DRAFT AGENDA
BOARD OF DIRECTORS MEETING - REGULAR MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
JUNE 1, 2020
NO EARLIER THAN 11:00 A.M.,
VIA TELEPHONE CONFERENCE

The Dial-in #: 1-510-338-9438
Access Code: 790 145 929

CALL TO ORDER

I. Explanation of Procedure for conducting Telephonic Meeting

II. Moment of Silence

III. PMC's Vision – *Healing Families – Healing Communities*

IV. Approval of Agenda

V. Executive Session

VI. Review and Approval of Minutes (April 6, 2020)

VII. Open Forum for PMC Physicians

VIII. Public Comments

IX. Unfinished Business

X. New Business

A. COVID Testing – Mr. Waterman

B. Facility Updates – Mr. Loftin / Mr. Boyles

Motion to recommend the Board of Directors approve the resolution of the North Brevard County Hospital District recognizing a valid public emergency certified by the President and Chief Executive Officer in light of the COVID-19 State of Emergency declared by Governor DeSantis; approving an exception to the requirements of Parrish Medical Center Policy 9500-63 and subsection 287.055(3)(a) of the Florida Statutes pertaining to the purchase of professional services under the consultants' competitive negotiation act; providing an effective date.

C. Coronavirus Payments – Mr. Bailey

D. Administrative and Compliance Audit Services Work Plans – Mr. Jackson

Motion to recommend the Board of Directors approve the 2020/2021 Administrative and Compliance Audit Services Work Plans, as presented.

E. **Motion to Recommend the Board of Directors approve Policy 9500-2049, Alarm Management, as presented.**

F. **Motion to recommend the Board of Directors approve Policy 9500-2057, Donation after Circulatory Determination of Death, as presented.**

G. **Motion to recommend the Board of Directors approve the Public Notice of Never Events, as presented.**

XI. Other

XII. Closing Remarks – Chairman

XIII. Open Forum for Public

ADJOURNMENT

NOTE: IF A PERSON DECIDES TO APPEAL ANY DECISION MADE BY THE BOARD WITH RESPECT TO ANY MATTER CONSIDERED AT THIS MEETING, HE/SHE WILL NEED A RECORD OF PROCEEDINGS AND, FOR SUCH PURPOSES, MAY NEED TO ENSURE A VERBATIM RECORD OF THE PROCEEDINGS IS MADE AND THAT THE RECORD INCLUDES TESTIMONY AND EVIDENCE UPON WHICH THE APPEAL IS TO BE BASED.

PERSONS WITH A DISABILITY WHO NEED A SPECIAL ACCOMMODATION TO PARTICIPATE IN THIS PROCEEDING SHOULD CONTACTTHE ADMINISTRATIVE OFFICESAT 951 NORTH WASHINGTON AVENUE, TITUSVILLE, FLORIDA 32796, AT LEAST FORTY-EIGHT (48) HOURS PRIOR TO THE MEETING. FOR INFORMATION CALL (321) 268-6110 or TDD (800) 955-8770.

THIS NOTICE WILL FURTHER SERVE TO INFORM THE PUBLIC THAT MEMBERS OF THE BOARD OF DIRECTORS OF NORTH BREVARD MEDICAL SUPPORT, INC. MAY BE IN ATTENDANCE AND MAY PARTICIPATE IN DISCUSSIONS OF MATTERS BEFORE THE NORTH BREVARD COUNTY HOSPITAL DISTRICT BOARD OF DIRECTORS. TO THE EXTENT OF SUCH DISCUSSIONS, A JOINT PUBLIC MEETING OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT AND NORTH BREVARD MEDICAL

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
BOARD OF DIRECTORS – REGULAR MEETING

A regular meeting of the Board of Directors of the North Brevard County Hospital District operating Parrish Medical Center was held on April 6, 2020 via telephone conference. The following members were present via telephone:

Herman A. Cole, Jr., Chairman (via phone)
Stan Retz (via phone)
Billie Fitzgerald (via phone)
Robert L. Jordan, Jr., C.M. (via phone)
Maureen Rupe (via phone)
Peggy Crooks (via phone)
Elizabeth Galfo, M.D. (via phone)
Jerry Noffel (via phone)
Ashok Shah, M.D. (via phone, 11:06 a.m.)

Member(s) Absent:
None

A copy of the attendance roster of others present during the meeting is appended to the file copy of these minutes.

CALL TO ORDER

Mr. Cole called the meeting to order at 11:02 a.m. Mr. Cole noted this telephone conference was pursuant to Executive Order No. 20-69 issued by the office of Governor DeSantis on March 20, 2020, which provides that local government bodies may conduct meetings without having a quorum of its members physically present, and by utilizing communications media technology such as telephonic or video conferencing. Parrish Medical Center management has determined that it is necessary and appropriate for the Board of Directors to meet by telephone conference to help control and minimize the spread of COVID-19 and to ensure that the residents of North Brevard County and Florida remain safe and secure.

Mr. Cole called roll for the members of the Board of Directors appearing remotely and on the telephone for this meeting.

Mr. Boyles reviewed the process and procedure for the telephonic meeting, noting that any person or member of the public may be heard by the Board of Directors, through the Chairman.

MOMENT OF SILENCE

Mr. Cole led the Board of Directors, staff and public in a moment of silence for the Coronavirus pandemic and those affected.

PMC'S VISION – *Healing Families – Healing Communities®*

Mr. Cole led the Board of Directors, staff and public in reciting PMC's Vision – *Healing Families – Healing Communities®.*

APPROVAL OF AGENDA

Mr. Cole asked for approval of the agenda in the packet. Discussion ensued and the following motion was made by Mr. Jordan, seconded by Mr. Retz and approved (8 ayes, 0 nays, 0 abstentions). Dr. Shah was not present at the time the vote was taken.

***ACTION TAKEN*: MOTION TO APPROVE THE AGENDA AS PRESENTED.**

CORONAVIRUS

Mr. Mikitarian addressed information previously sent to the Board of Directors regarding staffing and the District budget as it relates to the Coronavirus pandemic as well as testing for Coronavirus.

EXECUTIVE SESSION

At this time, Mr. Cole announced the Board would recess the public meeting to convene in Executive Session to discuss matters of credentialing. Mr. Cole noted that Executive Session will be held on a separate conference line as it is closed to the public, and members of the public may remain on this line until the Board of Directors return. During this time, a representative of PMC will periodically announce that the Board is meeting in Executive Session.

The Board of Directors public meeting recessed at 11:59 a.m.

The Board of Directors reconvened in open session at 12:20 p.m.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Ms. Crooks, seconded by Dr. Shah and approved (9 ayes, 0 nays, 0 abstentions).

***ACTION TAKEN:* MOTION TO APPROVE THE MINUTES OF THE FEBRUARY 3, 2020 REGUALR MEETING, AS PRESENTED.**

OPEN FORUM FOR PMC PHYSICIANS

There were no physician comments.

PUBLIC COMMENTS

There were no public comments.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

Mr. Bailey summarized the resolution contained in the packet relative to the authorization of short term borrowing in the form of a revolving line of credit. Discussion ensued and the following motion was made by Ms. Crooks, seconded by Mr. Jordan, and approved (9 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: MOTION TO APPROVE THE RESOLUTION OF THE BOARD OF DIRECTORS OF NORTH BREVARD COUNTY HOSPITAL DISTRICT IN LIGHT OF THE STATE OF EMERGENCY DECLARED BY GOVERNOR DESANTIS AS A RESULT OF COVID-19; AUTHORIZING SHORT-TERM BORROWING ON AN EMERGENCY BASIS IN THE FORM OF A REVOLVING LINE OF CREDIT WITH REGIONS BANK, AN ALABAMA BANKING CORPORATION; DESIGNATING AUTHORIZED SIGNERS FOR REVOLVING LINE OF CREDIT DOCUMENTS.

OTHER

Mr. Jordan took this time to say thank you to Administration and to the staff for taking such wonderful care of the health care needs of North Brevard, noting how proud he was of the organization and its staff .

Dr. Shah shared his appreciation of Administration as well and the doctors and nursing care for patients.

