ABBEVILLE GENERAL HOSPITAL
AGENCY, CONTRACT, STUDENT, PRN ORIENTATION / EDUCATION PACKET
CLINICAL
Revised 5/23/2022

HISTORY OF HOSPITAL

Abbeville General Hospital was opened in February 1966. We are **Hospital District No. 2** created by the Police Jury of Vermilion Parish to provide a parish owned hospital for the people of Vermilion Parish. The hospital is governed by a 7 member Board of Commissioners appointed by the policy jury.

OUR BOARD OF COMMISSIONERS

John Boudreaux, Chairman
Oswald Broussard, Vice-Chairman
Anita Levy, Member
John Budden, M.D., Member
Jody Landry, Member
Daleon Primeaux, Member
Kelly Richard, Member

Abbeville General Hospital is a 60-bed acute care facility, fully licensed and accredited and meets all requirements of the State of Louisiana and The Joint Commission.

OUR MANAGEMENT TEAM

Michael Bertrand	Chief Executive Officer
Thomas Pigott	Chief Operating Officer
William Troy Hair	Chief Financial Officer
Heidi Broussard	Chief Nursing Officer
Brittany Thibodeaux	Chief Quality Officer
Dondi Arceneaux	Chief Support Services Officer
Chuck Guidry	Chief Information Officer
Weston Miller, MD	Chief Medical Officer

2022 MEDICAL STAFF APPOINTMENTS

Chief of Staff	Gregory Fontenot, MD
Vice Chief of Staff	Claude Meeks, MD
Secretary/Treasurer	Rick Faul, MD
Chief of Medicine	Myriam Hutchinson, MD
Chief of Surgery	Weston Miller, MD

MISSION AND VISION

Our Mission is provide the community provide **Access to Quality Care Close to Home**

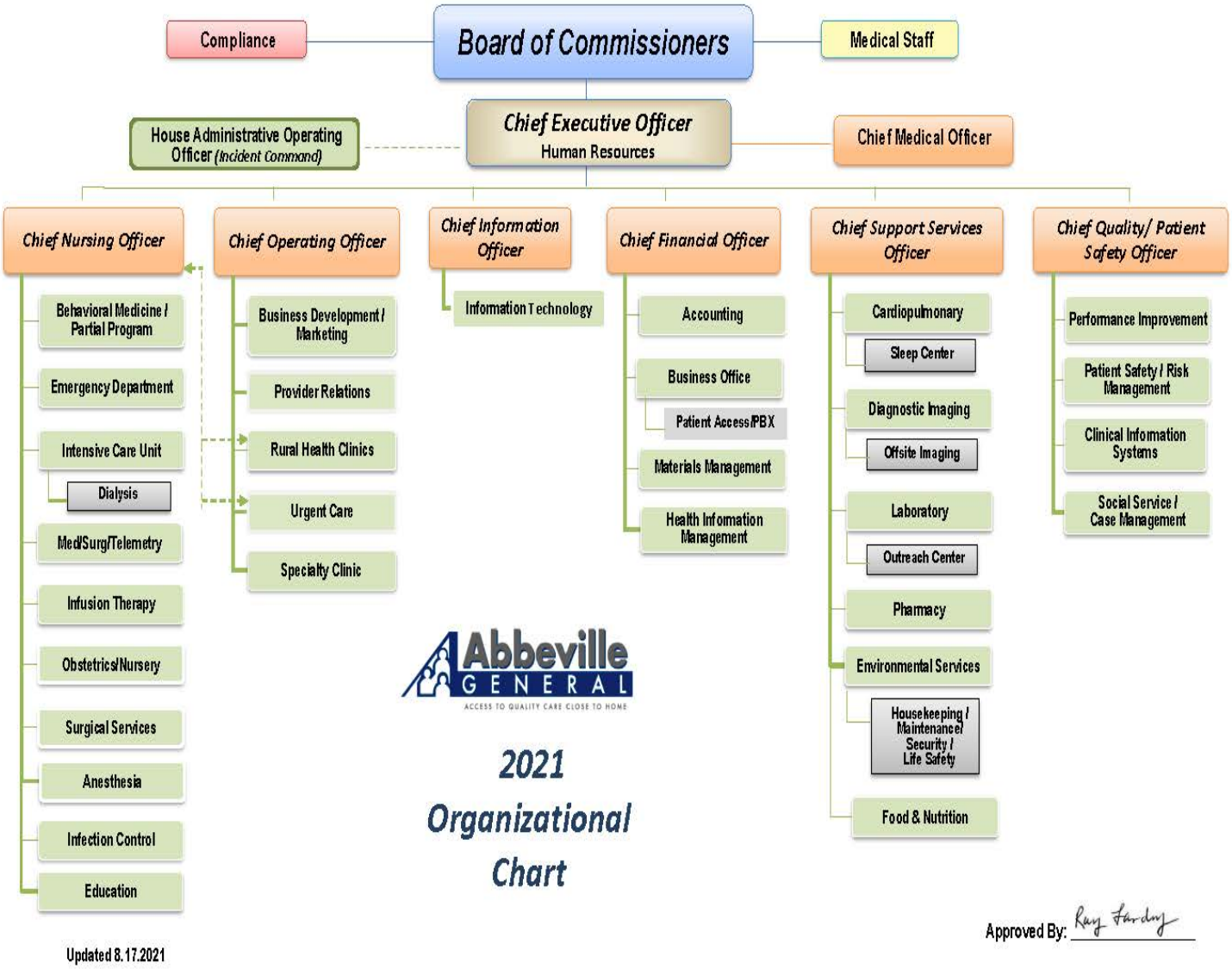
Our Vision: Abbeville General Hospital will be recognized as the hospital of choice for Vermilion Parish

PHILOSOPHY & VALUES

Philosophy**:** To create an environment that supports continuous improvement and innovation in the delivery of patient care. We do this by ensuring that patient's rights are maintained and that all patients receive that same quality of care. Documentation will reflect actual care provided. Records, reports and other documentation will be accurate and complete. Healthcare professionals must function as patient advocates. Healthcare professionals should practice in accordance with nationally accepted standards of ethical and professional conduct. A health system mission and vision can serve to help guide the operations of Abbeville General into the future.

Values**:** Maintain organizational standards of demonstrated behavior by all Abbeville General, epitomized by: **Accountability, Communication, Courtesy, and Excellence in Service, Professional/Privacy and Teamwork.** Principles that guide our daily practice will display the consideration of moral and ethical values of the individual as well as the organization. We will strive to maintain these principles through excellent relations with our customers, suppliers, other healthcare providers, educational institutions, payers and the community.

- Website: www.abbevillegeneral.com
- Check us out on Facebook: facebook.com/abbevillegeneral


Compliance
Board of Commissioners
Medical Staff
House Administrative Operating Officer (Incident Command)
Chief Executive Officer
Human Resources
Chief Medical Officer
Chief Nursing Officer
Chief Operating Officer
Chief Information Officer
Chief Financial Officer
Chief Support Services Officer
Chief Quality/ Patient Safety Officer
Behavioral Medicine / Partial Program
Emergency Department
Intensive Care Unit
Dialysis
Med/Surg/Telemetry
Infusion Therapy
Obstetrics/Nursery
Surgical Services
Anesthesia
Infection Control
Education
Business Development / Marketing
Provider Relations
Rural Health Clinics
Urgent Care
Specialty Clinic
Information Technology
Accounting
Business Office
Patient Access/PBX
Materials Management
Health Information Management
Cardiopulmonary
Sleep Center
Diagnostic Imaging
Offsite Imaging
Laboratory
Outreach Center
Pharmacy
Environmental Services
Housekeeping / Maintenance/ Security / Life Safety
Food & Nutrition
Performance Improvement
Patient Safety / Risk Management
Clinical Information Systems
Social Service / Case Management
Abbeville GENERAL
ACCESS TO QUALITY CARE CLOSE TO HOME
2021
Organizational
Chart
Updated 8.17.2021
Approved By:

Our Mascot
The Whooping Crane

ONE LEVEL OF CARE

Patients enter the system at differing points, but may have the same health problems and/or the same needs; these patients should receive uniform care. For example, a patient is in E.R. with a diagnosis of pneumonia, the patient will be admitted to 3rd floor. At present there is no room available, the patient will stay in E.R. or go to ICU until a room becomes available. While waiting for a room the patient will be fed, orders carried out, medications given just like they would on 3rd floor.

- Access to appropriateness of care and treatment is not dependent on the patient's ability to pay or source of payment
- Acuity of the patient's condition determines the resources needed to meet the patient's needs.
- The level of care provided to the patient who has been administered anesthesia in areas outside the operating room is comparable to that provided in the operating room.

AIDET

- A stands for "Acknowledge the patient." By their last name if possible.
- I is for "introduce." Introduce yourself, your skill, your professional certification, and your training.
- D is for "Duration. Describe the test: how long it's going to take; how long they are going to be there; and how long they will have to wait on the results.
- E stands for "Explanation." Explain tests, the pain involved (be very honest), and what happens next. Explain you are going to be looking at their wrist band and why. Connect key words with patient safety and excellent care.
- T stands for "Thank you for choosing our hospital."

ABBEVILLE GENERAL HOSPITAL'S STANDARDS OF BEHAVIOR

A	Accountability
C	Communication
C	Courtesy
E	Excellence
P	Professionalism / Privacy
T	Teamwork

FMEA

Failure Mode Effects and Analysis
This procedure is used when we want to evaluate a procedure or situation to determine if there is a potential for a problem to occur.

Past FMEA Projects

2019 – Medication Reconciliation
Registration Process
Case Management Internal Denials

2020 – Direct Anticoagulants
Telehealth Service

2021 – Critical Value Reporting
Prepare/Prevent/Respond to COVID
Medication FMEA: Precedex

HOSPITAL-WIDE POLICY AND PROCEDURE MANUALS

The hospital-wide manuals can be found on Abbeville General's M-drive. To access the M:drive, click on the start button, click on Computer, then click on Public-drive (M:) – then click on the hospital-wide Policy Manual folder.

In this folder you will find the following Manuals:

- Compliance
- Emergency Management (EM)
- Environment of Care (EC)
- Governing Board
- Human Resources (HR)
- Infection Prevention and Control
- Information Management (IM)
- Leadership (LD)
- Life Safety (LS)
- Medical Staff (MS)
- Medication Management (MM)
- National Patient Safety Goals (NPSG)
- Patient Safety Organization (PSO)
- Performance Improvement (PI)
- Provision of Care, Treatment and Services (PC)
- Record of Care, Treatment and Services (RC)
- Rights and Responsibilities of the Individual (RI)
- Waived Testing (WT)

All AGH Policy and Procedure Manuals can be found electronically on the M: Drive on any AGH computer. A physical back-up manual is kept in the Administration Office in the event of a power failure.

LEADERSHIP MANUAL

This manual contains policies on leadership plan, governance/management of the hospital, performance improvement, information management, and Medical staff. It can be found on the M: Drive on any AGH computer.

PERFORMANCE IMPROVEMENT LEADERSHIP MANUAL

Performance Improvement Coordinator- Megan Landry
Risk Manager/Patient Safety/Complaint Officer – Stacy Broussard

Abbeville General Hospital uses a mechanism to plan, design, measure, aggregate/analyze, and improve

PDMAI

- **PLAN**

Identify a problem or process to improve.

- **DESIGN**

Identify important functions and dimensions of performance impacted. Determine if a PI team is necessary. If a PI team is to be formed, select members.

- **MEASURE**

Select indicators to be measured.

Collect data.

- **AGGREGATE AND ANALYZE**

Analyze the data. Use PI tools to assist in analyzing results: (histogram, Pareto chart, run chart)

Determine if action(s) is/are necessary and if so, implement the action(s).

Educate staff, management, and Medical Staff on changes. Determine the effectiveness of the action(s).

- **IMPROVE**

Verify that quantifiable improvements exist. Incorporate the plan and/or solution into department policy or standards.

Inform and educate all involved. Distribute the new policy/standard to all key individuals. May monitor periodically to ensure improvement is maintained.

SENTINEL EVENT RISK REDUCTION STRATEGIES

We have implemented several strategies to reduce the risk of a sentinel event occurring. Listed below are some measures:

1. Two patient Identifiers- # 1 of the patient safety goals
2. Fall prevention measures
3. Universal protocol- For patients having any type of invasive procedure or surgery- fill out the Operative/Invasive Procedure Checklist
4. Patients at risk for suicide- # 15 safety goal
5. Medication reconciliation form
6. Hand washing to reduce spread of infection # 7 safety goal
7. Critical test result reporting form- # 2 patient safety goal
8. Hand-off communication

2021 NATIONAL PATIENT SAFETY GOALS

NPSG.01.01.01– Use at least two patient identifiers when providing care, treatment, and services.

1. Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 7 and 10; PC.02.01.01, EP 10)

AGH POLICY
AGH 2 PATIENT IDENTIFIER IS NAME AND DATE OF BIRTH
BMC 2 PATIENT IDENTIFIERS ARE PICTURED ID AND DATE OF BIRTH

2. Label containers used for blood and other specimens in the presence of the patient. (See also PC.02.01.01, EP 10))

NPSG.02.03.01- Report critical results of tests and diagnostic procedures on a timely basis.

1. Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following:
- The definition of critical results of tests and diagnostic procedures
- By whom and to whom critical results of tests and diagnostic procedures are reported
- The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures
2. Implement the procedures for managing the critical results of tests and diagnostic procedures.
3. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.

AGH POLICY
The Nursing staff will record, notify Physician/LIP and document their
Response of critical test results using the AGH Critical Value Communication form in the EMR
The Nursing staff will have a 60 minute time limit to notify the physician/LIP of critical results.

For Outpatient Parenteral Therapy Patients that have expected critical values consistent with their condition and have been previously reviewed with their Physician/LIP, the AGH communication form will be completed at least every six (6) months or when the pt. is discharged then readmitted.

ED POLICY
Pt.'s presenting to the ER with Chest Pain will have an EKG result given to the ER MD within 10 minutes of arrival and a Troponin level result given to the ER MD within 60 minutes of collection to rule out MI.

Pt.'s presenting to the ER with s/s of a stroke will have a CT within 20 minutes and the results given to the ER MD w/in 25 minutes (pt. arrival to report time= 45 min total) to r/o Cerebral Hemorrhage.

(NPSG.03.04.01) Label all medications, medication containers, or other solutions on and off the sterile field in perioperative and other procedural settings.
NOTE: Medication containers include syringes, medicine cups, and basins

AGH POLICY
1. Medications & solutions both on and off the sterile field are labeled even if there is only one medication being used.
2. Labeling occurs when any medication/solution is transferred from the original packaging to another container.
3. Medication & solution labels include the medication name, strength, amount, diluent and volume,(if not apparent on the label),expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hrs. Note: The date & time are not necessary for short procedures.
4. All medications or solution labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication**.**
5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.
6. Any medications or solutions found unlabeled are immediately discarded.
7. All original containers from medications or solutions remain available for reference in the perioperative or procedural area until the conclusion of the procedure.
8. All labeled containers on the sterile field are discarded at the conclusion of the procedure.
9. 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.

(NPSG.03.05.01) Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

AGH POLICY
1. The hospital uses approved protocols and evidence-based guidelines for the initiation and maintenance of anticoagulant therapy that address medication selection; dosing, including adjustments for age and renal or liver function; drug-drug and drug-food interactions; and other risk factors as applicable.
2. The hospital uses approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication.
3. The hospital uses approved protocols and evidence-based practice guidelines for perioperative management of all patients on oral anticoagulants.

4. The hospital has a written policy addressing the need for baseline and ongoing laboratory tests to monitor and adjust anticoagulant therapy.
5. The hospital addresses anticoagulation safety practices through the following: Establishing a process to identify, respond to, and to report adverse drug events, including adverse drug event outcomes.
6. The hospital provides education to patients and families specific to the anticoagulant medication prescribed, including the following: Adherence to medication dose and schedule, Importance of follow-up

appointments and laboratory testing (if applicable), potential drug-drug and drug-food interactions, the potential for adverse drug reactions.
7. The hospital uses only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.
8. When heparin is administered intravenously and continuously, the hospital uses programmable pumps in order to provide consistent and accurate dosing.

