner shall state the problem and that the Practitioner is required to behave professionally within the Center.
 - d. The Practitioner may submit a rebuttal to the report. Such rebuttal will be maintained as a permanent part of the peer review record.
8. If such behavior continues, the Medical Director or Chairman, as the case may be, will advise the Practitioner that such conduct is intolerable and must stop. This meeting is not a discussion, but rather the final warning. It shall be followed with a letter reiterating the warning. A copy of the letter will be filed in the Practitioner's credentialing file.
9. Any further substantiated reports of intimidating/disruptive behavior after the individual has agreed to stop the offensive conduct, or the Practitioner's refusal to agree to stop the disruptive behavior, shall result in disciplinary action according to the medical staff bylaws.
10. Reports of disciplinary action or investigation will be made to the appropriate licensing board in accordance with state law.

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Reference:

The Joint Commission. *Comprehensive Accreditation Manual for Ambulatory Care (CAMAC)*. Oakbrook Terrace, Illinois: Author.

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STANDARDS OF PRACTICE FOR THE USE OF LASERS IN SURGERY

Page 1 of 2
2001

Reviewed: August 1,

08/01/03,
06/24/08
Implemented: August 1,

2001

SUBJECT: Standards of practice for the use of lasers in surgery.

PURPOSE: To ensure that all physicians that request to use the laser have been trained in laser physics, safety and have had practical experience with the laser.

SCOPE: All physicians requesting use of facility's laser.

POLICY: Physicians requesting the use of the laser will be properly trained and certified.

PROCEDURE:

A. The following statement is proposed:

Hospital privileges are and must remain the responsibility of the hospital governing body. Those requesting privileges to use lasers shall meet all the standards of the hospital with regard to board certification, board eligibility, special training, ethical character, good standing, judgment, indications for application, etc.

B. In addition, the following laser training and experience is recommended:

1. The applicant shall review the pertinent literature and audiovisual aids and shall attend laser training course(s) devoted to teaching of laser principles and safety. These courses shall include basic laser physics, laser tissue interaction, discussions of the clinical specialty field and hands-on experience with lasers. Such courses should be a minimum of 8-10 hours, although courses ranging from 14-16 hours may be more appropriate for first time attendees. Approximately 50% of the course time should involve hands-on training, with the number of registrants assigned to each laser small enough (3 or 4) to ensure enough actual hands-on time.

2. The individual shall have spent time with an experienced operator in the specialty area involved when appropriate and practical. Such time may consist of several brief visits or a more prolonged stay with a minimum of 6-8 hours observation and hands-on involvement.
3. In lieu of the above, the applicant may present a letter from the program director of an accredited residency in which laser utilization is part of the experience obtained. Individuals in training are urged to obtain laser experience as part of their residency. As in 1 and 2 above, this must include a minimum of 6-8 hours observation and hands-on involvement.

STANDARDS OF PRACTICE FOR THE USE OF LASERS IN MEDICINE AND SURGERY

Page 2 of 2

4. The physician will submit a copy of certificate of completion of course on laser safety and practice.