Mr. Retz noted he has received several inquiries from organizations regarding where to send food for care partners. It was noted that all donations are being organized through the Foundation.

CLOSING REMARKS

Mr. Cole shared his appreciation for staff of the organization, noting he is thankful for all of our fantastic care partners who do an amazing job every day.

OPEN FORUM FOR PUBLIC

No members of the public spoke.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 12:39 p.m.

Herman A. Cole, Jr.
Chairman

COVID-19 Testing

Pre-registration is required at all testing locations. Text “covid test” to 321-204-1966 or visit parrishhealthcare.com/COVID19Registration

Once the test administration is complete, it will be sent for processing using the RT-PCR test approved by the FDA. Your test results are expected in two business days. All insurance accepted. Self-pay $0/no charge.

Tuesday Afternoons
Parrish Health and Fitness Center
2210 Cheney Hwy Titusville, FL 32780
Parking lot

Wednesday Afternoons
Greater St. James Missionary Baptist Church
2396 Harry T. Moore Ave. Mims, FL 32754
Grass lot south of church

Thursday Afternoons
Harry T. Moore Social Services Center
725 S. Deleon Ave. Titusville, FL 32780
Parking lot

Friday Mornings
Parrish Medical Offices
7075 US 1 Port St. John FL, 32927
Parking lot

Saturday Mornings
Gibson Youth Center
835 Sycamore St. Titusville, FL 32780
Parking lot

PARRISH® MEDICAL GROUP
PARRISH HEALTHCARE

parrishmedgroup.com
Healing Families—Healing Communities®

RESOLUTION

of the
BOARD OF DIRECTORS
of the
NORTH BREVARD COUNTY HOSPITAL DISTRICT

RECOGNIZING A VALID PUBLIC EMERGENCY CERTIFIED BY THE PRESIDENT AND CHIEF EXECUTIVE OFFICER IN LIGHT OF THE COVID-19 STATE OF EMERGENCY DECLARED BY GOVERNOR DESANTIS; APPROVING AN EXCEPTION TO THE REQUIREMENTS OF PARRISH MEDICAL CENTER POLICY 9500-63 AND SUBSECTION 287.055(3)(a) OF THE FLORIDA STATUTES PERTAINING TO THE PURCHASE OF PROFESSIONAL SERVICES UNDER THE CONSULTANTS' COMPETITIVE NEGOTIATION ACT; PROVIDING AN EFFECTIVE DATE

Whereas, on March 9, 2020, Governor DeSantis issued Executive Order 20-52, as extended by Executive Order 20-114, declaring a state of emergency for the entire State of Florida pursuant to Chapter 252 of Florida Statutes based upon substantial harm related to COVID-19.

Whereas, there is an immediate need in Parrish Medical Center for architectural and construction work related to the needs of COVID-19 patients.

Whereas, the architectural and construction work falls within the public announcement procedures of Parrish Medical Center Policy 9500-63 and may fall under the public announcement and qualification procedures set forth in Section 287.055 of the Florida Statutes.

Whereas, an exception is provided to the requirements of Parrish Medical Center Policy 9500-63 and Section 287.055 of the Florida Statutes in the case of a valid public emergency certified by the President and Chief Executive Officer of the North Brevard County Hospital District.

Now therefore, be it resolved by the Board of Directors of the North Brevard County Hospital District that:

1. Certification and Approval of the Public Emergency. The President and Chief Executive Officer of the North Brevard County Hospital District hereby certifies as set forth in **Attachment A** that a valid public emergency exists in light of COVID-19 and the Executive Orders issued by the Governor of the State of Florida which requires Parrish Medical Center to move quickly forward with entering into contracts for architecture and construction services to satisfy the needs of COVID-19 patients. The Board of Directors of the North Brevard County Hospital District recognizes and approves this public emergency.

2. Parrish Medical Center Policy 9500-63 and Section 287.055 of the Florida Statutes. The North Brevard County Hospital District is not required to comply with the notice and

competitive negotiation requirements set forth in Parrish Medical Center Policy 9500-63 and Section 287.055 of the Florida Statutes.

3. Authority of the President and Chief Executive Officer. The President and Chief Executive Officer of the North Brevard County Hospital District is hereby authorized to take all steps necessary to enter into and sign the contracts necessary for the COVID-19 construction project without further action of the Board of Directors.

4. Effective Date. This Resolution shall become effective immediately upon enactment.

This resolution is approved and adopted in a meeting of the Board of Directors of the North Brevard County Hospital District held on June 1, 2020, via media technology, consistent with Executive Order 20-69, extended by Executive Order 20-123, issued by the Governor of Florida and consistent with Florida law.

NORTH BREVARD COUNTY HOSPITAL DISTRICT

By:_____
Herman A. Cole, Jr., Chairman

ATTEST:

By:_____
Peggy Crooks, Secretary

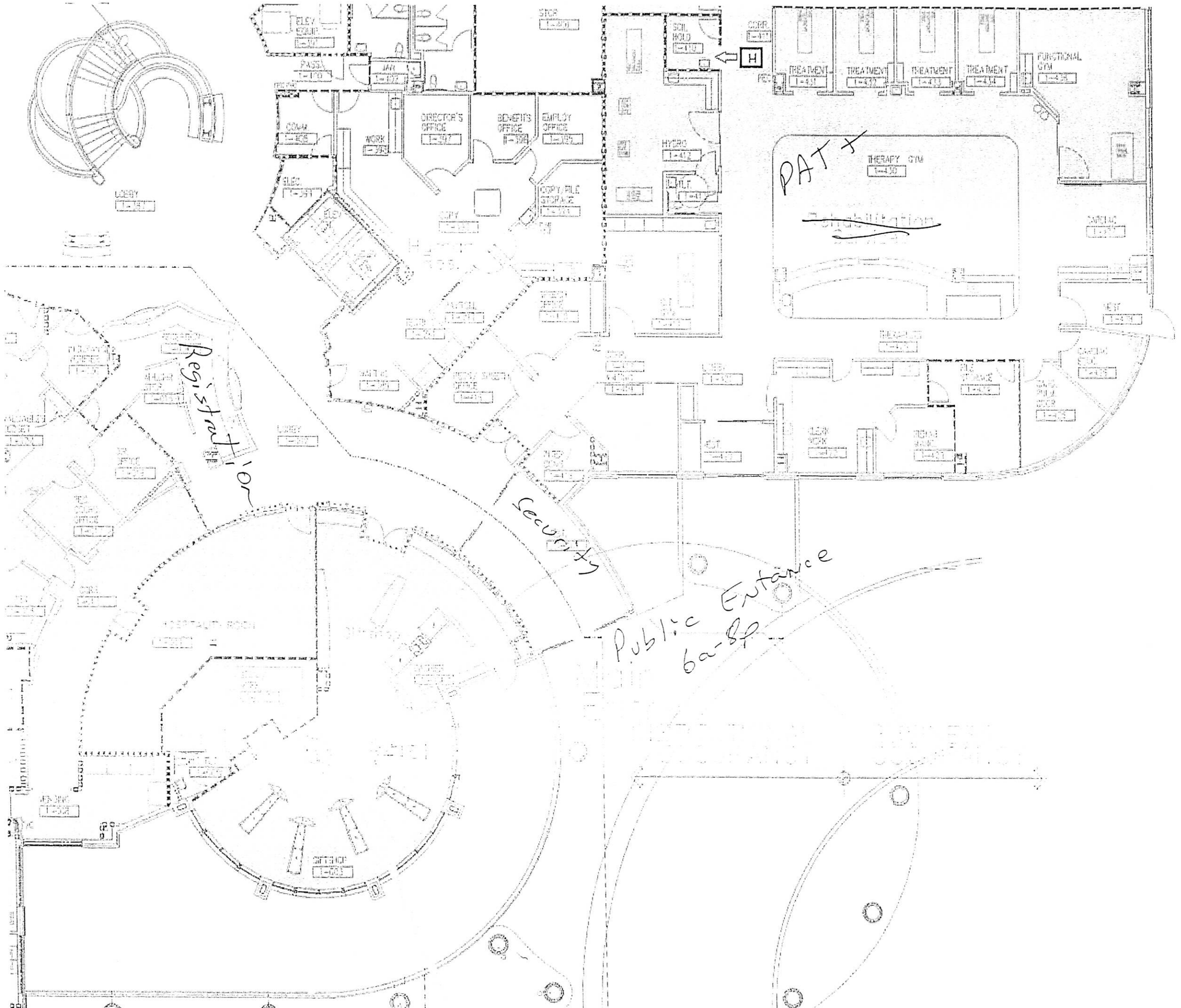
PARRISH MEDICAL CENTER
PARRISH HEALTHCARE

951 North Washington Ave.
Titusville, FL 32796
P: 321-268-6111
parrishmed.com

Attachment A

I, George Mikitarian, President and Chief Executive Officer of the North Brevard County Hospital District, d/b/a Parrish Medical Center, do hereby certify that a valid public emergency exists in light of COVID-19 and the Executive Orders issued by the Governor of the State of Florida which requires Parrish Medical Center to move quickly forward with entering into contracts for architecture and construction services to satisfy the healthcare needs of COVID-19 patients.