DOACs (Direct Oral Anticoagulants) which include Eliquis®, Bevyxxa®, Pradaxa®, Savaysa® and Xarelto® are the Number 2 top medications involved in error incidents causing death or serious harm. You cannot stop bleeding in patients on DOACs the same way you can for patients on warfarin (Coumadin®) or heparin. Some DOACs have NO FDA-approved reversal agent at this time, so patients on these DOACs need to be assessed according to guidelines on the management of DOACs. Assess bleeding risk before surgery and outpatient procedures. Follow evidence-based practice guidelines for baseline and ongoing laboratory tests to ensure that patients on a DOAC are monitored and dosed appropriately.

Direct Oral Anticoagulant Brand Name	Direct Oral Anticoagulant Generic Name	Reversal Agent for each Medication	Monitoring
Eliquis	Apixaban	Kcentra	renal / hepatic function
Pradaxa	Dabigatran	Praxbind	renal function
Xarelto	Rivaroxaban	Kcentra	renal / hepatic function
Bevyxxa	Betrixaban	Kcentra	renal / hepatic function
Savaysa	Edoxaban	Kcentra	renal / hepatic function
Anticoagulant Brand Name	Anticoagulant Generic Name	Reversal Agent for each Medication	Monitoring
Coumadin	Warfarin	Vitamin K	INR
	Heparin	Protamine sulfate	PTT / platelet count
Lovenox	Enoxaparin	Protamine sulfate	renal function / platelet count

(NPSG.03.06.01)

Maintain and communicate accurate patient medication information.

1. Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting.

NOTE 1: Current medications include those taken at scheduled times and those taken on an as- needed basis.
NOTE 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.

2. Define the types of medication information (for example, name dose, route, frequency, purpose) to be collected in non-24-hour settings.
3. Compare the medication information the patient brought to the hospital with the medication ordered for the patient by the hospital in order to identify and resolve discrepancies.
4. Provide the patient (or family, caregiver, or support person as needed) with written information on the medication the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter.
5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.

AGH POLICY
At the time the patient enters the hospital or is admitted, a complete list of the medications the patient is taking at home (including dose, route, and frequency) is created and documented. The patient. and/or family is involved in creating this list.
When the patients care is transferred within the hospital (for example, from ICU to a floor), the current provider informs the receiving provider about the up-to-date reconciled medication list and documents the communication.

The hospital obtains & documents an accurate list of the patients current meds and known allergies in order to safely prescribe any setting-specific meds (for example, IV contrast media, local anesthesia, antibiotics) and to assess for potential allergic or adverse drug reactions.
When only short-term medications (for example, a pre-procedure medication or a short term course of an antibiotic) will be prescribed and no changes are made to the patients current medication list, the patient and, as needed, the family are provided with a list containing the short term medication additions that the patient will continue after leaving the hospital.
In these settings, a complete, documented med reconciliation process is used when: *Any new long-term (chronic) medication is prescribed.*
In these settings, a complete, documented medication reconciliation process is used when: *There is a prescription change for any of the patients current, known long-term meds.*

In these settings, a complete, documented mediation reconciliation process is used when: *The patient is required to be subsequently admitted to an organization from these settings for ongoing care.*
When a complete, documented, medication reconciliation is required in any of these settings, the complete list of reconciled medications is provided to the patient and their family as needed, and to the patients known primary care provider or original referring provider or a known next provider of service.
Medications ordered for the patient while under the care of the hospital are compared to those on the list created at the time of entry to the hospital or admission.
Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the patient is under the care of the hospital.

(NPSG.06.01.01) Improve the safety of clinical alarm systems.
Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

AGH POLICY

1. All alarm systems incorporated into medical equipment and into patient monitoring systems must be activated whenever the piece of equipment is in use. This applies to all alarm systems that are triggered by physical or physiological monitoring of the individual.
2. Each clinical care area will ensure that existing and newly introduced clinical alarms will have effective alarm coverage, that the clinical alarms are used appropriately and that they are adequate.
3. Specific procedures for effective use of alarm systems are as follows:
    a) Clinicians using the device must be thoroughly familiar with its operation, including any equipment self-check procedures for verifying the alarms operation before and during use. Training should be readily accessible to all those using devices and especially for new users.
    b) All active medical device alarms must be:
        - Activated whenever the medical device is in use.
        - Verified at the start of each shift
        - Verified if the patient is transported between clinical areas.
    c) When clinical alarms are annunciated, staff should personally check the patient and evaluate the reason for the alarm before resetting it. The alarms may be muted or suspended for the brief period of time only when the staff member is monitoring, evaluating, and/or treating the patient. Before turning attention away from the patient, the alarm must be reactivated.
    d) The volume level of clinical alarms must be sufficiently audible with respect to distances and competing noise to be heard by the responsible clinicians in the immediate patient care area.
    e) Special care must be provided to high risk medical device alarms, e.g. ventilators and provide immediate response when these clinical alarms are annunciated.
    f) Biomed will perform Prevented Maintenance (PM) inspections on medical equipment according to risk-based assessment of each device type. Clinical alarms associated with medical device are inspected and tested according to PM inspection protocols. For all staff, any medical device found to have non-functioning alarm systems should be immediately removed from service until repaired.

GOAL #7 – Reduce the risk of health care associated infections (prevent infection) (NPSG.07.01.01) Comply with the WHO Hand Hygiene Guidelines.

AGH POLICY

1. Visibly dirty or contaminated hands- wash with either non-antimicrobial or microbial soap and water. Wash before eating and after using the restroom.
2. Wet hands first, then apply product to hands. Rub hands together for 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water & dry thoroughly with a disposable towel. Use towel to turn off facet. Use warm but not hot water.
3. If hands are not visibly soiled, use an alcohol-based hand rub for decontaminating hands in all other clinical situations. Examples:

- Before direct contact with a patient's intact skin
- Before donning sterile gloves when inserting a central intravascular catheter.
- Before donning gloves to insert invasive devices.
- After skin or mucus membrane contact.
- Moving from contaminated body site to a clean body site during patient care.
- After contact with inanimate objects (including med. Equipment) in the immediate vicinity of the patient.
- After contact with mucus membranes, non-intact skin, body fluids or excretions and wound dressings if hands are not visibly soiled.

4. Apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are not visibly soiled.

1. Artificial nails are not to be worn when having contact with patients in high risk areas. All nail tips should not exceed ¼ inch in length.

(NPSG.15.01.01) The hospital identifies safety risks inherent in its patient population. Reduce the risk for suicide

AGH POLICY

All patients admitted to the hospital will be assessed and screened with a validated screening tool to determine the risk of self-harm and level of monitoring required. Patients will be assessed in the Emergency Room by the triage nurse using the CSSRS ED Version (Columbia Suicide Severity Rating Scale). Once this is complete, if the patient is at risk for self -harm, the system will generate a Discern Alert for a consult to Social Services who will complete a Psychosocial Assessment of the suicidal ideation. The nurse alerts the ED physician, and an order is written for the patient to be placed on Suicidal Precautions as needed, including level of observation and staff supervision. Suicidal Precautions can be initiated by the nursing staff prior to securing an order by the physician. Patients that are at high risk for suicide will be placed on 1:1 observation status in the chart. All patients are reassessed using the CSSRS Screen Short Version per Assessment Policy and documented by the nurse as per policy in Hospital-Wide Provision of Care, Treatment and Services (PC) Manual. Environmental Safety Management is completed and documented in the medical record every shift or as needed.

For patients admitted to the BMC (Behavioral Medicine Center), a Psychiatric Evaluation is implemented by the provider within 60 hours of admission and a Psychiatric Assessment is implemented by Social Services within 72 hours of admission.

Revised policy shows where to document (M: Hospital-wide Manual/Patient Care Services/Provision of Care, Treatment and Services (PC)/Suicidal Precautions)

Education: High Risk Patients and Families will be given information on suicide prevention. Evidence of education will be documented on the Education Form in the patient's record. Suicide assessments are ongoing and communicated between all staff. Staff who care for individuals at risk for suicide are trained in competency annually. Leadership rounds are conducted monthly to identify any potential risks with plans for mitigation.

UP-1 UNIVERSAL PROTOCOL

For preventing wrong site, wrong procedure, and wrong person surgery.
--- Conduct a perioperative verification process.
--- The physician marks the site with his initials.
--- A"time out" is conducted immediately before starting the procedure.

UP-1 UNIVERSAL PROTOCOL

Conduct a preprocedure verification process

Guidelines for the Universal Protocol For Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery

Pre-operative verification process

- Verification of the correct person, procedure, and site should occur (as applicable):
  - At the time the surgery/procedure is scheduled
  - At the time of admission or entry into the facility.
  - Any time the responsibility for care of the patient is transferred to another caregiver.
  - With the patient involved awake and aware, if possible.
  - Before the patient leaves the preoperative area or enters the procedure/surgical room.

- A preoperative verification checklist may be helpful to ensure availability and review of the following, prior to the start of the procedure:
  - Relevant documentation (e.g. H&P, consent)
  - Relevant images, properly labeled and displayed
  - Any required implants and special equipment

MARKING THE OPERATIVE SITE

- Make the mark at or near the incision site. Do NOT mark any non-operative site(s) unless necessary for some other aspect of care.

- The mark must be unambiguous (e.g., use initials or "YES" or a line representing the proposed incision; consider that "X" may be ambiguous).
- The mark must be positioned to be visible after the patient is prepped and draped.
- The mark must be made using a marker that is sufficiently permanent to remain visible after completion of the skin prep. Adhesive site markers should not be used as the sole means of marking the site.
- The method of marking and type of mark should be consistent throughout the organization.
- At a minimum, mark all cases involving laterally, multiple structures (fingers, toes, lesions), or multiple levels (spine). Note: In addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level.
- The person performing the procedure should do the site marking.
- Marking must take place with the patient involved, awake, and aware, if possible.
- Final verification of the site mark must take place during the "time out".
- If a patient refuses to have the site marked, the patient's physician will review with the patient the rationale for site marking.
- If the patient still refuses site marking an ID band with the procedure written on the band will be placed on the designated side of the surgical procedure and placed in a location that can be verified during the "time out".

- **Exemptions**
  - Single organ cases (e.g., C-Section cardiac surgery)
  - Interventional cases for which the catheter/ instrument insertion site is not predetermined (e.g., cardiac catheterization)
  - Teeth- BUT, indicate operative tooth name(s) on documentation OR mark the operative tooth (teeth) on the dental radiographs or dental diagram.

"Time Out" immediately before starting the procedure

Must be concluded in the location where the procedure will be done, just before starting the procedure. It must involve the entire operative team, use active communication, and be briefly documented, such as in a checklist (the organization should determine the type and amount of documentation) and must, at least, include:

- Correct patient identity
- Correct side and site
- Agreement on the procedure to be done
- Correct patient position
- Availability of correct implants and any special equipment or special requirements.

The organization should have processes and systems in place for reconciling differences in staff responses during the "time out".

Procedures for Non-OR settings including bedside procedures

- Site marking must be done for any procedure that involves laterally, multiple structures or levels (even if the procedure takes place outside of an OR).
- Verification, site marking, and "time out" procedures should be as consistent as possible throughout the organization, including the OR and other locations where invasive procedures are done.

- Exception: Cases in which the individual doing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent from the patient through to the conduct of the procedure may be exempted from the site marking requirement. The requirement for a "time out" final verification still applies.

REPORTING SAFETY/QUALITY CONCERNS TO JOINT COMMISSION

If you have concerns about patient safety or quality of care, report those concerns through the **chain of command of the Hospital- Charge Nurse, Nursing Manager, Nursing Supervisor, Director of Patient Care Services, Administrator**, and stopping at the point that your concern is addressed. If your concerns have not adequately been addressed through the Chain of Command system you can report those concerns to The Joint Commission by phone or email. No formal disciplinary actions or informal punitive actions will be threatened or carried out in retaliation for reporting concerns to The Joint Commission. For any concerns that are not resolved by the hospital, you may contact the Joint Commission by emailing Patientsafetyreport@jointcommission.org or go to the website jointcommission.org and fill out an online complaint report. Fax# 630-792-5636

ROOT CAUSE ANALYSIS

When a sentinel event happens, a Root Cause Analysis (RCA) is conducted to determine the cause of the event.

A RCA can be performed anytime a problem or near miss occurs, or something unexpected happened. It is not just conducted for sentinel events. It is a process that allows you to discover where failures occur and what needs to be implemented to improve the process.

INCIDENT/OCCURRENCE REPORTING

Writing an Incident Report

- Incident reports are discoverable:
- Critical comments or comments blaming others for the incident must never occur
- Incident Reports must be timely, objective, complete, and factual
- Incident report must answer the "who, what, where, why, and how of the incident

Who reports the incident?

- The person who has the best knowledge of the incident

Charting

- The medical records should only document the occurrence, with no reference that an Incident Report was completed. Example: "65 mg of Darvon administered in error instead of ordered 32 mg". Dr. Jones notified; vital signs monitored as ordered.

Employee Injury Rep

- To report an employee's injury, illness, or incident no matter how minor, fill out an Employee Report of Injury/Illness/Incident Report which can be found on RL Solutions
- Incident reports should be completed on all employee incidents and near-misses
  Complete report at the time of incident & submit to supervisor within shift

Completely fill out the hospital-wide form, Confidential Hospital Occurrence Report, according to the policies and procedures of the risk management plan. You will find the incident reports online in RL Solutions which can be found under Favorites on any hospital computer.

Risk Management

Incident Reporting

- An Incident Report is a primary tool for collecting data about an incident, analyzing the data, and translating the information into a strategy for change.
- An Incident Report should be completed for any unusual occurrence involving persons or property.

Examples of unusual occurrences:

- An unexpected occurrence involving death or serious physical or psychological injury such as loss of limb or function
- Significant deviations from usual processes for providing health care services of managing the hospital
- An event that has undermined, or has significant potential for undermining the public's confidence in the hospital
- Physical harm to patients, staff, or third parties (visitors, workers, students, etc.)
- Unauthorized leave by patients
- Accidents in which patients, staff, or third parties are injured or die
- Drug or alcohol use or traffic from outside
- Examples of occurrences:
- Damage to property
- Unusual occurrences not resulting in injury, but with potential for injury

Writing an Incident Report

- Incident reports are discoverable:
- They must never be altered or rewritten
- Critical comments or comments blaming others for the incident must never occur
- Incident Reports must be timely, objective, complete, and factual
- Incident report must answer the "who, what, where, why, and how of the incident

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  Complete report at the time of incident & submit to supervisor within shift

CIVIL RIGHTS

Federal and State laws have been enacted over the years to ensure that no person in the U.S. will, on the ground of race, color, sex, age, disability, religion, national origin, sexual orientation or political belief be excluded from participation in, be denied of the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. However, the Americans with Disabilities Act applied to all employees and services providers whether or not they receive any Federal financial assistance.

DISCRIMINATION – To make distinctions; good taste, discernment; and the use of good judgment; a showing difference or favoritism in treatment. This is against the law.

Title VI of the U.S. Civil Rights Act (1964)
…protection of certain classes of persons called "protected classes" (Race, color, national origin)
…public notification of non-discriminatory services
…written complaint procedures
…and other regulations aimed at eliminating discrimination
Section 504 of the Rehabilitation Act of 1973
…protection of persons with disabilities
…selection of someone to function as a 504 compliance coordinator
…compliant and compliance stipulations similar to Title VI
The Age Discrimination Act of 1975
…has provisions to eliminate practices of discrimination on basis of age
Americans with Disabilities Act of 1980 (ADA)
A broad-ranging law which provides for nondiscrimination of persons with disabilities. Its provisions are not limited to persons involved in programs which receive Federal funds. It applies to just about everyone who is an employee or operates a business.

ABBEVILLE GENERAL'S NOTICE OF NONDISCRIMINATION
Pursuant to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act (ADA) of 1990, Abbeville General does not discriminate in admissions, provision of services, hiring and employment on the basis of race, color, national origin, sex, religion, age or disability (including AIDS and related conditions).

For further information or to file a complaint, please contact:

Abbeville General Hospital
Penny Zenon, Human Resources Director, 504 Coordinator
Telephone number: 337-898-6441
State Relay number: 7-1-1

OR

Office for Civil Rights, Region VI
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone (800) 368-1019
FAX (214) 767-0432
TDD (800) 537-7697

ABBEVILLE GENERAL'S NOTICE OF PROGRAM ACCESSIBILITY

Abbeville General and all of its programs and activities are accessible to and useable by disabled persons, including persons who are deaf, hard of hearing, or blind, or who have other sensory impairments. Access features include:

» Convenient off-street parking designed specifically for disabled persons;
» Curb cuts and ramps between parking areas and buildings;
» Level access into first floor level with elevator access to all other floors;
» Fully accessible offices, meeting rooms, bathrooms, public waiting areas, cafeteria, patient treatment areas, including examining rooms and patient wards;
» A full range of assistive and communication aids provided to persons who are deaf, hard of hearing, or blind, or with other sensory impairments. There is no additional charge for such aids. Some of these aids include:
  - Qualified sign language interpreters for persons who are deaf or hard of hearing
  - Relay services for external telephone with TTY users for use by persons who are deaf, hard of Hearing, or speech impaired.
  - Readers and taped material for the blind and large print materials for the visually impaired.
  - Flash cards, alphabet boards and other communication boards.
  - Assistive devices for persons with impaired manual skills.

GRIEVANCE PROCEDURE

Abbeville General has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973. Any person who believes she or he has been subjected to discrimination on the basis if disability may file a grievance under this procedure. It is against the law for Abbeville General to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Grievances must be submitted to the Section 504 Coordinator within 30 days of the date the person filing the grievance becomes aware of the discriminatory action. A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought. The Section 504 Coordinator, or designee, will conduct an investigation of the complaint, affording all interested persons an opportunity to submit evidence relevant to the complaint.

The 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.

The person filing the grievance may appeal the decision by writing to the Chief Executive Officer within 15 days of receiving the decision. The Chief Executive Officer will issue a written decision in response to

the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the:

Office for Civil Rights, Region VI
U.S. Depaertment of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone (800) 368-1019
FAX (214) 767-0432
TDD (800) 537-7697

Abbeville General will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

HEALTH INFORMATION MANAGEMENT

The HIPAA Privacy Officer is **Wendy Broussard** – Health Information Manager

Office Phone is **6112**

Call Wendy if you have a question about Privacy / confidentiality / HIPAA Law or to report a potential violation.

PROTECTED HEALTH INFORMATION (PHI)

- Defined as any oral, written, or electronic individually identifiable health information collected or stored by a facility

PHI EXAMPLES

- Name
- Address including street, city, county, zip code and equivalent geocodes
- Name of relatives
- Name of employers
- Dates (e.g., birthday, date of admission/discharge)
- Telephone numbers
- Fax numbers
- Electronic email addresses
- Social Security Number
- Medical Record Number (MRN)
- Health plan beneficiary number

- Account Number (FIN, Encounter Number, Visit Number, Patient Number)
- Certificate/license number
- Any vehicle or other device serial number
- Web Universal Resource Locator (URL)
- Internet Protocol (IP) address number
- Finger or voice prints
- Photographic images
- Any other unique identifying number, characteristic, code

USE 2 PATIENT IDENTIFIERS (PATIENT NAME AND DATE OF BIRTH) WHEN

- Reviewing films on the PACS system
- Reviewing lab results
- Reviewing or documenting on patient records
- Performing procedures or administering medication
- Transferring patients to another facility
- Hand-off communication- from physician to physician, physician to nurse, etc.

Checking 2 patient identifiers to documents, results, or films prevents mistakes in treating the wrong patient as a result of reviewing the results for another patient. It also prevents a provider from giving patient documents that contain another patient's identification.

***AGH policy** is to **highlight** name and date of birth of patient on every document printed for the patient with a Berol® highlighter provided by the hospital to ensure that documents are given to the correct patient.

HIPAA DO'S AND DON'TS

- Don't look up a patient's medical record without a valid reason. (i.e. providing direct patient care or your job requires you to collect information.)
- Don't look up your own medical record in the EMR, contact HIM Department at Ext. 6542 to review and/or request copies of your record.
- Don't let anyone use your computer user ID and password.
- Don't take pictures of any patient, visitor, family, or employee without a signed photography consent from that person.
- Don't use your cell phone to take pictures, video record, or audio record any patient, visitor, family member, or employee, or take pictures of any part of the medical record.
- Don't ask another employee- Who's that patient? Why is that patient in the hospital?
- Don't ask a visitor, patient, or your family member that you see in the hospital: What are you here for?, unless you are providing direct patient care to that person.
- Don't look at the census of other departments or surgery schedule to see who is in the hospital or having surgery
- Don't eaves drop on conversations where the healthcare team is providing hand-off communication.

- Don’t read patient information that is on someone’s desk, workstation, or computer unless you are providing direct care to that patient or your job requires you to collect information.
- Don’t give information about patients or anyone you see at the hospital to your spouse, fiancé, family, or friends.
- Don’t post confidential information on social media.
- Do keep all patient information out of sight of any employee not providing direct patient care, visitors, or family members.
- Do report potential HIPAA violations.
- Do sign a release of information form with HIM if you would like a copy of your medical record.
- Do remember that IT can track where you go on the computer and can also track where you go in the electronic medical record.
- Do always sign into the computer with your own user ID and password.
- Do always log off of the computer when you leave your workstation.
- Do protect the patient’s identity, and remember that some patients want to remain confidential and do not want to be on the census.

INFORMATION BLOCKING

Information Blocking is a practice that is likely to interfere, prevent, or materially discourage access, exchange, or use of electronic health information, and which if conducted by a healthcare provider, such provider knows that such practice is unreasonable and likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information.

Information Blocking Rule (IBR) applies to electronic health information (i.e., information in the EHR)

The IBR does NOT change HIPAA, but it requires certain treatment-related disclosures that HIPAA permits but does not require.

INFECTION CONTROL MANUAL

Michelle Glatter, RN, CIN is the Infection Control Nurse. Ext: 6242

HANDWASHING IS THE BEST WAY TO PREVENT THE SPREAD OF INFECTION

Standard precautions should be used on all patients (hand washing, use of PPE as appropriate)

When you suspect an infection or you have a diagnosis of infection then you would use *transmission precautions* (refer to infection control manual for appropriate isolation precautions)

For patients with TB, call maintenance to get NQ500 negative pressure machine from materials management and set up in the patient’s room. Note: there are specific procedures to follow, logs to fill out, specific observations to be made, test to be conducted. Refer to manual for TB policy.

Post exposure policy: For exposure to TB, Meningitis, COVID 19 or other communicable infections, notify your supervisor and the infection control nurse.

If you are exposed to a needle stick, wash the area with soap and water immediately and notify your supervisor and the infection control nurse. Fill out a post exposure Employee Injury
Report electronically in RL Solutions on any AGH computer. Do not leave work until labs have been drawn on you and the patient. You will be sent to the ED and your labs will be drawn there.
To prevent needle sticks follow these precautions:

- Do not recap needles
- Use the safety guard on the needles
- Place all sharps in the sharps container immediately after use

Soiled Linen is to be placed in a Blue bag

Latex Allergy: If a patient has a latex allergy, obtain a latex allergy cart from materials management.

The Infection Control Committee of the hospital meets quarterly.

AGH INFLUENZA VACCINATION POLICY

AGH is a mandatory flu vaccine facility.

- All health care workers are required to receive the seasonal influenza vaccine or submit proof as having had the vaccine by November 1st.
- A colored sticker will be attached to all healthcare workers facility issued ID badges to indicate that they have received the seasonal flu vaccine.
- Written documentation of receipt of the annual influenza vaccine from another facility or location will suffice as proof of vaccination. Badge marker will be provided upon receipt of documentation.
- Any healthcare worker choosing to decline the administration of the influenza vaccine will be required to sign an active declination form indicating Medical, Religious, or Philosophical reasons for declination and will be required to wear a surgical mask in all patient care areas from Nov 1st through Mar 31st.

INFLUENZA SYMPTOMS

Influenza (also known as the flu) is a contagious respiratory illness caused by flu viruses. It can cause mild to severe illness, and at times can lead to death. The flu is different from a cold. The flu usually comes on suddenly. People who have the flu often feel some or all of these symptoms:

- Fever* or feeling feverish / chills
- Cough
- Sore throat
- Runny or stuffy nose
- Muscle or body aches
- Headaches
- Fatigue (tiredness)
- Some people may have vomiting and diarrhea, though this is more common in children that adults

** It's important to note that not everyone with flu will have a fever*

CLABSI (Central Line Associated Blood Stream Infection)

"According to CDC, CLABSI is defined as bacteria or other organisms travel down the fluid path of the central catheter or are introduced through the skin during placement and enter the blood stream. There is also a risk of infection from the post insertion catheter dressing assessment and care."

MDRO (Multi Drug Resistant Organisms)

- MRSA (Methicillin Resistant Staphylococcus Aureus)
- CRE (Carbapenem-Resistant Enterobacteriaceae)
- ESBL (Extended Spectrum Beta-Lactamase Producers)
- C-DIFF (Clostridium Difficile)
- VRE (Vancomycin Resistant Enterococcus)
- VRISA (Vancomycin Resistant and Intermediate Staphylococcus Aureus)

ARTIFICIAL FINGERNAILS

- Artificial nails are any product not growing from the body and applied to the existing nail area including but not limited to any fingernail enhancement or resin bonding product, extensions, tips, acrylic overlay, gels, shellacs, resin wraps, glitter, appliques, or acrylic fingernails.
- The above listed artificial nails are prohibited by staff members who fall into the following categories:
    - Provide or assist with direct patient care.
    - Prepare or handle medications
    - Handle sterile/clean supplies outside of the primary shipping container
    - Handle, prepare, or serve food In clinical/patient areas
    - Work with soiled or clean linens
    - Perform decontamination or reprocessing activities
    - Perform environmental cleaning
    - Routinely wear protective gloves for any reason
    - Are prohibited by specific departmental policy

COVID (Coronavirus)

Prevention:
- Wash your hands often
- Cover your cough/sneeze with tissue
- Don't touch your eyes, nose, or mouth
- Avoid close contact with sick people
- Clean high-touch surfaces often
- Stay home when you are sick

For current AGH Policy regarding COVID, go to:
Public-Drive (M:) > Department Manuals > Infection Control > COVID-19 Update

ENVIRONMENT OF CARE MANUAL

Policies on Safety, Risk Management, Security, Hazardous Waste, Emergency Plan, Life Safety, Medical Equipment, Utility Systems, can be found in the *Environment of Care Manual* which can be found on the M: Drive on any hospital computer.

AGH WATER MANAGEMENT POLICY

Waterborne microorganisms, to include bacteria, fungi, and viruses are considered opportunistic pathogens with primary hospital-acquired infections being associated with *Legionella (*causative agent in 90% is *Legionella pneumophila).*
AGH has an established monitoring system with includes controls for all water-borne pathogens through an inter-disciplinary approach of system design and inspection, laboratory testing and clinical surveillance.

SAFETY MANAGEMENT

The Environment of Care Committee meets quarterly.

Whenever a condition exist, that poses an immediate threat to human life or hospital property that is essential to the safe operation of the hospital, the Safety Officer should be notified.

Should the Safety Officer/Director be unavailable, the Administrator on call should be contacted. If neither is available, the House Administrative Officer will be designated to act in the Safety Officer/Director capacity.

The Safety Officer/Director or designee will analyze the existing condition for the need to take immediate action. If it is felt that no immediate action is necessary, appropriate parties will be notified of the condition and asked to respond appropriately.

SMOKING POLICY

Abbeville General is a Tobacco-Free, Smoke-Free Campus. Smoking and the use of tobacco products (includes but is not limited to cigarettes, cigars, pipe, pipes or rolling tobacco, chewing or spit tobacco, snuff, tobacco substitutes -i.e. clove cigarettes, or any type of electronic smoking device, an e-cigarette, e-cigar, e-pipe, e-hookah, vape pen, nicotine inhaler, or under any other product name or descriptor) are not permitted by anyone on the campus/property of any Abbeville General Hospital and Abbeville
General Rural Health Clinics, and Abbeville General owned properties, or in hospital owned/leased vehicles. This includes using tobacco in your personal vehicles while on any hospital property.

What are considered Abbeville General hospital/clinics, properties/facilities?

Rural Health clinics- Erath/Delcambre Clinic on North Road in Erath, Abbeville General Rural Health Clinics across from the ED- which consist of the Pediatric Clinic, AGH Clinic, and Women's Health of Vermilion on Alonzo Drive, and Maurice Community Care Clinic on Milton Road in Maurice.

All of the property of Abbeville General including the buildings, parking lots, grass areas, road to the BMC off Hospital Drive and the BMC property and parking lot, The Old Nursing home building (on Alonzo Drive) and it's grounds, sidewalks, driveways, and parking lot; The house, grounds, driveways across from the hospital at the corner of hospital drive and South Road; the empty lot next to the AGH clinic across from the ED on Alonzo Drive; and the empty lot across from the elementary school on Odea Street between Dr. Gupta and Dr. Roland Miller's offices.

CELLULAR PHONES

- Employees/Contract/Agency Nurses/Students are to use the hospital phones for hospital business only.
- Please inform your friends and relatives that you may not be called at work except in cases of emergency.
- *Employees/Contract/Agency Nurses/Students are not permitted to receive or make personal calls from cell phones while at work.*
- Cell phones are issued to certain employees in connection to their duties.
- Employees/Contract/Agency Nurses/Students should not use cell phones while driving hospital vehicles.
- Use of personal cell phones for non-business purposes is prohibited, such as camera use, text, messaging, Facebook, or similar phone functions.

SECURITY MANAGEMENT

We have a security guard 24 hours a day. If you leave the hospital after dark have the operator call the security guard to escort you to your car. If you are a female coming in after dark you can call the hospital ahead of arriving to make sure the security guard is in the parking lot when you arrive.

The Security Management Plan applies to all employees and all areas of the hospital grounds. Security coverage is provided by a contractual agreement between Abbeville
General Hospital (AGH) and a private security agency, which provides for a security force on duty 24 hours a day, who are qualified to perform duties customarily undertaken by security guards, with the expressed stipulation that the security force will be unarmed and will not engage in any type of police actions. In the event that such police actions are needed, assistance will be sought from local law enforcement agencies.

Use of Personal Electrical Equipment by Patients and Staff
Electrical equipment brought into the hospital by the medical staff or employees *must be tested* (only) for electrical grounding and electrical isolation by the Engineering Department. If such equipment is approved, it shall be so tagged.

WEAPONS
Employees, patients, visitors, and medical staff of the hospital are not permitted to bring weapons into the hospital; it is against the law. In the event that it is discovered that a person has a weapon in their possession, the House Supervisor will be advised immediately. The House Supervisor or the Security Officer on duty will inform the person(s) possessing the weapon of the hospital's weapon policy and request the person (s) to remove the weapon from the hospital premises immediately. The weapon will be

confiscated and the house supervisor will obtain advice from the Abbeville Police Department as to disposition. If the person(s) refuses, the police department will be notified. The only time firearms may be carried in the hospital is by law enforcement officers on official business in the hospital.