By: _____
George Mikitarian
President and Chief Executive Officer of the North Brevard County Hospital District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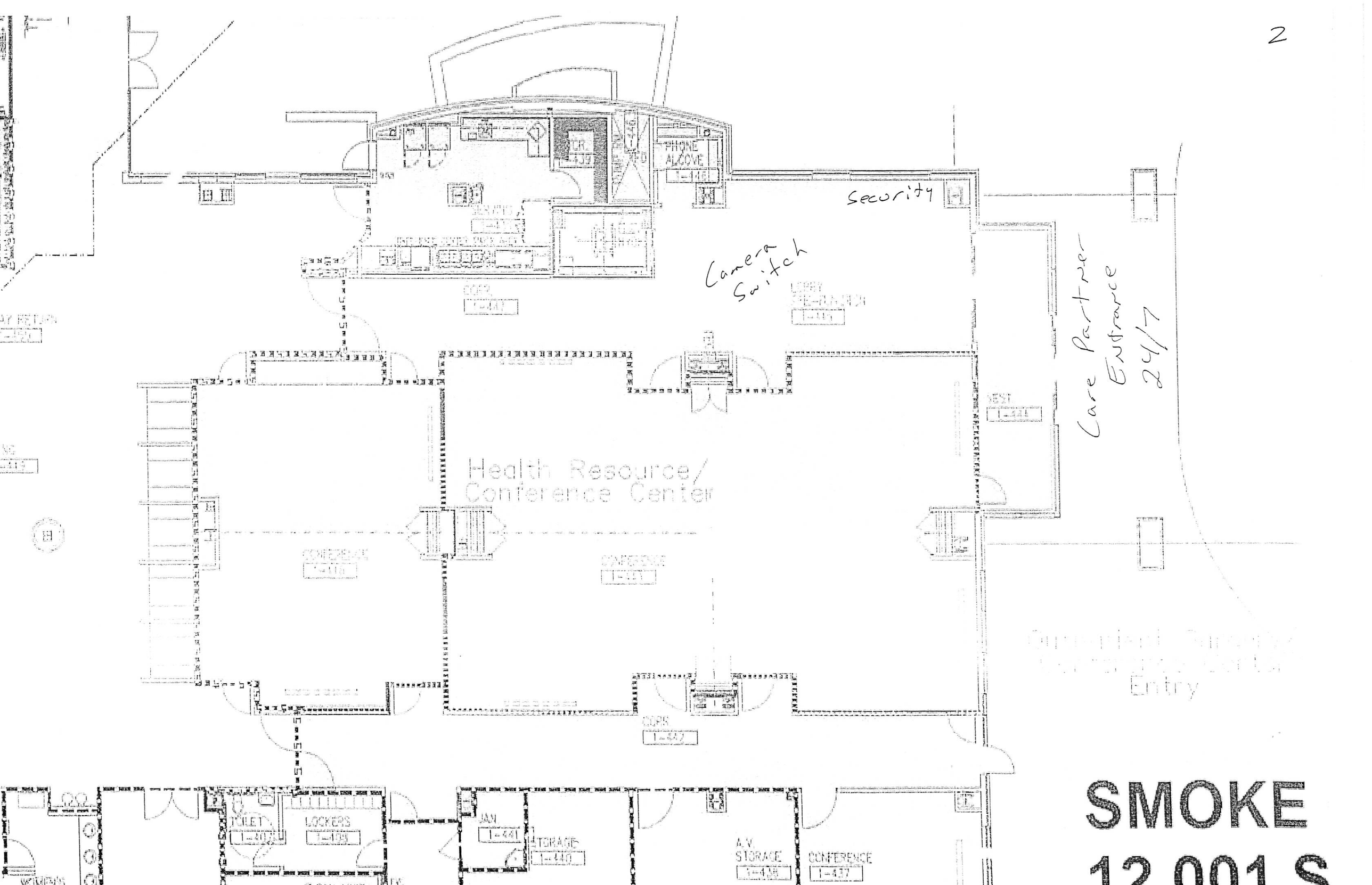