AGH EMERGENCY CODES:
CODE RED- Fire
CODE BLUE- Cardiopulmonary Arrest
CODE PINK- Abduction
CODE GREY- Severe Weather
CODE YELLOW- Disaster (Mass Casualty)
CODE WHITE- Security Alert- Violent/Hostage
CODE ORANGE -Hazardous Materials
CODE GREEN- Evacuations
CODE BLACK- BOMB
CODE SILVER- SHOOTER-MOVE TO A SECURE AREA IMEDIATELY

NOTE: TO CALL A CODE AT ABBEVILLE GENERAL HOSPITAL DIAL **6111** **AND ANNOUNCE THE CODE TO THE OPERATOR THREE TIMES**

FIRE SAFETY

Fire Alarm Pulls are located at each stairway and Exit. There are 3 fire extinguishers clearly marked down each stairway. Code for fire is code Red. When a Code Red is called and the fire is not in your area, stay in your area and wait for instructions.

If the fire is in your area follow the **RACE** formula:

R ……..Rescue
A……...Alarm
C……Contain
E……Evacuate/Extinguish

Rescue: Remove patients/persons from immediate danger. If practical, they should be sent to a safer location on the same floor.

Alarm: Activate the nearest fire alarm box by pulling the handle or dial **"6111" from any in house phon**e. The PBX operator will announce a "CODE RED".

Contain: Contain the fire by reducing drafts as follows:

- Turn off air conditioners and fans in the patients rooms. (Corridor air handlers in the affected area will automatically shut down in the event of fire).
- Close windows and doors.
- Place wet linens under doors.
- Attempt to extinguish only very small fires with portable fire extinguishers.

Extinguish/Evacuate: Extinguish the fire or Evacuate the immediate area if you feel that you are in danger.

The **PASS** formula is used to operate the fire extinguishers:
P……..Pull
A…….Aim
S……..Squeeze
S……..Sweep

Departmental responsibilities (General Description)

A.If a fire is in your area:

- Implement the RACE formula and other applicable policies for your area.
- If you are not in your department when the alarm sounds, you should respond as a member of the fire brigade.
- Be prepared to prioritize and remove any records threatened by fire or water damage.

B. If the fire is remote to your area:

- Respond to the scene of the fire if you have been designated as a member of the fire brigade.
- Remain in your department, implement departmental policies as indicated and await further instructions.
- If you are in another area, implement the RACE formula until your assistance is not needed (usually with the arrival of the fire brigade of the Fire Department), then return to your department and await further instructions.

Fire Brigade Members

- Director of Plant Operations
- Nursing Supervisor
- Department Manager or representative of involved area
- Respiratory Therapist on duty
- Security Guard
- For additional assistance, call " Code White"

General Instructions

- **Elevators-** reserved for use by the Fire Department. Never use the elevators during a fire unless instructed to do so by the Fire Department
- **Bedding or Mattress fire-** Consider this a large fire. Remove everyone from the room and close the door. Douse fire with water from the faucet or fire extinguisher or cover with wet towel of blanket. Never remove mattress from room yourself Plant operations will remove it for you.
- **Oxygen involved fire**: Cut off supply of oxygen at individual unit. If fire is from a tank, turn the tank cutoff valve to the OFF position. If necessary, the oxygen to the area can be cut off at the zone valve with the approval of the Nursing Unit Manager in consultation with the Respiratory Therapy Department charge person.

- **Fire Extinguishers:** Never put a used fire extinguisher back in its storage space, call Plant Operations immediately to replace or recharge the extinguisher.
- **Hallway Carts:** Remove all carts and equipment from hallways if evacuation is necessary.
- **Sensory input:** Utilize your senses: Smell for smoke, Feel doors for heat prior to opening, Look for evidence of smoke or flame, Listen for fire alarm or other sounds associated with a fire

CODE PINK – ABDUCTION OR LOCKDOWN SITUATION

- Upon notification that a patient has been abducted, immediately call "**6111"**, and instruct the PBX Operator to announce a **CODE PINK**,; give the age, race and sex of the missing patient, and location in which the abduction might have occurred.
- Notify the Unit Manager, Charge Nurse and Administrative Supervisor
- The Administrative Supervisor will call Security and report to the area of abduction.
- **Seal off the immediate area of where the possible abduction occurred.**
- Do not disturb or touch anything
- Do not allow any patients, visitors, or staff to leave the area until instructed otherwise. Question those in area for descriptions of persons and activities prior to the abduction.
- If possible abductor is witnessed, confront the person in a delicate manner; concentrate on getting a good description of the person, physical, mental and emotional characteristics, and immediately report any information to the Command Center.

Department	Position	Entrance/Exits
XR Staff	Employee parking lot near northwest external stairwell	Main building west exits. Employee parking lot gated exits 1,2,3.
BMC Staff	Outside northeast corner of BMC.	Main Building southwest exits. Employee parking lot gated exit 4.
Respiratory Staff	Outside southeast corner of main building near OB	Main building southeast exits, south and southeast external stairwells. Employee parking lot gated exit 4. Southeast and East Visitor parking lots.
3N Staff	Outside Ambulatory	Ambulatory Services

	Services entrance.	exit. East external stairwells. East Visitor parking Lot.
Lab Staff	Outside Administration Entrance.	Administration and Emergency exits. Northeast and north Visitor parking lots.
ER Staff	Outside Ambulance entrance	Ambulance entrance. DECON entrance. North Visitor parking lot(Partial) Employee parking lot exit.

CODE

GREY- SEVERE WEATHER/TORNADO

Basic Safety Rules:

1. Go to the lowest level of the building; If there is not time to get to the lowest floor, the middle of the building is usually safer than near exterior walls, especially those with windows.
2. Get away from windows and exterior doors. Hallways can provide more protection than rooms with windows or exterior walls, but under certain circumstances wind flow in hallways that have exterior doors at each end can be enhanced by the wind tunnel effect.
3. Close interior doors to help impede wind flow through a structure. Interior stairwells are usually good places to take shelter, and if not crowded, allow you to get to a lower level quickly.
4. Do not use elevators; you could be trapped in them if electrical power is lost

If a tornado or unusually severe storm appears inevitable, precautions should be taken that include the following:

1. Draw all shades and close all drapes as protection against shattering glass.
2. Lower all patient beds to the lowest position, and move the bed away from the windows as much as possible.
3. Place blankets on all bed patients.
4. Close all doors.
5. Get as many ambulatory patients as possible into the hallways
6. Direct visitors to safe areas.
7. Do not use the elevators
8. Do not return patients to unprotected areas until “all clear” has been given.

CODE YELLOW – INTERNAL OR EXTERNAL DISASTER

- Internal disaster- fire, bomb
- External disaster- accident with mass casualties, bus accident, train accident, etc.

CODE WHITE – VIOLENCE OR HOSTAGE SITUATION

- Stay calm
- Empathize and sympathize – ask what you can do to help him/her
- Have someone dial 911 and call **CODE WHITE TO YOUR AREA**
- If you are unable to call operator or police yourself, press the nearest panic button if able
- To report verbal threats or suspicious behavior: Notify your immediate supervisor and/or Security
-

CODE ORANGE – HAZARDOUS MATERIALS

- Managers and Security report to the dining room to be briefed on the situation and to obtain job action sheets/ duties.
- Employees will be briefed by managers

CODE GREEN – EVACUATION PROCEDURE

If it is necessary to evacuate your area you should try to evacuate horizontally first, past the fire doors.
The first patients to evacuate should be ambulatory, those that need assistance, then total bed patients
If you cannot evacuate horizontally, go vertically.
If a total evacuation is called, Know your evacuation route, each department has two planned evacuation routes that get them directly to the outside of the hospital.
For total Hospital Evacuation- You will evacuate patients down the East or West stairway that leads to the outside.
Only the Chief Executive Officer, The Safety Officer, the Nursing Administrator of the Fire Department can call for a total hospital evacuation.

CODE BLACK – BOMB THREAT PROCEDURE

If you are the employee that receives the Bomb Treat:

- Notify department head
- Call PBX operator and advise of threat
- Remain at your duty station until relieved by supervisor.

The PBX Operator Will Notify:

- Administration
- Security
- Director of Maintenance
- Call a Code Black
- City Police

Director of Maintenance:

Verifies threat information, and initiates appropriate notification procedure:

- If caller indicates bomb location, affected area will be searched immediately.
- If no location is indicated, Administration is notified.

Administration:
Coordinates hospital search.

See hospital policy in the Environment of Care manual for more details of this policy.

Procedure for receiving a telephone Bomb Threat:
Remain Calm- The more information you obtain from the caller, the better our chances for dealing effectively with the threat.

When you receive the call

- Prolong the conversation as long as possible
- Document the **Time** the call was received:_____AM/PM
- Ask **Where** bomb is located
- Ask When bomb will explode
- Is Caller: Male, Female, Adult, or Child
- Is Caller: Calm, Angry, Joking
- Is Callers Voice: Loud, Soft, Distinct, Garbled
- Can you hear any background noise, such as: Traffic, Airplanes, Animals, Machinery, Music

CODE LOCK DOWN

- Utilized in the event if an emergency which threatens the safety of patients, employees, staff and visitors and/or operations.
- Halts pedestrian and vehicular traffic
- Directed by Chief Executive officer, House Administrative Operating Officer or Safety Officer (Incident Commander)
- May be complete lockdown- only uniformed Law Enforcement or AGH Security may enter or exit.
- May be partial lockdown- Single entry for Medical Screening: Staffed by Security Guard and RN to perform Triage assessment.
- See policy in the EOC manual under Emergency Management for other types of lockdown.
- PBX will page **"Code Lock Down, Code Lock Down, Code Lock Down"**
- PBX will call 911, notify all AG off-site campus (RHC clinics, off-site Imaging Center and Outreach Centers) and the BMC of Lock Down Status
- Security- lock all doors to entry and exit
- Select Hospital staff deploy near entrance/exits as per Code Pink P & P to prevent and report entry/exit.
- **Staff will remain inside building.**

CODE SILVER – ACTIVE SHOOTER / PERSON WITH A WEAPON

"Active Shooter" is a term used to describe a situation that could well be your worst nightmare come true. It is a person, or persons, whose intentions are nothing less than to harm or kill as many people as can be before either killing themselves or being killed. Methods employed to accomplish this can be knives, guns, explosives, bio-hazards or other forms of deadly weapons and dangerous instruments. The shooter(s) could have a specific plan, or could be acting completely random. Regardless, the situation will be dynamic, evolve rapidly and will call for strategic reaction. This document is intended to provide guidance to faculty, staff and students who may be caught in such a situation, and describes what to expect from responding police officers. You are encouraged to continue to read this. Your life may well depend on it.

Planning Ahead

We must recognize there simply is no manner to completely prepare for every bad situation that could occur. Start planning by thinking in terms of "target hardening", which means trying to be less vulnerable. This is a mind-set we all should work on. Which way does your door swing when you open it, in or out? What type of lock does it have, one that can be locked from the inside or not? If there are windows, do you have anything inside you could cover it with and limit the view to your area? Can you break an outside window to escape? Which direction do you face when you set at your desk? How far is the outside exit door from where you are?

Whenever you walk around, what potential cover exists? Where could you hide if you had to? What am I willing to do to protect myself against armed suspects when I am unarmed?
The decision to hide or run should be dictated by the events you are witnessing. If you hear the commotion and feel it is far enough from you, you may choose to run. If you feel it is too close, you may need to secure in place. If the situation comes to you, there will be harder decisions to make. Remember, shooters are mobile.

- Move to a secure area immediately
- Accept, Assess, Act, and Alert
- Avoid, Barricade, or Fight
- Lock doors/barricade, turn off lights and silence cell phones
- Call 911, give info such as how many, weapon, and location of shooter
- Be quiet, don’t scream, it will give your hiding place away.

Accept

- Accept the situation that you are in as real and actually taking place.
- First steps toward survival- rapidly assess the situation and evaluate available options

Assess

- Assess both external and internal risk factors
- How are you going to survive?
- Can you get out?
- Is there a path of escape?
- Should you hide?
- Is there a chance to get to where the shooter might not find you?
- Or are you in a situation where the only option is to try to stop the shooter anyway you can?
- This assessment must continuously cycle through your mind throughout the event.

Act: Avoid, Barricade, or Fight

- These are your 3 options
- The last option applies ONLY if you find yourself face to face with the shooter and no way to Avoid or Barricade.

Avoid

- If you can avoid the shooter and get to a safe area than do so.
- Get out fast.
- Don't wait for other to validate your decision.
- Leave your belongings behind.
- The best way to survive an active shooter situation is not to be where the shooter is-and not to go where he can see you.
-

Barricade

- You may have to Barricade if the shooter is between you and the only exit and you can't get out, or you would have to enter the area or hallway where the shooter is positioned.
- It might be safer to remain in place if you are well hidden and well protected.
- If you can't get out, then you must find a place to barricade yourself from the shooter.

Fight

- Escaping or hiding from danger are solid survival strategies, but they may not always be possible
- The shooter may directly confront you.
- Your only option may be to fight
- Be prepared to know what you have to do and understand that neutralizing the shooter in some manner may be your only way to survive.
- It involves behavior and a mindset that few people ever have to consider.
- The difference between life and death may be coming to terms with what needs to be done and then committing to it.

Neutralizing the Threat

- You'll need to become more aggressive than you ever thought possible.
- Either disrupt his actions or incapacitate him.
- Throwing things, yelling, using improvised weapons can be effective but, total commitment and absolute resolve are critical

Alert

- When you get out, immediately alert authorities.
- Do not assume that someone else has called.
- Dial 911 and calmly and quickly tell them where you are and what's occurring.
- Include the name of the shooter, if known; number of shooters; description of the shooter; and number and type of weapons carried by the shooter.
  Be persistent when calling since the phone lines may be jammed with other calls

Tom Pigott, RN

Emergency Preparedness Coordinator

Hospital Incident Command System (HICS)

Hospital Incident Command System (HICS) is an incident command system (ICS) designed for hospitals and intended for use in both emergency and non-emergency situations. It provides hospitals of all sizes with tools needed to advance their emergency preparedness and response capability—both individually and as members of the broader response community.

HICS is helpful for managing events such as:

•Mass Casualty Incidents

•Surge Capacity incidents

•Severe Weather

•Staffing Shortages

•Power Loss

•Pandemic Influenza

You can find the HICS forms and Job Actions Sheets on the AGH website by going to employee login and then click on HICS 2014.

HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN

Spill Procedure

In the event of a spill or leak of a hazardous material occurs, the following emergency response procedure is to be used:

- **Isolate** the immediate area for all non-essential personnel and deny entry.
- **Notify** immediate supervisor of spill.
- Before attempting to clean up any hazardous chemical spill, **identify** the chemical.
- **Follow** the directions on the **MSDS** for cleaning up the spill or leak.
- Ensure adequate **ventilation**.
- Obtain appropriate **protective safety equipment**, such as a **spill kit**.
- Complete an **incident report** on the spill or leak.
- The maintenance department is responsible for cleaning up massive spills or leaks that require additional personnel and equipment.

Maintenance department Manager is the Safety Officer

Each department has a spill kit and personal protective equipment – find out where these items are kept.

SAFETY DATA SHEETS (SDS)

Abbeville General Maintains Safety Data Sheets electronically using MSDS online.

To access this, an employee must go to the internet and click on favorites and open the AGH folder, scroll down and click on MSDS online.

Your computer may also have a shortcut to the MSDS online on your desktop.

Once in the MSDS online:

If you are unable to find a document in our data base, you will be prompted to search MSDS online for the document. There you can view the SDS and add it to the Abbeville General database by using the request tool to obtain the SDS from Abbeville MSDS online Administrator.

If an internet failure would occur, the Abbeville General MSDS online Administrator has a backup eBinder. The Administrator may be contacted at 6567.

UTILITIES SYSTEM MANAGEMENT PLAN

The following are procedures for department utilities failure:

Elevators

Use emergency button in elevators to summon help if the elevator service is interrupted, and telephone to communicate with PBX Operator.

All Elevators are on emergency generator unless load shed takes place. Then 1 and 3 will be the only elevators available.

Use stairways.

Communications

All patient care areas - communications will be done with messengers and 2-way radio used by Plant Operations personnel. In-house paging is not available if telephone systems are disabled; In-house pagers power failure lines, and direct fax lines can be used to communicate.

Natural Gas

Notify Plant Operations if failure occurs.

Medical Gas / Vacuum

Portable suction machines and oxygen tanks will be used.

Anesthesia machines operate by battery.

Water

In most areas patients will be encouraged to drink canned beverages or bottled water. For inpatients one pitcher of water/day will be supplied to pts. Extra water issued on request.

No bathing unless soiled.

Toilets flushed daily and after each bowel movement.

For Surgery- Allocated water will be brought from the rear of the hospital. Water may be used for scrubbing and instrument cleaning. Use sterile water as appropriate.

NOTE: In the Red Environment of care manual is a Chart that outlines what each department would do in case the Hospital would lose water service or would not be able to use town water system.

Heating/ Air conditioning

Notify Plant operations. Use blankets as necessary to keep warm. Request fans from housekeeping for the patients

Electrical Power:All departments will have full Emergency Power. Red or illuminated outlets will be the last to go out if Generator load sheds. If Emergency power fails, use flashlights. Open refrigerators as little as possible.

Emergency Electrical Outlets

- Throughout the hospital are emergency back-up electrical outlets.
- These outlets are illuminated (or back lit) or red in color.
- All critical medical equipment must be plugged into an emergency outlet.
- If the generator fails it will shed (turn off all non-emergency circuits) the least critical outlets first.
- Therefore, all critical medical equipment must be plugged into these outlets at all times.
- Critical medical equipment are: Anesthesia machines, Defib/monitors, incubator/infant, ventilators, warmers/infants

Use of Extension Cords

- Only power strips and extension cords that meet the UL (underwriters Laboratories) requirements are permitted.
- Power strips and extension cords used in the patient care areas must meet **UL 1363A** or **UL 6060-1**.
- Power strips and extension cords used in Non-patient care areas must meet **UL 1363**.
- Any hospital made extension cords or duplex connections that do not meet the UL requirements referenced above must be removed from the patient care environment.

Broken Equipment

Fill out the Red Tag below and attach it to the piece of broken equipment and send to maintenance

Date:_____ Dept:_____
Name of Person Sending Item:_____
Problem:
Broken_____ For Repair_____ For Discard _____
Explain Problem:
_____
_____

Safety/Storage of Compressed Air

- All free standing cylinders must be stored in a rack, a cart, or another enclosure to protect them.
- Unsecured cylinders could fall, breaking the valve and possibly resulting in a rapid release of the gas, propelling the cylinder and turning it into a dangerous projectile.
- Make sure all cylinders are segregated, keeping full and empty (including partially used) cylinders separated so staff will not be confused when retrieving a cylinder in an emergency situation.
- If transporting a single cylinder cart, once it leaves your possession, it needs to be stored securely 5 feet from any doorway and against the wall.

Authority to shut off medical gas in an Emergency

- AGH facility policy is that the Unit Charge Nurse and Respiratory Therapist need to be present to shut off the Medical Gas (i.e. oxygen).
- These 2 individuals know which patients will be affected by which gas- for instance, how many patients are on oxygen- and can implement clinical interventions as the medical gases are shut off.

MRI SAFETY FOR NON-MRI PERSONNEL

The Joint Commission requires yearly MRI safety training for MRI personnel as well as non MRI personnel that may perform jobs or enter into the MRI area.

The following types of injuries can and have occurred during the MRI scanning process:

- "Missile effect" or "projectile" injury in which ferromagnetic objects (those having magnetic properties) such as ink pens, wheelchairs, and oxygen canisters are pulled into the MRI scanner at rapid velocity.
- There have been cases of death that have occurred due to projectiles.
- Many people- including Health care workers- are unaware that the magnets in the MRI scanner are always "on" and that turning them "off" (Quenching) is an expensive and potentially dangerous undertaking, involving the controlled release of cryogenic gases that can be deadly if released into a contained area.
- As a result of the magnets, many of the objects pulled into the MRI scanner are cleaning equipment, or tools taken into the MRI suite by housekeeping staff or maintenance workers.

Safety Precautions to Prevent Injury in the MRI

- There is a 4 zone process to restrict access to the MRI suite. This 4 zone concept provides for progressive restrictions in access to the MRI scanner:
  - ✓ Zone I: General Public
  - ✓ Zone II: Unscreened MRI patients/non MRI staff
  - ✓ Zone III: Screened MRI patients and non MRI staff
  - ✓ Zone IV: Screened MRI patients/non MRI staff under constant direct supervision of trained MRI personnel

- MRI technologist will screen any non MRI personnel such as maintenance and their tools prior to allowing entrance into ZONE II and IV. Signs are posted in the MRI area/building to let you know what zone you are entering and the requirements for entering that zone.
- In general, do not bring any device or equipment or tool into the MRI environment unless it is proven to be MR Safe or MR Conditional. MR Safe items pose no known hazard in all MRI environments, and MR Conditional items have been demonstrated to pose no known hazards in a specified MRI environment with specified conditions of use. The safety of "MR Conditional" items must be verified with the specific scanner and MR environment in which they will be used.
  Only use equipment (housekeeping buckets, buffers, tools) that has been tested and approved for use during MRI scans.

- Best practice is for a non MRI personnel (housekeeper or maintenance) to not enter an MRI suite with a patient in the suite and only with an MRI technologist escort.

MEDICAL RADIATION SAFETY

ALARA is the acronym for **A**s **L**ow **A**s **R**easonably **A**chievable. All organizations and personnel are responsible for taking steps to keep radiation doses to all people ALARA. AGH follows this radiation safety principle by establishing procedures personnel are to follow and by utilizing reasonable methods that minimize radiation doses and releases of radioactive materials to work and public places. ALARA is not only a safety principle but is a regulatory requirement for all radiation safety programs.

HUMAN RESOURCES MANUAL

Cultural and Age Specific Competencies

- Cultural competency/ cultural Diversity

  - In the workplace, diversity refers to the differences we recognize in ourselves and others, such as:
    - Gender type
    - Culture
    - Race
    - Ethnicity
    - Age
    - Religion
    - Sexual Orientation
    - Physical and mental abilities or challenges

  - Diversity is further defined to recognize differences relating to our workplace relationships, such as:
    - Management vs. non-management
    - Headquarters vs. field office
    - Techies vs. non-techies
    - Employees with families vs. single employees

Diversity is not about being like others or requiring people to be like one another.

Diversity is about allowing differences and respecting differences until the differences don't make a difference anymore

Diversity can create wholeness in an organization y contributing to healthier working relationships which, in turn, will lead to increased productivity.

Acknowledging Prejudice:
We are said to be prejudiced when we ascribe general characteristics to a large group of people and don't allow new information to change this tendency to stereotype others
Prejudice is a natural human emotion. We all have a natural fear or distrust of people different than ourselves. It is important, however to overcome fear or distrust in order to accept other people for who they are.
You don't have to like or agree with everyone, but you do have to treat each person with respect and equality. What you think is your business- what you do concerns others.

COMMUNICATION FOR A DIVERSE WORKPLACE

- Communication Tips- Openness, active listening and respectful language
- Think before you Speak- Be sensitive to others. If you do accidentally offend someone, apologize immediately.
- Listen more- Being heard increases a person's self-esteem and confidence.
- Avoid generalized Language- Refrain from using words, images, and situations that suggest that all or most members of a particular group are the same. We aren't
- A word about Humor- Be careful with humor. Sometimes people are so relaxed in their conversations that they forget to consider how off-the-wall comments or jokes might hurt others. Of color, sexist, religious, political or ethnic remarks are bound to offend someone.

At the same time, recognize other people's intentions when they speak. Don't be hypersensitive to a thoughtless remark and don't take things too seriously.

The three things that make us different culturally are**: *Language, Religion***, and ***Food.***

Population Specific Competency
Involve understanding the development, and the health needs, of the population groups you work with.

ASSISTIVE DEVICES

Listed below is a list of assistive devices used at Abbeville General

- Maxi-Slides
- Slider Boards
- Mechanical Lifters
- ARJO STEDY Transporter

You will receive in-services on these devices from your department manager

WORKPLACE VIOLENCE

Workplace violence can come from internal or external sources. Internal violence can come from employees, patients, or family members. Reasons for employee violence: layoffs, termination, passed over for promotion, and psychological instability. Reasons for patient and family violence may be unsatisfactory service, long wait times, mistakes that are made, and promises that are not kept.

Know the warning signs of violence

- Verbal threats
- Unusually argumentative
- Does not cooperate well with others
- Has a problem with authority figures
- Frequently blames others for his or her problems
- Displays marked changes in work patterns like tardiness or absenteeism
- Demonstrates extreme or bizarre behavior
- Frequently appears depressed
- Is involved in alcohol or drug abuse
- Has a history of violence

Reporting Workplace Violence

Take every threat seriously. It is crucial that you report any violence, verbal or physical. Do not ignore it. If the perpetrator actually commits the violence he or she threatened, the consequences can be devastating. Thoroughly report the actual behaviors or threats that were made. Just give the facts, where and when it happened, who witnessed it and what was said. Also, make sure to document your report.

In the case of a violence or civil disturbance from patient, employee, or family member, try to calm the person down. Empathize and sympathize. Ask the person what you can do to help him or her. To call for assistance, have someone dial 611 and call a ***CODE WHITE*** to your area.
This will alert all available personnel to your area for a show of force, it will also alert security.
At the very least, to report verbal threats or suspicious behavior, notify your immediate supervisor, security, and possibly Human resource director.

SEXUAL HARRASSMENT

There is Zero tolerance for sexual harassment. Report sexual harassment to your immediate supervisor. Your supervisor will report it to Human Resource Director, if it is found to be sexual harassment the employee could be terminated immediately. *You must write up the incident to be presented to the Human Resource Director.*
Sexual Harassment can come from fellow employees, physicians, visitors, and patients.
The first step to take is to let the person know that their behavior is offensive to you and should stop.

RECOGNIZING / REPORTING SIGNS OF EMPLOYEE IMPAIRMENT AT WORK

Impairment may be due to such things as the use of alcohol or other substance (legal or illegal) or medical and/or psychological conditions.

An employee who is impaired should not remain at his or her work site because of increased risk for accidents and other dangerous or hostile behavior. For the safety of the impaired employee and others at Abbeville General Hospital, it is important that the impaired employee leave the work site immediately in a

safe and orderly manner. Since safety is the primary objective, all employees are encouraged to take appropriate action when faced with the possible impairment of a co-worker.

When an employee suspects another employee is impaired, he or she shall notify the impaired employee's immediate supervisor. If an employee suspects his or her supervisor is impaired, he or she shall notify the Supervisor's immediate supervisor. In either case, if the immediate supervisor is not available, the next higher level supervisor shall be notified.

Patient Care Manual

Abuse and Neglect

Any person or employee who, in the scope of his/her employment at the hospital has knowledge of or has reasonable cause to believe that any patient has been or is being abused has an *obligation* to report the incident to his/her supervisor. Any confirmed incident of abuse or neglect of a patient will be grounds for dismissal of any staff member actively or passively involved.

In the event of physical or verbal abuse, the nursing or therapy staff will:

1. Report the incident or condition to their supervisor.
2. A photograph of the area will be taken by the nursing staff and placed in the patients chart (to include description, size, and location of the marks or bruises).
3. Patient complaint form will be offered to the patient (or family) to be completed and routed to Case Management/ Social Services, Director of Patient Care Services, or Chief Executive Officer,

In the event of abuse or neglect of a patient by an employee the Director of Patient Care Services or the Chief Executive Officer will record the allegations of abuse, immediately investigate, take appropriate action against staff (civil or criminal charges if warranted) and complete an incident report.

All healthcare providers are mandated reporters in the state of Louisiana.

The Case Manager/ Social Worker, Administration, along with the hospital attorney, will be responsible to ensure that such reports are transmitted to the appropriate authority and is designated as the official hospital representative in terms of communications sent to or received from the state.

Report orally or by telephone within twenty- four (24) hours of the discovery to the Department of Health & Human Services, Bureau of Protective Services.

Report in writing within two (2) working days of discovery to DHH.

Any incident or alleged patient abuse or neglect will be reported immediately to the Administrator, DON and Case Management / Social Services. To observe an incident of abuse or neglect by another staff member and not to report the occurrence will be construed as passive abuse or neglect by the observing staff member.

ADVANCED DIRECTIVES

During the registration process, the admitting/registration department will inquire if the patient has a living will.
If patient has a living will, they will be asked for a copy. If they do not have a copy with them on admission, the patient will be referred to social services via "Patient Education Referral Form" to follow up on obtaining the Advanced Directive. The Social worker will ask the family to bring the Advanced Directive to the hospital and a copy will be placed on the chart and one copy will be sent to Admitting/Registration.
If the family does not bring the Advanced Directive, the social worker will offer the patient a new form to fill out.
If the patient does not have a living will and does not want one, they will sign declining the information.

PATIENT RIGHTS

- Patients have the right to treatment regardless of age, race, color, national origin, religious creed, gender or handicap, or ability to pay.
- Patients have the right to privacy
- Right to confidentiality
- Right to be spoken to in their own language. We have a list of interpreters for sign language, French, Spanish, and Vietnamese. If a patient does not have a family member with them that can interpret, we have to provide them with an interpreter.
- Right to informed consent.

When a patient is admitted they are given a copy of their rights. The above are just some of the rights listed in the patient booklet.

INTERPRETING AND TRANSLATION SERVICES

The hospital will maintain an agreement with a telephone/video interpreting service that has trained interpreters available at all times.

The telephone number and instructions for use is located at the nursing stations and with the Nursing Supervisor.

The nurse must document the name of the Interpreting service and interpreter ID# used in the patient record.

SPEECH/HEARING IMPAIRMENTS

Auxiliary aids for speech and/or hearing impaired patients are maintained by the hospital and are located in the Maintenance Department and BMC. Auxiliary aids available include:

- Interpreting and translation services through contract arrangement with local agency.
- Telecommunications Device for the Deaf (TDD).
- Tele caption-Closed Caption Decoder

FALL REDUCTION PROGRAM

A patient is assessed for risks of falls on admit by an RN and every shift thereafter by the patient's nurse. If at anytime the patient is found to be at risk for falls a **green** dot is placed on their ID bracelet letting everyone know that fall reduction measures must be in place. Once determined to be at risk for falls fall reduction measures are put into place (i.e., bed alarm on, call bed in reach, side rails up, night light on). The bed alarm is a unique feature of our fall reduction program because it is tied into the Nurse Call bell system. If the patient gets out of bed the nurse call alarm will sound at the nurse's station.

PUP (PRESSURE ULCER PREVENTION)

The Braden Scale is used for predicting pressure ulcer risk and is filled out on admission and every 12 hours by a nurse. The scale encompasses 6 categories: Sensory perception, moisture, activity, mobility, nutrition and friction/shear. Nursing staff should document in the plan every 12 hours. If a patient's Braden score changes throughout the hospital stay, nursing staff is responsible for updating/initiating appropriate phase of Pressure Ulcer Prevention care plan to coincide with current Braden score and falls precautions are initiated and maintained.

RAPID RESPONSE TEAM

Improve recognition and response to changes in its patient population

Rapid Response team has been developed to allow nurses to ask for additional help from specially trained personnel to improve patient outcomes

Members of Rapid Response Team

- Charge Nurse
- Respiratory
- Nursing Supervisor

Nurse sees change in patient condition→Notify Charge Nurse→Assess patient→Call MD→Call operator to page RRT to room and beep Resp. and Supervisor→Assess pt. together→response→SBAR

CODE OF ETHICAL BEHAVIOR

As a staff member or agency nurse you have access to the Code of Ethical Behavior policy in the hospital wide policy manual located on the M: Drive on every hospital computer.

Abbeville General Hospital will not tolerate unlawful or unethical behavior, will not condone reckless or criminal conduct, will demand conduct according to applicable laws and regulations, and will expect maintenance of the highest ethical standards and avoidance of even the appearance of unlawful conduct

It is believed that if we all do what is right for the patient at all times,
Then we will be in compliance with this Code of Ethics.