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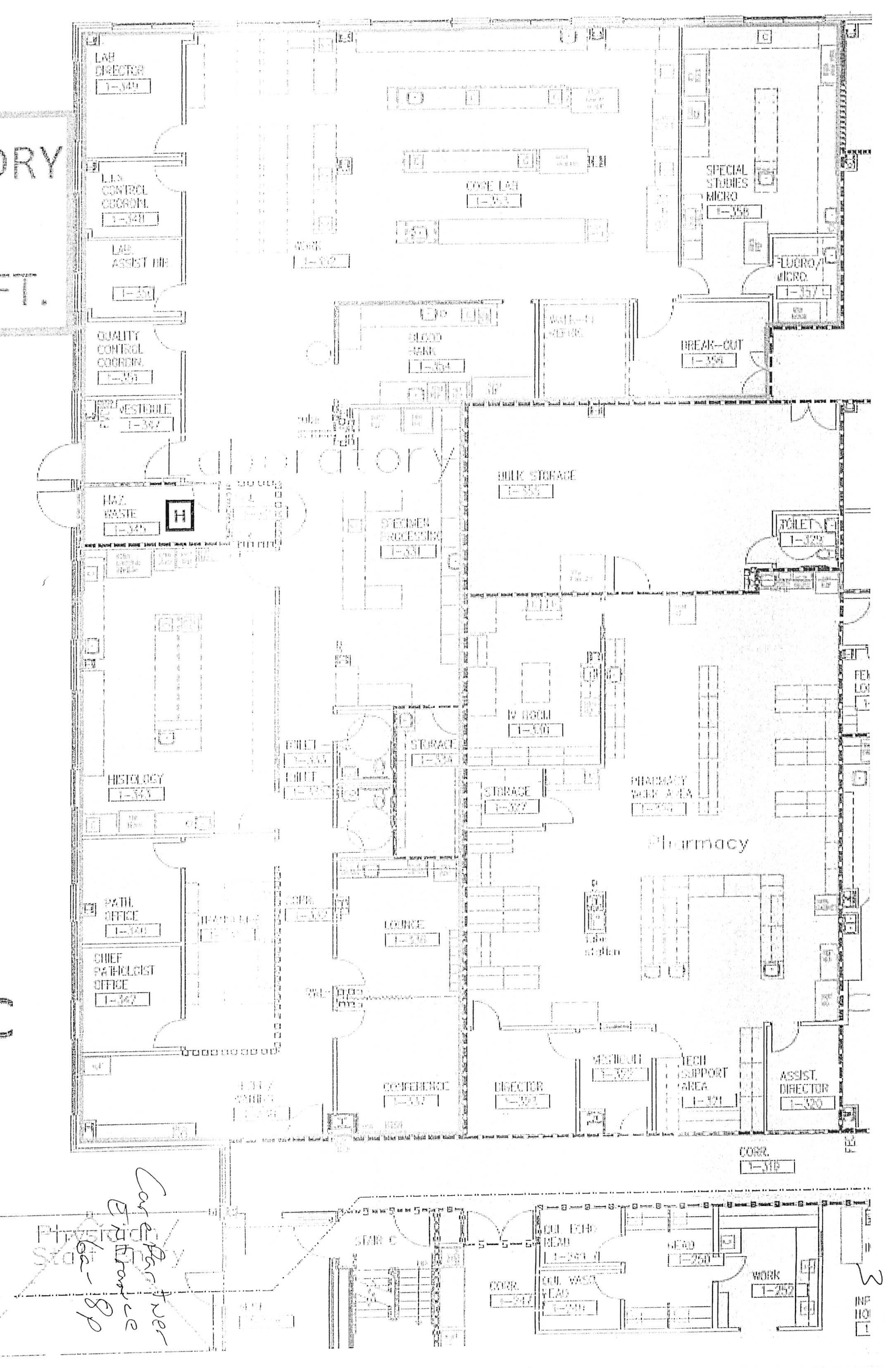
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TOILET
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PATH. OFFICE
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CHIEF PATHOLOGIST OFFICE
1-342
LOUNGE
1-339
CONFERENCE
1-337
DIRECTOR
1-336
ASSEMBLY
1-325
TECH SUPPORT AREA
1-321
ASSIST. DIRECTOR
1-320
CORR.
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Physician's Staff
WORK
1-252
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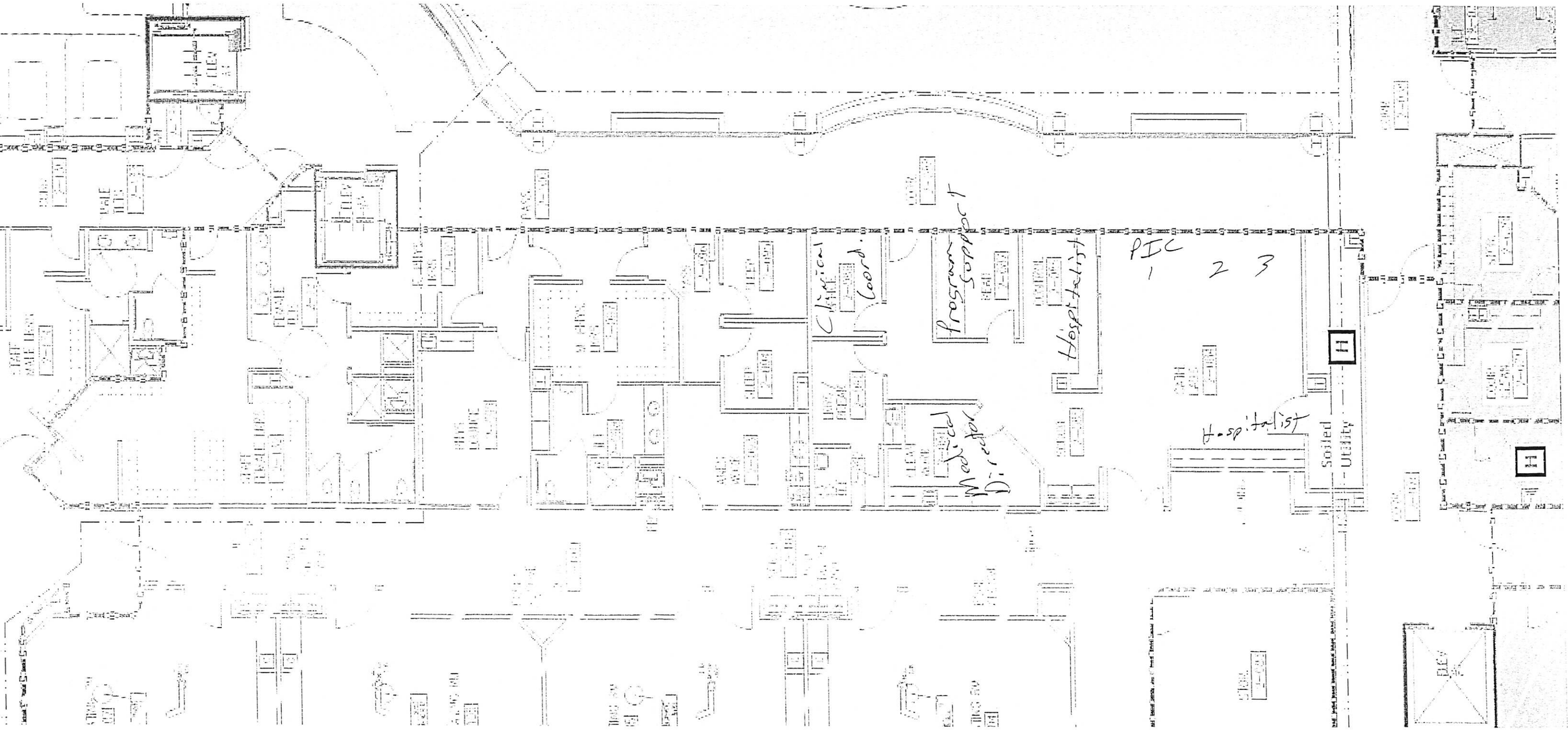
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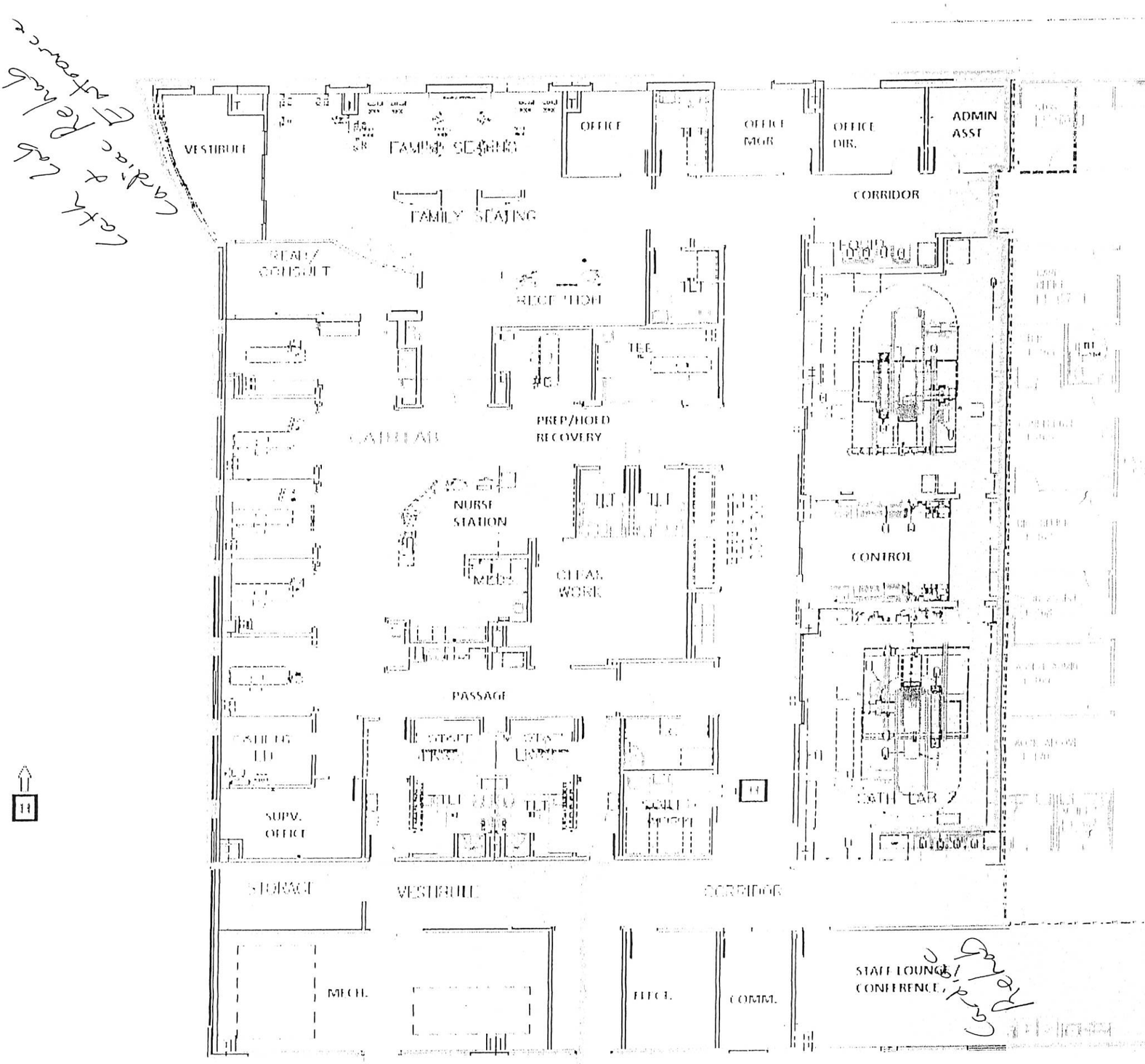