AGH CORPORATE COMPLIANCE PROGRAM

The hospital has adopted a Corporate Compliance Program to ensure that the hospital operates in full compliance with the applicable laws. An important component of the program is the Standards of Conduct, which sets out basic principles which all hospital directors, officers and employees must follow. The Standards apply to all business operations and personnel.

- Any concerns of any aspects of this plan, including applicable laws and regulations, have been violated should be directed to the designated *Compliance Officer- Wendy Broussard*
- *wendy.broussard@abbevillegeneral.com*
- *Compliance Hotline 337-898-6112*
- *Compliance Fax 337-898-6590*
- Individuals may report issues anonymously, in writing, personally, or through the Compliance Hotline
- Every effort will be made to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports possible misconduct.
- There will be no retribution or discipline for anyone who reports possible misconduct or violation in good faith.

COMPLIANCE IS …

The prevention, detection and correction of any unwanted act within the organization, such as:

Fraud and abuse
Violations of law, regulations, or policies and procedures

Policies and procedures apply to everyone.
DO THE RIGHT THING

Goals of compliance…

- Assure that patient bills are complete and accurate
- Supply adequate documentation to support services billed
- Detect wrongdoings and take corrective measures
- Promote ethical behavior

- Create a system of checks and balances to deter, detect and prevent fraud, abuse and mistakes.
- Communicate and demonstrate day-to-day to all of our employees, physicians, and patients that we are committed to conducting business in an honest and ethical manner.

Examples of compliance issues…

- Billing for services that were not medically necessary, not documented or not provided.
- Billing for services provided by an individual who is not properly licensed or has been excluded by the government from providing goods or services to Federal healthcare beneficiaries (Medicare and Medicaid).
- Paying or receiving payment for referrals.
- Altering claims for higher payment.
- Inappropriate access and/or release of patient health information.
- Unethical or inappropriate care of patients.
- Lack of correct or sufficient documentation in transferring or discharging patients.

AGH Standards of Conduct

One of the hospital's strongest assets is a reputation for integrity and honesty. A fundamental principle on which the hospital will operate its business is full compliance with applicable laws. The hospital will also conduct its business in conformance with sound ethical standards.

The Standards of Conduct educate staff on the relevance of compliance throughout the hospital and provide general guidelines for conducting business activities in full compliance with all hospital policies and procedures, Federal, state and local laws and regulations.

- All employees and affiliated professionals with Abbeville General Hospital will conduct all activities in a manner that will promote integrity and compliance while practicing sound ethical and professional judgment.
- All employees and affiliated professionals of Abbeville General Hospital will abide by regulations set forth by the state and Federal healthcare programs.
- All employees and affiliated professionals of Abbeville General Hospital will prepare complete and accurate medical records, financial information and bills.

The Standards of Conduct document in its entirety is attached to this end of this educational document and may be found at:
Public Drive (M:) > Hospital-Wide Policy Manuals > Compliance > Compliance Program > Standards of Conduct

EMPLOYEE OBLIGATIONS

- All employees will attend and/or complete the *mandatory* training requirements in a timely manner.
- All employees will participate in any reviews, investigations or audits whether conducted internally or by an external agency.
- All employees will disclose to the Compliance Officer any information received from the state or Federal healthcare programs.
- All employees will refuse any type of illegal offer, remuneration or payment to induce referrals or preferential treatment from a third party.
- All employees will adhere to the Standards of Conduct as a condition of employment at Abbeville General Hospital.
- All employees and affiliated professionals can be suspended, terminated or barred from further employment/affiliation with Abbeville General Hospital as a result of non-compliant behavior.

REPORTING

Abbeville General Hospital employees and affiliated professionals will report suspected non-compliant behavior that violates any statute, regulation, or guideline applicable to a state or Federal healthcare program or Abbeville General Hospital's policies.

- Incidents may be reported through the chain of command – Supervisor, Manager, etc. - *or* to the Compliance Officer.
- All reports are *confidential*. All employees have the right to remain anonymous.
- Abbeville General Hospital *will not retaliate* upon any employee who reports suspect behaviors in any form or fashion.

EMTALA & HIPAA

EMTALA – All persons must be aware that as a Medicare participating hospital, we have an obligation to provide a medical screening examination by a qualified medical person to any individual who comes to this facility seeking medical treatment (whether or not eligible for insurance benefits and regardless of ability to pay) to determine if the individual has an emergency medical condition.
HIPAA – Any individual employed by or working on behalf of Abbeville General Hospital has an obligation to respect and protect patient health information at all times. Violation of patient confidentiality policies may result in disciplinary action, up to and including discharge. In addition, ANYONE in the organization may be subject to individual civil and/or criminal penalties – fines up to $25,000 or jail time up to 10 years or both.

EMTALA (EMERGENCY MEDICAL TREATMENT AND LABOR ACT)

All patients that come to your E.D. / O.B / BMC with an emergency medical condition, contractions/active labor, emergency psychiatric condition must be evaluated (have a medical screening) by doctor and must be stable prior to transfer.

CONFLICT RESOLUTION

Patient Care Conflicts- In the event that conflict exists among those with equal authority to make medical decisions for the patient, the hospital staff shall remain neutral in recognition of the principle that informed consent is a process that involves the physician and the patient and/or family or legal surrogate.

- If there is continue conflict an Ethics Committee may be convened by the Chief Executive Officer to present all the facts concerning the case. The Ethics Committee may present alternatives and choices, so that the family/legal surrogate may reach decisions.

ETHICAL ISSUE RESOLUTION

Ethical issues and potential dilemmas relevant to the care of patients are resolved by utilizing the following chain of command:

- The patient, guardian, surrogate or hospital employee immediately discusses the issue with the Supervisor/Department Manager; if resolved, this will end the issue.
- If the Supervisor/Department Manager cannot resolve the issue, it will be discussed with appropriate Administrative Personnel (Administrator, Chief of Staff, Human Resource Director). The appropriate administrative designee will inform the patient and/or family on how to gain access to the Ethics Committee.

- If the issue continues not to be resolved by the appropriate Administrative level, it will be discussed at the hospital's Ethics/Medical Executive committee for resolution. The patient or his designee has the right to be a member of the Ethics Committee. Committee Membership can include, but is not limited to:

    - Member of the Medical Executive Committee

    - Others as indicated:
        - Physician/Nurse involved in care
        - Patient or Representative
        - Family member
        - Social Services Director
        - Minister
        - Volunteer Organization Representative

- In the event the Ethics Committee is unable to reach a resolution legal resources will be consulted.

COMPLAINT / GRIEVANCE POLICY

Every effort will be made to handle the complaint and/or grievance at the point of origin.

Patient Complaint

Definition:

CMS defines complaint as "any expression of dissatisfaction by a patient or patient's representative regarding care or services (inpatient or outpatient) that can be addressed at the time of the complaint by the staff present". Staff present includes any hospital staff present at the time of the complaint or who can quickly be at the patients' location to resolve the complaint.

EXAMPLE:

- An unclean room- clean the room.
- Food tray with wrong diet- reorder tray

Patient Grievance

Definition:

Any formal or informal written or verbal expression of dissatisfaction with care or service that is expressed by the patient or the patient's representative that is not solved at the time by the staff present.

A ***written complaint*** is always a grievance; as are complaints alleging abuse, neglect, patient harm, charges/billing or non compliance with CMS Regulations.

- If a patient requests that a complaint be handled as a formal complaint or requests a written response, it must be considered a grievance.

Complaint/Grievance Report

Complaint/Grievance report should be filled out completely by the employee receiving the complaint/grievance, and should include:

1) The person who initiated the report
2) Who the problem was referred to
3) Identification of the patient and complainants concerns.
4) Objective statement of the complainants concerns.
5) Description of the investigation and the findings
6) Description of the action taken to resolve the problem.

Report is forwarded to the Complaint Officer for review, and then forwarded to the appropriate manager/committee for further investigation.

- The findings and actions are documented on the report and returned to the Complaint officer
- Complaint officer forwards the findings/ actions taken to CEO

Grievance/Medical Executive Committee

- Members of the Medical Executive Committee

Others as Indicated:

- Physician/Nurse involved in care
- Patient or Representative
- Family Member
- Social Services Director
- Minister
- Volunteer Organization Representative

In the event the Grievance Committee is unable to reach a resolution, legal resources will be consulted.

Service Recovery

Service recovery is the process used to "recover" dissatisfied or lost customers or patients by identifying and fixing the problem or making amends for the failure in customer or clinical service.

Excellent service recovery programs are an effective tool for retaining customers or patients and improving their level of satisfaction. Good service recovery programs can turn frustrated, disgruntled, or even furious patients or customers into loyal ones. A good recovery can turn angry and frustrated customers into loyal customers. In fact it can create even more goodwill than if things had gone smoothly in the first place.

SBAR COMMUNICATION

SBAR is a communication tool that can be utilized by Nursing Staff to communicate/ convey critical information including but not limited to the following situations

- Nursing shift/other reports
- Transfer to another unit or area
- Notification of physician about a patient's condition
- Physician to physician communication
- Critical test results

S	situation	A concise statement of the problem (What is going on now)	
B	Background	Pertinent and brief information related to the situation	(What has happened?)
A	Assessment	Analysis and considerations of options (What you found / think is going on)	
R	Recommendation	Request/recommend action (What you want done)	

ORGAN DONATIONS

- Every death will be reported to the Louisiana Organ Procurement Agency (LOPA). The physician, charge nurse, nurse caring for the patient or hospital representative will call LOPA to facilitate donor evaluation.
- All deaths require completion of Louisiana "Notification of Death "form or the Hospital's equivalent death paperwork. The nurse caring for the patient is responsible for completing this form.
- Hospital personnel will refer ALL patients meeting the Clinical Trigger (ventilator dependent patients, with either: clinical findings of a Glasgow Coma Scale (GCS) </= 5 (or equivalent clinical findings) absent CNS depressants or an induced coma, or if the patient is in the ED or a Critical Care Unit, and there is a plan to discontinue mechanical/pharmacological support) to LOPA for evaluation of potential organ donors prior to approaching families with the option of organ donation or disconnecting the patient from the ventilator. LOPA will request permission of attending physician to review the patient's medical record.

INFORMED CONSENT

It is the physicians responsibility to educated the patient/family and obtain an informed consent and document in the chart.

PATIENT RESTRAINT AND SECLUSION POLICY

Patients have a right to receive safe care in a safe environment. However, the use of restraint is inherently risky. When the use of restraint is necessary, the least restrictive method must be used to ensure a patient's safety. The use of restraint for the management of patient behavior is not considered a routine part of care.

The use of restraints for the prevention of falls will *not* be considered a routine part of a **falls prevention program**.

Time Limits for Orders

Behavioral or Seclusion

1. 4 hours for individuals ages 18 and older
2. 2 hours for children and adolescents ages 9 to 17
3. 1 hour for children under age 9

Orders for the use of restraints or seclusion are not written as a standing order or on an as needed basis (prn**). All orders are time-limited**. The condition of the restrained patient will be monitored and documentation must occur at least every hour on the restraint documentation form. Update Plan of Care (POC) every shift, at the minimum every 24 hours.

Time frame for Conducting Assessments (Nursing)

Behavioral or Seclusion

- Every 15 minutes

Medical-Surgical

- Every 2 hours

Required Documentation – Review of Systems

- Signs of any injury associated with the application of restraint or seclusion
- Nutrition/hydration status
- Circulation and range of motion to the extremities
- Breathing
- Hygiene and elimination
- Physical and psychological status and comfort
- Readiness for discontinuation of restraint or seclusion
- Removal of restraint/repositioning
- Attempts to reduce restraints
- Skin integrity

It is the philosophy of Abbeville General Hospital to create an environment, which supports continuous improvements, and prevent, reduce and strive to eliminate use of restraint and seclusion.

PAIN MANAGEMENT / ASSESSMENT

A Registered Nurse is responsible for the initial pain assessment on *admission.* Abbeville General has defined criteria to screen, assess and reassess pain. The nurse must choose pain assessment scales that are consistent with the patient's age, condition and ability to understand. AG reassesses and responds to the patient's pain through evaluation and documentation of responses to pain intervention. Pain is reassessed during each shift and prn.

**If a patient has pain, the nurse will include pain in the Plan of Care. The POC must include goals, interventions and timeframes, which are expected to meet the patient or families' goals. Revisions or updates to POC are documented on every shift

OPIOID SIDE EFFECTS

Respiratory Depression is one of the most serious side effects of opioid utilization. The Rapid Response or Code Team is available to assist with patient care during emergent situations.

See Narcan Administration Policy in the Medication Management Hospital-Wide Manual, which will provide guidelines for the administration of Naloxone (Narcan®) for the treatment of opioid-induced respiratory depression/overdose.

Other side effects could include, but are not limited to the following:

Dizziness, Nausea, Vomiting, Constipation, Sedation, Delirium, Hallucinations, Falls, Hypotension, Aspiration Pneumonia or any other side effects on package inserts.

The nurse is responsible for monitoring the patient for side effects of all pain medications, intervening for any side effects noted, and notifying the physician to obtain orders if indicated.

PASERO OPIOID INDUCED SEDATION ASSESSMENT/SCALE (POSS)

If a patient is in pain and receiving opioids for pain relief, the nurse should perform the Pasero Opioid Induced Sedation Scale (POSS) post opioid administration, and as needed as indicated for patient care needs or changes in patient status.
This will help guide the nurse to assess patients that are high risk for adverse outcomes related to opioid treatment and intervene as early as possible to avoid unwanted effects of opioid use.

If a patient has pain, a comprehensive pain assessment is completed using the following factors:

- Physical exam/ character
- Description – Quality / character
- Intensity- Using **pain scale of 0-10** for adolescents/adults/geriatric patients along with the **Wong-Baker Facial Scale** for pediatrics
- Onset, duration, variations, and patterns
- Aggravating factors
- Alleviating factors
- Associated symptoms
- Present pain management regimen and effect
- Spiritual, personal, cultural and/or ethnic considerations
- Pain management History
- Effects of pain on daily life, sleep, etc.
- Patient's pain goal

Assessment factors in the non-verbal or cognitively impaired patient include:

- Facial grimacing
- Writhing
- Withdrawal of limb
- Moaning
- Tearing

Assessment factors in the pre-verbal/infant aged child include:

- Facial expressions- brow bulges, eye squeeze, chin quiver, restlessness/inability to sleep, inability to console, grimace.
- Cry – moaning, crying, scream
- Torso- neutral, shifting, tense, shivering, legs squirming/kicking, drawn up/tensed
- Touch- child is reaching, but not touching wound, child is gently touching wound area, and child is grabbing vigorously at wound area.

VERBAL ORDERS

- **Nursing Staff must *not accept telephone orders from office nurses given orders by the M.D.***
- Orders dictated over the telephone shall not be accepted until the physician giving the orders has been correctly identified by a responsible nurse or properly authorized person acting within his/her scope of practice
- Verbal communication of prescription or medication orders should be limited to urgent situation where immediate written or electronic communication is not feasible. For example, an emergency situation (code) or the physician is scrubbed in for surgery.

Color Coded Dots on Patient Arm Bands

- **Red Dot-** Not Resuscitate (DNR)
- **Dark Blue-** High Risk for Sleep Apnea
- **Green Dot-** Risk for Falls

CARE AT THE END OF LIFE

Patients, who are suffering from an incurable and irreversible condition where death is pending, will be treated with dignity. It is the policy of AGH to comfort such patients through the provision pf pain management based upon a pain assessment process and the identification and treatment of symptoms that will respond to treatment, as desired by the patient and/or family. Further, it is the policy of AGH to assist the patient and family in coping with the grieving process.

Comfort and dignity are optimized during End of Life Care. The patient at or near the end of his or her life has the right to physical and psychological comfort. The hospital provides care that optimizes the dying patients comfort and dignity and addresses the patient's and his or her family's psychosocial and spiritual needs.

MALIGNANT HYPERTHERMIA

- Genetic cause
- Hypermetabolic crisis triggered by an anesthetic agent – succinylcholine
- Symptoms: elevated temperature, increasing ETCO2, trunk or total body rigidity, clinching teeth together, tachycardia/tachypnea
- Treated with Dantrolene (kept in Malignant Hyperthermia cart in OR), Chilled Fluids, Ice
- Monitor: Urine output, Urine color, Temperature, Vital Signs, EKG, Electrolytes, pH

JC/CMS CORE MEASURES

NATIONAL HOSPITAL QUALITY MEAURES / RATIONALE

ED Measures	High Volume, High Risk, Problem Prone
Perinatal Care	High Risk, Problem Prone
Stroke (also includes eCQMs)	High Risk, Problem Prone
VTE (also includes eCQMs)	High Risk, Problem Prone

OUTPATIENT MEASURES:

- ED AMI / Chest Pain / SCIP / OP ED,
- OP Pain Management for Long Bone Fracture,
- OP Stroke (ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who receive Head CT Scan Interpretation within 45 minutes of arrival)
- **CMS Global Measures – Immunization of Influenza**

Psychiatry Measures

HCAPS (Hospital Consumer Assessment of Healthcare Providers and Systems)
---30 Day Mortality, 30 Day Re-admissions
---Satisfaction Surveys

Hospital Acquired Infections

Medicare Spending per Beneficiary (MSPB)

ADVERSE DRUG REACTION

Definition- the development of undesired side effects or toxicity caused by the administration of drugs.
Protocol for reporting Adverse Drug Reactions

- Notify the patient's physician
- Notify the pharmacist
- Record the ADR in the Progress Notes of the patient's chart.

Completely fill out the hospital-wide form, Confidential Hospital Occurrence Report, according to the policies and procedures of the risk management plan.

COUMADIN PROTOCOL

All patients taking Coumadin as a home medication will have an INR ordered and reviewed by Nursing Staff upon arrival prior to administering Coumadin in the hospital. The Nursing Staff will place the Coumadin Protocol orders on the chart and obtain an order from the M.D.
The M.D. will choose and check the box indicating which INR Goal the Nursing Staff is to follow for Coumadin administration. Additional space is provided to write other specific orders for Coumadin and INR levels not addressed in the protocol.

SCREENING FOR OBSTRUCTIVE SLEEP APNEA

Patients are screened on admission for obstructive sleep apnea. For patients who are high risk an alert will be placed on the chart, a blue bracelet/sticker will be placed on the patient and the screening questionnaire will be faxed to the attending physician.

ANTIBIOTIC STEWARSHIP

AGH Policy:
To promote the appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. Collaboration between members of the healthcare team to achieve an antibiotic stewardship culture.

LOOK ALIKE - SOUND ALIKE DRUGS

DOPamine	DOBUTAmine
Quelicin (succinylcholine)	Integrilin (eptifibatide)
Xylocaine (lidocaine)	Xylocaine with EPINEPHrine
Sensorcaine (bupivacaine)	Sensorcaine with EPINEPHrine
HydrOXYzine	HydrALAzine
Albuterol	Atenolol
Fosinopril	Lisinopril
Furosemide	Torsemide
Flomax	Fosamax
Erythromycin	Azithromycin
CloNIDine	KlonoPIN
DiaBeta (GlyBURIDE)	Zebeta
Digoxin	DoxePIN
CeleBREX	CeleXA
Cozaar	Zocor
Levothyroxine	Lanoxin
EPINEPHrine	EPHEDrine
LevETIRAcetam	LevoFLOXacin
CefOXitin	CeFAZolin

Exhibit A Reviewed 3.10.2021

Official "Do Not Use" List[1]

Unacceptable Abbreviations (MM 3.20)

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for "O" (zero), the number "4" four or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "international Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d., qod (every other day	Period after the Q mistaken for "I" and the "O" mistaken for "I"	Use "every other day"
Trailing zero (X.0mg)	Decimal point is missed	Write X mg
Lack of leading zero (.Xmg)	Decimal point is missed	Write 0.Xmg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

[1] Applied to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

* Exception: A "Trailing zero" may be used only when required to demonstrate the level of precision of the value being
reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Do Not Use	Potential Problem	Use Instead
> (greater than) < (less than)	Misinterpreted as the number “7” (seven or the letter ”L”	Write “greater than” Write “less than.”
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to may practitioners; confused with metric units	Use metric units
@	Mistaken for the number “2” (two)	Write “at”
cc	Mistaken for U (units) when poorly written	Write “ml” or “milliliters”
mg	Mistaken for Mg (milligrams) resulting in one thousand-fold overdose	Write “mcg” or “micrograms”

Pharmaceutical Disposal Reference Guide

P-Listed Waste	RCRA-Hazardous Waste	Trace Chemo Waste	Non-Hazardous Waste	CSRX Waste	Non-Compatible Waste
(SPDP Coded)	***(BKC Coded)***		***No Waste Code***	***(CSRX Coded)***	***(SP, SPC, SPO, SPI Coded)***
Send Back to Pharmacy	**Large Black Floor Stand Container**	**Yellow Container**	**Large Blue Floor Container**	**Cactus Sink Med-Room/Nurse Station**	**Send Back to Pharmacy**
(Examples Include but not limited to) **Antilirium™ (Physostigmine)** **Coumadin™ (Warfarin)** **Nicotine (*all dose forms*)** **Nipride™ (Nitroprusside)**	(Examples Include but not limited to) **Argatroban** **Cleocin™ (Clindamycin)** **Crofab™ (Antivenin Crotalidae FAB)** **Insulin** **Kwell™ (Lindane)** **Silvadene™ (Silver Sulfadiazine)** **Toradol™ (Ketorolac)** Bulk Chemo (>3%) of original chemical or any PPE saturated with Chemo will be disposed of in a **Black** container	Trace Chemo (<3%) of original [empty syringes, IV bags and Personal Protective Equipment (PPE) for administering or admixing Chemo] disposed of in a **Yellow** container.	**NO Waste Code**	**All controlled substances/narcotics** **Always use a witness for disposal**	(Examples Include but not limited to) **Ammonia Inhalant** **Cetacaine** **Benzocaine Hurricaine ™** **Dermoplast™** **Epifoam™** **Lugol's (Iodine Solution)** **Nitromist™** **Proctofoam HC™** **Silver Nitrate** **Inhalers (Propellant Delivered)**
					

Questions? Please Call *(888) 959-2783 Ext. 816* OR *E-Mail Msteffan@medwastemgmt.net*
This reference guide lists common pharmaceuticals and is NOT a complete list. Please refer to the drug reference codes

Standards of Conduct

The Standards of Conduct for Abbeville General Hospital have been developed to assist us in carrying out our daily activities within high ethical and legal standards. These obligations apply to our relationships with patients, physicians, third-party payers, subcontractors, independent contractors, vendors, consultants, volunteers and one another.

The Standards of Conduct are an important part of our Compliance Program. The Standards have been developed to ensure that we meet our ethical standards and comply with applicable laws and regulations. They are intended to be comprehensive and easily understood.
Subjects are covered completely in some cases, but additional guidelines for individuals directly involved in a specific area may be necessary due to the complexity of the subject.

Leaders must ensure that those on their team have sufficient information to comply with law, regulation, and policy, as well as the resources to resolve ethical dilemmas. They must help to create a culture which promotes the highest standards of ethics and compliance. This culture must encourage everyone in the organization to address concerns when they arise. We must never sacrifice ethical and compliant behavior in the pursuit of business objectives.

OUR COMMITMENTS TO ETHICS AND COMPLIANCE

To our patients:
We strive to provide excellence in quality and compassion in the delivery of healthcare that reflects our concern for people through sensitive, compassionate, responsive and efficient care.

To our employees:
We are committed to a work setting which treats all employees with fairness, dignity and respect, and affords them an opportunity to grow, to develop professionally, and to work in a team environment in which their ideas are considered.

To third-party payers:
We are committed to dealing with our third-party payers in a way that demonstrates our integrity and commitment to contractual obligations and reflects our shared concern for quality healthcare and bringing efficiency and cost effectiveness to healthcare.

To regulators:
We are committed to an environment in which compliance with rules, regulations and sound business practices is woven into our corporate culture. We accept the responsibility to aggressively self-govern and monitor adherence to the requirements of law, our policies and Standards of Conduct.

To our community:
We are committed to understand the particular needs of the communities we serve and provide to these communities high quality, cost-effective healthcare service. We realize as an organization that we have a responsibility to help those in need.

To suppliers:
We are committed to fair competition among prospective suppliers and the sense of responsibility required of a good customer.

To our volunteers:
We are committed to ensure that our volunteers feel a sense of meaningfulness from their volunteer work and receive recognition for their volunteer efforts.

To our physicians:
We are committed to providing a work environment that has a team of valued, caring and highly skilled healthcare professionals.

PATIENT CARE AND RIGHTS

We want to be the first choice for those in need of healthcare by providing the highest quality of service to all of our patients. We treat all patients with respect

and dignity and provide care that is both necessary and appropriate. We make no distinction in the admission, transfer or discharge of patients or in the care we provide based on race, color, religion, or national origin. Clinical care is based on identified patient healthcare need, not on patient or organizational economics or financial incentives.

Upon admission, each patient is provided with a written statement of patient rights. This statement includes the rights of the patient to make decisions regarding medical care and conforms to all applicable state and Federal laws. Patients will be given choices of providers for services and supplies such as durable medical equipment, long term care and home health services.

We assure patients' involvement in all aspects of their care and obtain informed consent for treatment. As applicable, each patient or patient representative is provided with a clear explanation of care, including but not limited to, diagnosis, treatment plan, right to refuse or accept care, care decision dilemmas, advance directive options, organ donation and procurement, and an explanation of the risks and benefits associated with available treatment
options.

Patients have the right to request transfers to other facilities, and in such cases, the patient will be given an explanation of the benefits, risks and alternatives.

Patients are informed of their right to make advance directives. Patient advance directives will be honored within the limits of the law and the organization's capabilities.

Patients and their representatives will be accorded appropriate confidentiality, privacy, security and protective services, and opportunity for resolution of complaints. Any restrictions on a patient's visitors, mail, telephone or other communications must be evaluated for their therapeutic effectiveness and fully explained to and agreed upon by the patient or patient representative.

Patients are treated in a manner that preserves their dignity, autonomy, self-esteem, civil rights, and involvement in their own care. Compassion and care are part of our commitment to the community we serve. We strive to provide health education, health and wellness promotion, and illness-prevention programs as part of our efforts to improve the quality of life of our patients and our community.

EMERGENCY TREATMENT

We follow the Emergency Medical Treatment and Active Labor Act (EMTALA) in providing emergency medical treatment to all patients, regardless of ability to pay. Anyone with an emergency medical condition is evaluated and treated based on medical necessity. In an emergency situation, financial and demographic information will be obtained only after the immediate needs of the patient are met. We do not admit or discharge patients simply on their ability to pay.

Patients will be transferred to another facility only if the patient's medical needs cannot be met and appropriate care is knowingly available at another facility or at the patient's request. Patients may only be transferred after they have been stabilized and are formally accepted by the alternate facility.

PATIENT INFORMATION

We collect information about our patient's medical condition, history, medications, and family illnesses to provide the best possible care. We realize the sensitive nature of this information and are committed to maintaining its confidentiality. We do not release or discuss patient- specific information with others unless it is necessary to serve the patient or required by law.
Employees must never disclose confidential information that violates the privacy rights of our patients.

No employee, affiliated physician or other healthcare partner has a right to any patient information other than that necessary to perform his or her job.

Patients can expect that their privacy will be protected and that patient specific information will be released only to persons authorized by law or by the patient's written consent. In an emergency situation, when requested by an institution or physician then treating the patient, the patient's consent is not required, but the name of the institution and the person requesting the information will be verified.

PHYSICIANS

Any business arrangement with a physician must be structured to ensure precise compliance with legal requirements. Such arrangements must be in writing and approved by legal counsel and the Board of Commissioners. We do not pay for referrals. We accept patient referrals and admissions based solely on the patient clinical needs and our ability to render the needed services. Violation of this policy will have grave consequences for the organization and

the individuals involved, including civil and criminal penalties, and possible exclusion from participation in federally funded healthcare programs.

We do not accept payments for referrals that we make. No employee or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of patients. Similarly, when making patient referrals to another healthcare provider, we do not take into account the volume or value of referrals that the provider has made, or may make, to us.

CODING AND BILLING FOR SERVICES

We take great care to assure that all billings to the patient and to the government and private insurers reflect truth and accuracy and conform to all pertinent Federal and State laws and regulations. We prohibit any employee or agent of the hospital from knowingly presenting or causing to be presented claims for payment or approval which are false, fictitious or fraudulent.

We will operate oversight systems designed to verify that claims are submitted only for services actually provided and that services are billed as provided. These systems will emphasize the critical nature of complete and accurate documentation of services provided. As part of our documentation effort, we will maintain current and accurate medical records.

Any subcontractors engaged to perform billing or coding services must have the necessary skills, quality assurance processes, systems and appropriate procedures to ensure that all billings for government and commercial insurance programs are accurate and complete.

The False Claims Act (FCA) imposes civil liability on organizations and individuals that make false claims to the government for payment. Anyone who violates the FCA is liable for a civil penalty of not less than $11,665.00 and of no more than $23,607.00 per claim, plus three times the amount of the damages the government sustains. In addition, the government can exclude violators from participating in Medicare, Medicaid and other government programs. There is also a Federal criminal enforcement plan for intentional participation in the submission of false claims. A person violating this subsection will also be liable to the United States government for the cost of a civil action brought to recover any penalties or damages.

COST REPORTS

Our business involves reimbursement under government programs that require the submission of certain reports of our costs of operation. We will comply with Federal and State laws relating to all cost reports. These laws and regulations define what costs are allowable and outline the appropriate methodologies to claim reimbursement for the cost of services provided to program beneficiaries. Given their complexity, all issues related to the completion and settlement of cost reports must be communicated through or coordinated by the Chief Financial Officer.

REGULATORY COMPLIANCE

Our services will be provided only according to appropriate Federal, State and local laws and regulations. Such laws and regulations may include subjects such as certificates of need, licenses, permits, accreditation, access to treatment, consent to treatment, medical record keeping, access to medical records and confidentiality, patient rights, terminal care decision making, medical staff membership and clinical privileges, corporate practice of medicine restrictions, and Medicare and Medicaid regulations. The organization is subject to numerous other laws in addition to these healthcare regulations.

We will comply with all applicable laws and regulations. All employees, medical staff members, privileged practitioners and contract service providers must be knowledgeable about and ensure compliance with all laws and regulations, and should immediately report violations or suspected violations to a supervisor, member of management or the Compliance Officer.

We will be forthright in dealing with any billing inquiries. Requests for information will be answered with complete, factual and accurate information. We will cooperate with and be courteous to all government inspectors and provide them with the information to which they are
entitled during an inspection.

During a government inspection, we will never conceal, destroy or alter any documents, lie or make misleading statements to the government representative. We will not attempt to cause another colleague to fail to provide accurate information or obstruct, mislead or delay the communication of information or records relating to a possible violation of law.

In order to ensure that we fully meet all regulatory obligations, employees must be informed about stated areas of potential compliance concern. The

Department of Health and Hospitals (DHH) and particularly the Office of Inspector General (OIG) have routinely notified healthcare providers of areas in which these government representatives believe that insufficient attention is being accorded government regulations. We should be diligent in the face of such guidance about reviewing these elements of our system to ensure their correctness.

We will provide employees with the information and education they need to fully comply with all applicable laws and regulations.

LEGAL COMPLIANCE

Employees are expected to refrain from any conduct that violates the fraud and abuse laws. These laws prohibit:

- ⇒ Direct, indirect or disguised payments in exchange for patient referrals
- ⇒ Submitting false, fraudulent or misleading claims to third party payers or any government entity. This includes claims for services not rendered, describing the service differently than it was provided or any claim that does not comply with the program or contractual requirements.
- ⇒ Gaining or retaining participation in a program or receiving payment for service through false representation

ACCREDITING BODIES

We will deal with all accrediting bodies in a direct, open and honest manner. No action will ever be taken in relationships with accrediting bodies that would mislead the accreditor or its survey teams, either directly or indirectly.