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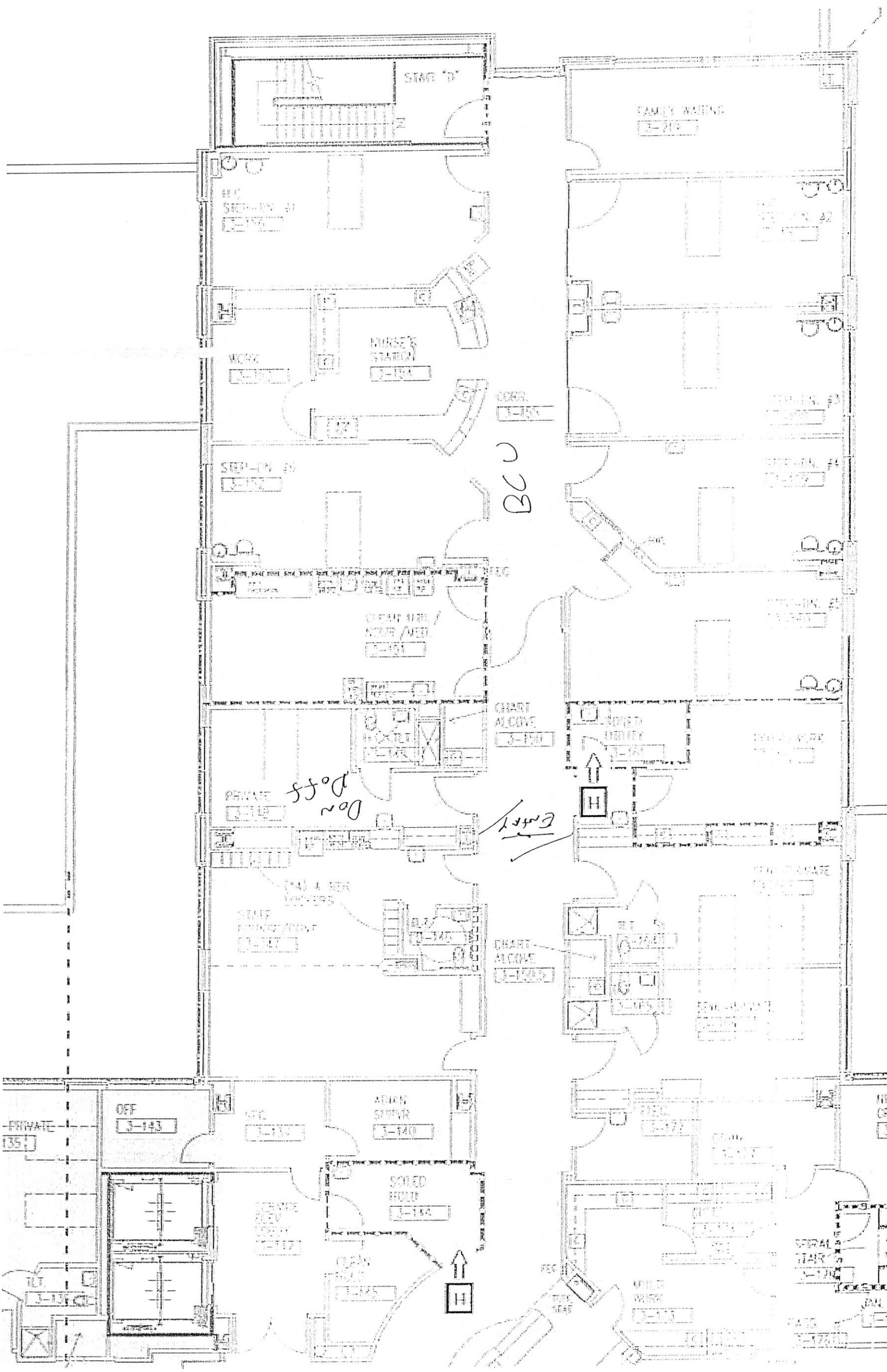
Patient Services

Emergency

Bump & Bruise Wait

Cough & Spec Wait

Resp Care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MEMORANDUM

TO: Board of Directors
FROM: Anual Jackson, Chief Compliance and Audit Officer
SUBJECT: Request for Years 2020/2021 Compliance Work Plans Approval
DATE: May 22, 2020

The Office of Corporate Compliance has set out on a long-term project to improve the overall effectiveness and efficiency of PMC's compliance program. To begin, the 2020 Corporate Compliance Work Plan is separated into two types of work plans: (1) Administrative Work Plans covering compliance administration, privacy administration, contract management and policy management and (2) Compliance Audit Services Work Plan covering compliance and privacy internal audits. Both the Administrative Work Plans and the Compliance Audit Services Work Plan are dynamic allowing for adjustments to meet operational priorities and emerging issues with available resources.

I am requesting the Board's review and approval of the 2020/2021 Administrative and Compliance Audit Services Work Plans.

Contact me at 321-268-6835 with any questions.

Thank you.

Office of Corporate Compliance | 2020/2021 Work Plans

Corporate Compliance | HIPAA Privacy | Corporate Compliance Audit Services
Business Ethics | Contract Management | Policy Management

ABOUT THE OFFICE OF CORPORATE COMPLIANCE ("OCC")

PMC's Office of Corporate Compliance conducts independent investigations, reviews and compliance audits and provides objective reports to the President/CEO, management, the Board of Directors and when warranted under the direction of legal counsel to government agencies[1].

ABOUT OCC'S WORK PLAN

OCC has set out on a long-term project to improve the overall effectiveness of PMC's compliance program. Beginning in 2020 Corporate Compliance Work Plan is separated into two types: (1) Administrative Work Plans covering compliance administration, privacy administration, contract management and policy management and (2) Compliance Audit Services Work Plan covering compliance and privacy internal audits. Both types of plans are dynamic allowing for plan adjustments to meet priorities and respond to emerging issues with available resources.

HOW OCC WORK IS PLANNED

OCC assess compliance risk in PMC programs and operations to identify areas most in need of attention. OCC considered internal and external sources impacting PMC, including without limitation:

- Input from management and Executive Ethics and Compliance Committee
- Internal compliance audits, privacy audits, investigations and hotline reports
- Distributed OIG work plans, bulletins, advisories and corporate integrity agreements
- Distributed compliance audits by the OIG, OCR, QIO, RAC, AHCA, MAC, MCFU[2]
- Emerging trends in the health care industry
- Statutorily required reviews and monitoring

Work Plans Approval

The Chief Compliance and Audit Officer presents the plan topics to the Executive Ethics and Compliance Committee for review, review draft work plans with the President/CEO and presents the draft plans to the Board of Directors for review and final approval.

Work Plans Monitoring

The work plans progress is to be tracked monthly to ensure timelines are met. Success will be defined by having the associated deliverables completed by the plans' respective time frames. Should plan items need to be flexed; the Chief Compliance and Audit Officer will advise the Executive Ethics and Compliance Committee and request approval from the Board of Directors. The work plans status is to be presented to the Executive Ethics and Compliance and to the Board of Directors or board appointed committee no less than quarterly.

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[1] To include without limitation to the Florida Medicare Administrative Contractor, Office of Inspector General, and Centers for Medicare and Medicaid Services

[2] OIG—Office of Inspector General; OCR—Office for Civil Rights; QIO—Quality Improvement Organization; RAC—Recovery Audit Contractor; AHCA—The Agency for Health Care Administration; MAC—Medicare Administrative Contractor; MFCU—Medicaid Fraud Control Unit

PARRISH MEDICAL CENTER

SUMMARY - CY2020 - CY2021 CORPORATE COMPLIANCE WORK PLANS

Acronym Legend: WIP – Work in process | | | WNS – Work not started | | | CR – Continuous Review

Corporate Compliance Administrative Work Plan

Action Plan Item	Objective	Time Frame	Plan Status
Program Evaluation	Self-directed Gap Analysis	Dec 2020	WIP
Compliance Policies	Revise and distribute policies (Board approval)	2020 / 2021	WIP
Compliance Program Plan	Update, amend and restate (Board approval)	Aug 2020	WIP
Staff Job Description	Update responsibilities	Jul 2020	WNS
Exclusion Screening	Screen care partners against OIG excluded List	Monthly	CR

HIPAA Privacy Administrative Work Plan

Action Plan Item	Objective	Time Frame	Plan Status
Program Evaluation	Self-directed Gap Analysis	Dec 2020	WNS
Notice of Privacy Practice	Revise, implement and distribute	Jan 2021	WNS
Breach Notification	Unauthorized disclosure of protected health information (Less than 500 individuals)	Feb 2021	WNS

Contract Management Administrative Work Plan

Action Plan Item	Objective	Time Frame	Plan Status
Hospital General Contract Policy	Revise, implement, and distribute (Board approval)	Aug 2020	WIP
Contracts	Prepare for uploading to contract system	Sep 2020	WIP
Contract Management System	Select and implement electronic system	Nov 2020	WIP

Policy Management Administrative Work Plan

Work Plan Item	Objective	Time Frame	Plan Status
Establishing Policies Policy	Revise, implement, and distribute	Apr 2020	Complete
Physician Arrangement Policy	Draft and distribute policy and procedure	Jul 2020	WIP
Policy Management System	Select and implement electronic system	June 2021	WNS

Corporate Compliance Audit Services Work Plan

Work Plan Item	Objective	Time Frame	Status
Hospital and Physician Financial Arrangement with Referral Sources	Evaluate compliance to Stark Law exceptions and Anti-Kickback safe harbors	June 2020	WIP
Outpatient Observation Services	Evaluate compliance to Medicare claims manual	Aug 2020	WNS
Real Estate Arrangement with Referral Sources	Evaluate compliance to Stark exceptions, Anti-Kickback safe harbors	2021	WNS
Records Retention and Disposal Management	Evaluate compliance with policies and applicable regulations	2021	WNS
Conflict of Interest	Distribute, collect and evaluate select employees COI disclosure forms	2020 / 2021	WNS
Hospital Coding Audits External Auditor	Coding accuracy audit; Coordinate with Health Information Management on coding audit	2021	WNS

PARRISH MEDICAL CENTER

DETAIL - CY2020 - CY2021 CORPORATE COMPLIANCE ADMINISTRATIVE WORK PLAN

Acronyms Legend:

ACRONYMS	DESCRIPTION	ACRONYMS	DESCRIPTION
BOD	Board of Directors	FSG	Federal Sentencing Guidelines
CFR	Code of Federal Regulations	HCPG	OIG Hospital Compliance Program Guidance
CIA	OIG Corporate Integrity Agreement	OCR	Office for Civil Rights
DOJ	Department of Justice	FCA	False Claims Act
WIP	Work In Process	WNS	Work Not Started

Corporate Compliance Administrative Work Plan (Standards: FSG; HCPG; CIA; DOJ, FCA)

Action Plan Item	Objective	Source	Completion BY Time Frame	Plan Status
Compliance Program Evaluation	Self-directed Gap Analysis—review against the: 1. 2020 CIA Compliance Program Framework[3] 2. 2019 DOJ Compliance Program Guidance[4]	DOJ, CIA, FSG, HCPG, FCA	Dec 2020	WIP
Corporate Compliance Policies & Procedures	Revise and distribute policies Requires Board of Directors Approval	FSG, HCPG, CIA, DOJ	2020 / 2021	WIP
Program Plan	Update, amend and restate program and plan Requires Board of Directors Approval	HCPG, CIA	Aug 2020	WIP
Staff Job Description	Update job description to include contract and policy management assisting responsibilities	FSG, HCPG, CIA, DOJ	Jul 2020	WNS
Exclusion Screening (Fed and State Requirement)	Monthly, screen employees, medical staff, vendors, BOD against Federal and State List of Excluded Individuals and Entities	OIG, CFR	Monthly	WIP

CY 2020 and CY 2021 Corporate Compliance Performance Metrics

1. Provide minimum of one compliance training session specific to Board members
2. Provide verbal (written if warranted) quarterly compliance report to the Board of Directors or board appointed committee
3. Implement Area Compliance Liaison program, Sep 2020
4. Meet quarterly with the Executive Ethics and Compliance Committee
5. Chief Compliance Officer conduct minimally four one-on-one meetings with the President/CEO
6. Provide annual written compliance report to the Board of Directors in December 2020

[3] CIA compliance program framework details the FSG elements into day-to-day operating compliance functions

[4] DOJ compliance program guidance document is meant to assist DOJ prosecutors in making informed decisions as to whether, and to what extent, the corporation's compliance program was effective

DETAIL - CY2020 - CY2021 HIPAA PRIVACY ADMINISTRATIVE WORK PLAN

Acronyms Legend:

ACRONYMS	DESCRIPTION	ACRONYMS	DESCRIPTION
CFR	Code of Federal Regulations	HIPAA	Health Insurance Portability & Accountability Act
OCR	Office for Civil Rights	HHS	U.S. Department of Health & Human Services
WIP	Work In Process	WNS	Work Not Started

HIPAA Privacy Administrative Work Plan (Standards: HHS, CFR, FTC, and ONC)

Action Plan Item	Objective	Source	Completion Time Frame	Plan Status
Program Evaluation	Self-directed Gap Analysis—review against the OCR HIPAA Privacy Rule	HHS, CFR, OCR	Nov 2020	WNS
Notice of Privacy Practice	Revise and distribute	HHS, CFR , OCR	Jan 2021	WNS
Breach Notification (Federal and State Requirement)	Report breach of protected health and personal identifiable information	HHS, CFR, OCR	Feb 2021	WNS

CY 2020 and CY 2021 HIPAA Privacy Performance Metrics

1. Provide minimum of one privacy training session specific to the Board members
2. Provide verbal (written if warranted) quarterly privacy report to the Board of Directors or board appointed committee
3. Implement Area Privacy Liaison program, Sep 2020
4. Meet quarterly with the Executive Ethics and Compliance Committee
5. Chief HIPAA Officer conduct minimally four one-on-one meetings with the President/CEO
6. Complete privacy program evaluation and risk assessment in 2020

DETAIL - CY2020 - CY2021 CONTRACT MANAGEMENT| POLICY MANAGEMENT ADMINISTRATIVE WORK PLANS

Acronyms Legend:

ACRONYMS	DESCRIPTION	ACRONYMS	DESCRIPTION
CFR	Code of Federal Regulations	HIPAA	Health Insurance Portability & Accountability Act
OCR	Office for Civil Rights	HHS	U.S. Department of Health & Human Services
WIP	Work In Process	WNS	Work Not Started

Contract Management Administrative Work Plan

Action Plan Item	Objective	Source	Completion Time Frame	Plan Status
Hospital General Contract Policy (BOD Level Policy)	Revise, implement, and distribute	OIG	Jul 2020	WIP
Contracts File Cleanup	Complete cleanup project	Compliance	Sep 2020	WIP
Seek to Reduce Contract Management System Cost Contract system terms 10/31/2020	1. Distribute 3 Requests for Proposal 2. Select System 3. Implement System 4. Complete Leadership Training	Compliance	Oct 2020	WIP

CY 2020 and CY 2021 Contract Administration Performance Metrics

1. Reduce contract management system cost by reducing current system cost or by selecting and implementing an electronic contract management system to replace current contract management system; September 2020
2. Contract system price goal is 20% below current contract management system price