The scope of matters related to accreditation of various bodies is extremely significant and broader than the scope of these Standards of Conduct. The purpose of our Standards of Conduct is to provide general guidance on subjects of wide interest within the organization. Accrediting bodies may be focused on issues of more focused interest.

ACCURACY, RETENTION AND DISPOSAL OF DOCUMENTS AND RECORDS

Every employee is responsible for the integrity and accuracy of our organization's documents and records, not only to comply with regulatory and legal requirements, but also to ensure that records are available to defend our business practices and actions. No one may alter or falsify information on any record or document.

Medical and business documents and records are retained in accordance with the law and our record retention policy. Medical and business documents include paper documents such as letters and memos, computer-based information such as e-mail or computer files on disk or tape, and any other medium that contains information about the organization or its business activities. It is important to retain and destroy records appropriately according to our policy.

Records will not be tampered with or removed or destroyed prior to the designated time as specified in the record retention policy.

PROPRIETARY INFORMATION

Confidential information about our organization's strategies and operations is a valuable asset. Although you may use confidential information to perform your job, it must not be shared with others outside the hospital or your department unless the individuals have a legitimate need to know this information and have agreed to maintain the confidentiality of the information. Confidential information includes personnel data maintained by the organization, patient lists and clinical information, pricing and cost data, information pertaining to acquisitions, affiliations and mergers, financial data, strategic plans, marketing strategies, employee lists and data maintained by the organization, supplier and subcontractor information, and proprietary computer software.

ELECTRONIC MEDIA

All communications systems, electronic mail, Intranet, Internet access or voice mail are the property of the organization and are to be primarily used for business purposes. Highly limited reasonable personal use of the communications systems is permitted; however, you should assume that these communications are not private. The hospital reserves the right to periodically access, monitor and disclose the contents of e-mail and voice mail messages.

Employees may not use internal communication channels or access to the Internet at work to post, store, transmit, download or distribute any threatening, maliciously false or obscene materials, including any constituting or encouraging a criminal offense, giving rise to civil liability, or otherwise violating any laws.

Additionally, these channels of communication may not be used to send chain letters, personal broadcast messages or copyrighted documents that are not authorized for reproduction. Nor are they to be used to conduct a job search or open misaddressed mail. Colleagues who abuse our communications systems or use them excessively for non-business purposes will be subject to disciplinary action.

FINANCIAL REPORTING AND RECORDS

Our financial records serve as a basis for managing our business and are important in meeting our obligations to patients, employees, suppliers and others. They are necessary for compliance with tax and financial reporting requirements. We will avoid unreasonable compensation arrangements not consistent with our not-for-profit tax exemption.

All financial information must reflect actual transactions and conform to general accepted accounting principles. The hospital maintains a system of internal controls to provide reasonable assurances that all transactions are executed in accordance with management's authorization and are recorded in a proper manner so as to maintain accountability of the organization's assets.

CONFLICT OF INTEREST

A conflict of interest may occur if your outside activities or personal interests influence or appear to influence your ability to make objective decisions in the course of your job responsibilities. A conflict of interest may also exist if the demands of any outside activities hinder or distract you from the performance of your job or cause you to use resources for other than hospital purposes. It is your obligation to ensure that you remain free of conflicts of interest in the performance of your responsibilities. If you have any question about whether an outside activity might constitute a conflict of interest, you must obtain the approval of your supervisor before pursuing the activity.

DIVERSITY AND EQUAL EMPLOYMENT OPPORTUNITY

We are committed to providing an equal opportunity work environment where everyone is treated with fairness, dignity and respect. We will comply with all laws, regulations and policies related to nondiscrimination in all of our personnel actions. Such actions include hiring, staff reductions, transfers, terminations, evaluations, recruiting, compensation, corrective action and promotions.

No one shall discriminate against any individual with a disability with respect to any offer, term or condition of employment. We will make reasonable accommodations to the known physical and mental limitations of otherwise qualified individuals with disabilities.

HARASSMENT AND WORKPLACE VIOLENCE

We will not tolerate harassment by anyone based on the diverse characteristics or cultural backgrounds of those who work with us. Degrading or humiliating jokes, photographs, slurs, intimidation, or other harassing conduct is not acceptable in our workplace.

Any form of sexual harassment is strictly prohibited. This prohibition includes unwelcome sexual advances or requests for sexual favors in conjunction with employment decisions. Moreover, verbal or physical conduct of a sexual nature that interferes with an individual's work performance or creates an intimidating, hostile, or offensive work environment will not be tolerated.

Harassment also includes incidents of workplace violence. Workplace violence includes robbery and other commercial crimes, stalking cases, violence directed at the employer, terrorism, and hate crimes committed by current or former colleagues. As part of our commitment to a safe workplace, we prohibit employees from possessing firearms, other weapons, explosive devices or other dangerous materials on hospital property. Employees who observe or experience any form of harassment or violence should report the incident to their supervisor, the Human Resources Department, a member of management or the Compliance Officer.

HEALTH AND SAFETY

Policies have been developed to protect you from potential workplace hazards. You should become familiar with and understand how these policies apply to your specific job responsibilities and seek advice from your supervisor or the Safety Officer whenever you have a question or concern. It is important for you to advise your supervisor or the Safety Officer of any serious workplace injury or any situation presenting a danger of injury so that timely corrective action may be taken to resolve the issue.

LICENSE AND CERTIFICATION RENEWALS

Employees and individuals retained as independent contractors in positions which require professional licenses, certifications or other credentials are responsible for maintaining the current status of their credentials and shall

comply at all times with Federal and State requirements applicable to their respective disciplines. To assure compliance, evidence of the individual having a current license or credential status must be verified. We will not permit any employee or independent contractor to work without valid, current licenses or credentials.

BACKGROUND INVESTIGATIONS

Offers of employment are contingent on information obtained through a background investigation based on job description requirements. No person who is currently suspended, excluded, debarred or otherwise ineligible to participate in the Federal healthcare programs or has been convicted of a criminal offense related to the provision of healthcare will be considered for employment.

PERSONAL USE OF RESOURCES

It is the responsibility of each employee to preserve our organization's assets, including time, materials, supplies, equipment and information. Organization assets are to be maintained for business related purposes. As a general rule, the personal use of any hospital asset without the prior approval of your supervisor is prohibited. The occasional use of items, such as copying facilities or telephones, where the cost is insignificant, may be permissible with supervisory approval. Any community or charitable use of organization resources must be approved in advance by your supervisor. Any use of organization resources for personal financial gain or political purposes is prohibited.

RELATIONSHIPS WITH SUBCONTRACTORS, SUPPLIERS AND EDUCATIONAL INSTITUTIONS

We must manage our subcontractor and supplier relationships in a fair and reasonable manner, consistent with all applicable laws and good business practices. We promote competitive procurement to the maximum extent practicable. Our selection of subcontractors, suppliers and vendors will be made on the basis of objective criteria including quality, technical excellence, price, delivery and adherence to schedules, service and maintenance of adequate sources of supply. Our purchasing decisions will be made on the supplier's ability to meet our needs, and not on personal relationships and friendships. We will always employ the highest ethical standards in business practices in source selection, negotiation, determination of contract awards, and the administration of all purchasing activities. We will not communicate to a third party, confidential information given to us by our suppliers unless directed

in writing to do so by the supplier. We will not disclose contract pricing and information to any outside parties.

Relationships with an educational institution must have a written agreement that defines both parties' roles and the hospital's retention of the responsibility for the quality of patient care.

SUBSTANCE ABUSE AND MENTAL ACUITY

To protect the interests of our employees and patients, we are committed to an alcohol and drug-free work environment. All colleagues must report for work free of the influence of alcohol and illegal drugs. Reporting to work under the influence of any illegal drug or alcohol, having an illegal drug in your system, or using, possessing or selling illegal drugs while on work time or property may result in immediate termination. We may use drug testing as a means of enforcing this policy.

ANTITRUST

Antitrust laws are designed to create a level playing field in the marketplace and to promote fair competition. These laws could be violated by discussing hospital business with a competitor, such as how our prices are set, disclosing the terms of supplier relationships, allocating markets among competitors, or agreeing with a competitor to refuse to deal with a supplier.

In general, avoid discussing sensitive topics with competitors or suppliers. You must also not provide any information in response to oral or written inquiry concerning an antitrust matter without first consulting corporate legal counsel.

MARKETING AND ADVERTISING

We may use marketing and advertising activities to educate the public, provide information to the community, increase awareness of our services, and to recruit employees. We will present only truthful, fully informative, and non-deceptive information in these materials and announcements.

ENVIRONMENTAL COMPLIANCE

It is our policy to comply with all environmental laws and regulations as they relate to our organization's operations. We will comply with all environmental laws and operate each of our facilities with the necessary permits, approvals and controls.

RECEIVING BUSINESS COURTESIES, GIFTS AND INVITATIONS

Nothing in this part of the Standards should be considered in any way an encouragement to make, solicit, or receive any type of invitation or gift. Gifts or other incentives will never be used to improperly influence relationships or business outcomes.

All employees of Hospital Service Districts, as public servants, are bound by the Louisiana Code of Ethics. The provisions restricting the receipt of gifts by public servants are found in

§1115 of Louisiana's Code of Governmental Ethics. In addition §1111A, applies to restrict the receipt of gifts in certain situations, and §1115.1 contains specific limitations concerning receipt of food and drink.

No public servant will solicit or accept, directly or indirectly, anything of economic value as a gift or gratuity from any person who has or is seeking a contractual, business or financial relationship with the public servant's agency. "A thing of economic value" is money or any other thing having economic value with exceptions: Promotional items having no substantial resale value, such as calendars, pens, hats and t-shirts which bear a company's name or logo, and food and drink consumed while the personal guest of the giver (In order for this second exception to apply, the giver or a representative of the giver must be present **when the food and drink are consumed.);** complimentary admission to a civic, nonprofit, educational or political event (This exception applies only when the public servant is giving a speech at the event, is on a panel for discussion during the event, or is a program honoree. Tickets to collegiate, professional and semi-professional sporting events are <u>not</u> included within the exception.); flowers or a donation in connection with the death of an immediate family member of the public servant, if the **value does not exceed $100.**

No public servant will solicit or accept, directly or indirectly, anything of economic value as a gift or gratuity from a person who is seeking, for compensation, to influence the passage or defeat of legislation by the public servant's agency. Legislation defined includes any laws, rules, ordinances, etc. which are considered by the public servant's agency.

No public servant will solicit or accept, directly or indirectly, anything of economic value as a gift or gratuity from a person who conducts operations or activities which are regulated by the public employee's agency. This restriction applies <u>only</u> to public employees and pertains to regulatory relationships such as permits or licenses.

No public servant will solicit or accept, directly or indirectly, anything of economic value as a gift or gratuity from a person who has substantial economic interests which may be substantially affected by the performance or nonperformance of the public employee's official job duty(ies).

In other words, although the public employee does not regulate the gift giver, nor does the giver have any type of contractual, business or financial relationship with the public employee's agency, the public employee is still in a position to affect the economic interest of the giver, and the gift is prohibited.

No person from whom a public servant or a public employee is prohibited from receiving anything of economic value will provide the public servant with more than sixty-five dollars ($65) in food, drink, or refreshment at a single event, regardless of the number of persons providing the food, drink or refreshments. An "event" is a single activity, occasion, reception, meal or meeting at a given time and place. Where a group of public servants is invited to an event, the $65 limit is calculated by dividing the total cost of the food, drink and refreshments by the number of persons invited to the event. The limitation of $65 does not apply to a gathering held in conjunction with a meeting related to a national or regional organization, or to a meeting of a statewide organization of governmental officials or employees.

No public servant will receive anything of economic value, other than the compensation and benefits to which he is entitled from his governmental employer, for the performance of the duties and responsibilities of his office or position. The most common violation of this section occurs with the payment of travel expenses.

No public servant or other person will give, pay, loan, transfer or deliver or offer to give, pay, loan, transfer or deliver, directly or indirectly, to any public servant or other person anything of economic value which such public servant or other person would be prohibited from receiving by any provision of the Ethics Code.

Persons who give prohibited gifts to public servants violate §1117 of the Code and are subject to the enforcement proceedings and penalties for their violation.

EXTENDING BUSINESS COURTESIES, GIFTS AND INVITATIONS

The same general guidelines for receiving business courtesies, gifts and invitations described above will apply to extending same. The hospital may

sponsor events with a legitimate business purpose. Reasonable and appropriate meals and entertainment may be offered.

US FEDERAL AND STATE GOVERNMENT EMPLOYEES

Hospital policy is to not provide any gifts, entertainment, meals or anything else of value to an employee of the Executive Branch of the Federal and State government, except for minor refreshments in connection with business discussions, valued at no more than ten dollars.

POLITICAL ACTIVITIES AND CONTRIBUTIONS

The conduct of any political action committee is to be consistent with relevant laws and regulations. It is important to separate personal and corporate political activities in order to comply with the appropriate rules and regulations relating to lobbying or attempting to influence government officials.

You may participate in the political process on your own time and at your own expense. While you are doing so, it is important not to give the impression that you are speaking on behalf of or representing the organization in these activities. You cannot seek to be reimbursed for any personal contributions for such purposes. Employees may be asked to make personal contact with government officials or to write letters to present our position on specific issues. In addition, it is part of the role of some hospital management to interface on a regular basis with government officials. If you are making these communications on behalf of the organization, be certain that you are familiar with any regulatory constraints and observe them.

THE CORPORATE COMPLIANCE PROGRAM

The Corporate Compliance Program is intended to demonstrate the commitment of the organization to the highest standards of ethics and compliance. That commitment permeates all levels of the organization.

We are committed to ethical and legal conduct that is compliant with all relevant laws and regulations, and to correcting wrongdoing wherever it may occur in the organization. Each employee has an individual responsibility for reporting any activity by any colleague, physician, subcontractor or vendor who appears to violate applicable laws, rules, regulations or these Standards to their supervisor, manager, someone in management or to the Compliance Officer.

You may report issues anonymously, in writing, personally, or through the Compliance Hotline, 337-898-6112. Every effort will be made to maintain, within

the limits of the law, the confidentiality of the identity of any individual who reports possible misconduct. There will be no retribution or discipline for anyone who reports a possible violation in good faith. Any employee who deliberately makes a false accusation with the purpose of harming or retaliating against another employee will be subject to discipline.

We are committed to investigate all reported concerns promptly and confidentially to the extent possible. The Compliance Officer will coordinate findings from investigations and recommend corrective action or changes that need to be made, if indicated. All employees are expected to cooperate with investigation efforts.

When an internal investigation substantiates a reported violation, it is the policy of the organization to initiate corrective action, including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, instituting whatever disciplinary action is necessary, and implementing systemic changes to prevent a similar violation from recurring in the future.

Violators of the Standards of Conduct or policies or procedures will be subject to disciplinary action as defined in the hospital policies and procedures. The precise discipline utilized will depend upon the nature, severity and frequency of the violation, and may result in any of the following: verbal warning, written warning, suspension or termination.

Abbeville General Hospital is committed to the aggressive monitoring of compliance with its policies. The organization routinely seeks means of ensuring and demonstrating compliance with laws, regulations and policy, and monitors facility compliance activities.

New employees will receive compliance training and a copy of these Standards, as part of the orientation process. We require that employees sign an acknowledgement upon hire and annually during careLearning education. A signature will indicate knowledge of how to locate the Standards of Conduct on the hospital's M-Drive as well as an understanding it represents mandatory policies of Abbeville General Hospital. A new hire's signature will also indicate receipt of a copy of the Standards of Conduct.

Additional compliance training will be provided to all levels of employees, as well as the Board of Commissioners, physicians, etc., at least annually.

Adherence to and support of the organizational Standards of Conduct, as well at the Compliance Program policies and procedures, and participation in related activities and training will be considered in decisions regarding hiring, promotion, and compensation for all candidates.