Policy Management Administrative Work Plan

Work Plan Item	Objective	Source	Completion Time Frame	Plan Status
Establishing Policies Policy	Revise, implement, and distribute		Apr 2020	Complete
Physician Financial Arrangement Policy	Draft and distribute policy	OIG	Jul 2020	WIP
Physician Financial Arrangement Standard Operating Procedure	Draft and distribute procedure	OIG	Jul 2020	WIP
Seek to reduce Policy System Costs Policy system terms 07/2021	1. Distribute 3 Requests for Proposal 2. Select System 3. Implement System 4. Complete Leadership Training	Corporate Compliance	June 2021	WNS

CY 2020 and CY 2021 Policy Management Performance Metrics

1. Reduce policy management system by reducing current policy management system cost or by selecting and implementing an electronic policy management system to replace current policy management system; June 2021
2. Policy system price goal is 20% below current policy management system 2020 price

PARRISH MEDICAL CENTER

DETAIL - CY 2020/2021 CORPORATE COMPLIANCE Audit Services Work Plan[5]

Acronyms Legend:

ACRONYMS	DESCRIPTION	ACRONYMS	DESCRIPTION
CFR	Code of Federal Regulations	HIPAA	Health Insurance Portability & Accountability Act
OCR	Office for Civil Rights	HHS	U.S. Department of Health & Human Services
WIP	Work In Process	WNS	Work Not Started

Work Plan Item	Objective	Source	Time Frame	Status
Hospital and Physician Financial Arrangement with Referral Sources	*Stark Law, Anti-Kickback Statute and Executed Agreement Compliance* Arrangements with referral sources that implicate the Anti-Kickback Statute and Stark Laws remain the number one healthcare enforcement priority for both the DOJ and OIG. Improper design and implementation of physician arrangements can result in penalties, denial of payments, and exclusion from federal health care programs. Audit Objective Provide an objective evaluation of risk and internal control systems (1) Evaluate active service arrangements' compliance risk to applicable Stark Law exception(s), Anti-Kickback Statute safe harbor(s) and to executed agreements (2) Evaluate policies, procedures and processes for analyzing, approving, and monitoring arrangements (3) Based upon audit results, provide recommended actions to fix arrangement compliance identified concerns Audit Scope: Jan 2020 – May 2020 Hospital | Physician financial agreements • Medical Directorship Services • Co-management Services • Chairperson, Policy & External Affairs • Physicians with multiple agreements Audit Work 1. Evaluate contracts, time logs, FMV reports, AP payment a. Review and analyze documents in number 1: b. Written agreement signed by hospital and physician c. Services documented in agreement d. Time limit documented in agreement e. Agreement active f. Agreement at FMV and how recent is FMV report g. Agreement commercially reasonable h. Stark exception / Anti-Kickback safe harbor met	OIG, CIA, CFR, SSA, CMS	June 2020	WNS

[5] The audit work plan is based on compliance risk areas prioritized by the Executive Ethics and Compliance Committee to address areas needing attention in years 2020 and 2021. The Board of Directors has final approval for the Corporate Compliance Audit Services Work Plan.

Continuation – CY 2020/2021 Corporate Compliance Audit Services Work Plan

Work Plan Item	Objective	Source	Time Frame	Status
Outpatient Observation Services	*Medicare Claims Processing Manual 100-4, Chapter 4 Section 290 – Outpatient Observation Services* Audit Objective Outpatient observation services span more than 48 hours (1) Evaluate use of observation services (2) Trend length of observation stays (3) Review observation services span more than 48 hours (4) Evaluate Medicare Outpatient Observation Notice compliance (5) Based upon audit results, provide recommended actions to fix identified concerns Audit Work (6) Interview Case Management (CM) (7) Physician order documenting placement in observation (8) Physician documented reason for observation over 24 hours (9) Number of patients placed in observation on weekend and remained in observation over weekend for outpatient test (10) Number of case not meeting criteria reviewed by physician advisor to advise patient status (11) Number of cases over 24 hours reviewed by physician advisor (12) Number of patients in observation transferred to SNF	OIG, CMS, MAC	Aug 2020	WNS
Real Estate Arrangement with Referral Sources	*Stark Law, Anti-Kickback Statute and Executed Agreement Compliance* Audit Objective Provide an objective evaluation of risk and internal control systems (1) Evaluate arrangements compliance risks to applicable Stark Law exception(s), Anti-Kickback Statute safe harbor(s) and compliance to executed agreements (2) Evaluate policies, procedures and processes for analyzing, approving, and monitoring arrangements (3) Based upon audit, provide actions to enhance arrangement compliance	OIG, CFR	2021	WNS
Records Retention and Disposal Management	*Florida Statute – Records Retention and Disposal Management* Audit Objectives Provide an objective evaluation of risks and internal control systems (1) Evaluate records management retention and disposal process (2) Evaluate compliance with policies and applicable regulations (3) Based upon audit results, provide actions to enhance records retention and disposal identified concerns	Florida Statutes, CIA, OIG	2021	WNS
Conflict of Interest	Distribute and collect select employees COI disclosure forms Evaluate reported actual and potential conflicts	PMC Policy	Yearly Oct	WNS
Coding Audits (External Auditor)	Coding accuracy audit; Coordinate with Health Information Management on hospital external coding compliance audit	OIG, CMS	2021	WNS

Origination:	*10/2014*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*04/2020*
Next Review:	*3 years after approval*
Areas:	*Emergency*
Tags:	*9500*
Applicability:	*Parrish Medical Center*

Alarm Management, 9500-2049

PURPOSE

To maximize patient safety and prevent alarm fatigue by improving the effectiveness of Parrish Medical Center's (PMC) clinical alarm system. Clinical alarms are used to provide continuous monitoring and early detection of potential life threatening events.

SCOPE

All care partners who provide care to monitored patients through PMC.

DEFINITIONS

A. Clinical Alarms**:** alarm systems that are either built in or attached to medical equipment and monitoring systems, and that are triggered by physiological changes in the patient, by variations in measured parameters or by system problems.

B. Alarm Fatigue: the psychological effect produced by too many alarms occurring in a clinical environment causing clinicians to miss true clinically significant alarms.

C. Non-Actionable ("nuisance") Alarms: alarms that are not clinically relevant and are not treated.

D. Licensed Care Provider: Physician, Registered Nurse, Nurse Practitioner, And Respiratory Therapist. (Refer to Section ~~IV~~VII for Responsibilities)

E. EMR: Electronic Medical Record.

F. Hemodynamic Pressure Tracings: Invasive measurement of systemic, pulmonary, arterial, and venous pressures and cardiac output.

PROCEDURES:

A. Settings for any alarm on a medical device that is intended to alert the staff that the patient needs immediate attention will be checked on admission, at the beginning of every shift, and with changes in the patient's condition/treatment goals to assure that they are on and set appropriately.

B. ~~Pressure~~Hemodynamic pressure tracings are zeroed (refers to Intensive Care Unit (ICU), Post Anesthesia Care Unit (PACU), Cardiac Catheterization Lab):

1. start of therapy

2. beginning of each shift
3. whenever disconnected or turned off
4. change in patient positioning
5. validation of reading accuracy

C. Patient's primary Registered Nurse (RN)should set customized alarms within one hour of assuming care.

D. Electrode area has to be washed with soap and water and wiped with wash cloth or gauze to allow better adherence of electrode to the skin. Alcohol should be avoided as this dries the skin out. Excessive hair at the electrode site should be clipped.

E. ECG electrodes should be changed at least daily.

F. Pulse oximetry sensors should be replaced when they no longer properly adhere to patient's skin.

CLINICAL DEVICE ALARMS

The alarms are categorized in three levels with specific equipment being discussed in ~~NetLearning~~Net Learning education.

A. Level 1 *Critical/Immediately life threatening alarms*

B. Level 2 *Potentially life threatening if left unattended for longer periods*

C. Level 3 *Non-life threatening but possible source of patient harm if not addressed*

GUIDELINES:

A. Alarm limit parameters will be adjusted only by a ~~licensed care provider~~licensed care provider as provided herein according to patient's clinical condition and/or age appropriate standards. These alarm limits may be set by a physician order and/or clinical judgment of the nurse. Customized alarm limits must be set within one hour of assuming care of patient.

B. Alarms used for monitoring critical vital signs and values should not be silenced or turned off indefinitely.

C. Always start with patient assessment first when assessing reason for an alarm.

D. Only a licensed care provider may silence a clinical alarm while remaining at the patient's bedside to troubleshoot the alarm and intervene as appropriate.

E. A non-functioning invasive pressure line should be addressed with the physician immediately for possible discontinuation.

F. ~~No alarms should be ignored.~~No alarms should be ignored. It is the responsibility of all care partners to report and/or respond as soon as possible within their scope of practice if any alarm is going off.

G. Provide proper skin preparation of electrode areas to enhance conductivity, minimize signal interference and false alarms.

H. Utilization of telemetry monitoring for specific patient population is based on Policy # 9500-2023 Telemetry Admission Criteria.

I. Bed exit alarms should be used for patients identified as a high fall risk.

RESPONSIBILITIES:

A. Registered Nurse (RN):

1. *(Please refer to Telemetry Monitoring Procedure # 24.21.01)*
2. Responds to all alarms.
3. Adjusts physiologic monitor alarm parameter settings (except for respiratory equipment) based on patient's clinical condition and/or physician's order.
4. Troubleshoots alarms in a timely manner.
5. Communicates verbally and visually any changes made on the alarm settings/parameters to the oncoming staff during shift change or after relieving staff for break in order for them to respond appropriately to the alarms.
6. Assesses need for cardiac monitoring daily and communicate assessment findings with physician. Avoid keeping the patient on telemetry monitoring longer than necessary.
7. Determines when to discontinue a bed exit alarm.
8. Reports any malfunctioning equipment/alarm to charge nurse.

B. Respiratory Therapist:
   1. Responds to alarms as necessary.
   2. Adjusts alarm parameters/settings for mechanical ventilators, NIPPV machines, and Capnography equipment outside the Operating Room.
   3. Communicates verbally and visually any changes made on the alarm settings/parameters to the oncoming staff during shift change or after relieving staff for break in order for them to respond appropriately to the alarms.
   4. Troubleshoots respiratory equipment alarms in a timely manner.
   5. Reports and enters work order requisition for any malfunctioning respiratory equipment/alarm.

C. Monitor Technician:
   1. *(Please refer to Telemetry Monitoring Procedure # 24.21.01)*
   2. Once a patient is discharged from the unit, the monitor technician will discharge patient from the central monitor station in order to recall the monitor default settings in preparation for a new patient.

D. Certified Nursing Assistant (CNA)/Emergency Medical Technician (EMT):
   1. Responds to alarms as necessary.
   2. Notifies patient's primary care nurse immediately of clinical device alarming.
   3. Reports any malfunctioning equipment/bed alarm to the nurse.
   4. May turn on a bed exit alarm for patient safety but cannot discontinue a bed exit alarm. It is up to the nurse's discretion when to discontinue a bed exit alarm.

E. Clinical Equipment Staff:
   1. Maintain inventory of alarm-enabled devices.
   2. Assist licensed professional in setting default parameters.
   3. Maintain, inspect and test all medical equipment on the inventory in accordance with risk factors.

F. Physician (MD)/Licensed Independent Practitioner (LIP):
   1. Identifies and orders parameter settings appropriate for patient's condition.

2. Responds to clinical alarms as necessary and communicates to the patient's primary nurse/and or respiratory therapist any changes made to the alarm settings.

EDUCATION

A. Patient and family education upon admission regarding significance of different clinical device alarms. Document in Electronic Medical Record (EMR).

B. Staff education on alarm safety management in Net Learning upon orientation.

C. Physiologic monitor alarm safety management competency will be completed annually for Registered Nurses, Respiratory Therapist, and Monitor Techs.

D. Educate ~~Licensed Independent Practitioners~~LIP's and Mid-Level Practitioners on orientation.

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~~No More "White Noise": Improving Patient Alarm Management. Retrieved from http://www.aacn.org/wd/chapters/chapterdocs/00312376/websites/docs/Patient%20Alarm%20Management%20Handouts.pdf~~

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A. American Association of Critical Care Nurses (AACN). "Managing Alarm in Acute Care Across the Life Span: Electrocardiography and Pulse Oximetry". Published April 2018. Critical Care Nurse, Vol 38, No. 2. Retrieved from: http://www.aacn.org/clinical-resources/practice-alerts/managing-alarms-in-acute-care-across-the-life-span.

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All revision dates: 04/2020, 10/2017, 11/2015

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board of Directors	Herman Cole: Chairman, Board of Directors	pending
President/CEO	George Mikitarian: President/CEO [AJ]	04/2020
Executive Management Committee	Executive Management Committee [AJ]	04/2020
Medical Executive Committee	Mark Storey [EH]	01/2020
Compliance	Corporate Compliance [NV]	12/2019
Executive Management	Edwin Loftin: SR Vice President/CNO	11/2019
	Michele Fackler: Director, Emergency & Critical Care Services	11/2019

Applicability

Parrish Medical Center

Origination:	*11/2017*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*12/2019*
Next Review:	*3 years after approval*
Areas:	*Periop*
Tags:	*9500, CMS, TJC*
Applicability:	*Parrish Healthcare System-Wide*

Donation After Circulatory Determination Of Death, 9500-2057

POLICY STATEMENT

Parrish ~~Medical Center~~Healthcare (~~PMC~~PHC) recognizes the continuing need for human organs and tissues for transplantation and medical research, and will collaborate with the Organ Procurement Organization to identify and refer all potential donor candidates. Hospital leadership believes that the principles of preservation of quality of life and compassionate delivery of healthcare are inherent in organ and tissue recovery for transplantation and medical research.

In compliance with Federal and State laws, when, based on accepted medial standards, a patient is at, or near death, the hospital President/CEO, or his designee shall, notify the designated organ procurement organization (OPO). The OPO, in accordance with law, shall evaluate the suitability of organ or tissue donation, access the donor registry, and if necessary, request consent from the family of the deceased patient.

PURPOSE

The purpose of this policy is to outline the process, standards, and criteria for Donation after Circulatory Determination of Death (DCDD).

DEFINITIONS

Appropriate candidates for DCDD shall be those patients who meet all the following criteria.

A. The patient has a non-recoverable illness or injury that has caused neurological devastation and/or other system failure resulting in ventilator dependency. For example, patients who are ventilator dependent, or dependent on ventricular assist device, pacemaker or ECMO.

B. The patient has not met criteria for declaration of brain death as set forth by hospital policy.

C. A decision is made with the family and physician to withdrawal mechanical ventilator and all sustaining artificial therapies.

PROCEDURES

A. OurLegacy shall be notified of a hospital referral when there is consideration by family or physician for the withdrawal of mechanical ventilator and all artificial support; and prior to physician discussion with the family regarding withdrawal option. Note: Referral must occur prior to ventilator withdrawal to allow for the

opportunity of organ donation.

B. Potential Organ Donor Evaluation

1. OurLegacy Coordinator will review the medical record to evaluate the patient and determine medical suitability in coordination with OurLegacy Medical Director.
2. If the patient is determined to be a candidate for DCDD, the OurLegacy Coordinator will consult with the physician regarding the timing of family care discussions.
3. The decision to stop treatment should be made prior to any mention or discussion of donation with the patient's family.
4. OurLegacy is not involved in making the decision to withdrawal artificial support.

C. Donor Authorization

1. Following the family and physician's decision to withdraw support, the OurLegacy Coordinator will huddle with bedside care providers in order to assess the timing of the donation discussion, and to collaborate with the care team on a plan to ensure the most compassionate and sensitive approach.
2. The donation discussion is to be conducted by a OurLegacy representative and is to include: modification of DNR decision so that care is not decelerated, explanation of the donation process, options for determining when and where extubation should occur, recovery procedure, arterial line placement, and use of anti-coagulants

D. Patient Management – To facilitate organ recovery, the patient must be hemodynamically supported for organ perfusion until the withdrawal of ventilator support occurs. The OurLegacy Coordinator will request medical consults and laboratory studies to assist in the determination of organ viability and placement. If lungs are being considered, a bronchoscopy will be requested.

E. Withdrawal of Artificial Support – The withdrawal of ventilator support, extubation, and the administration of comfort care medications are performed under the direction of the attending/treating physician or physician designee in accordance with hospital policy. The pronouncing physician must not be directly involved with either the OurLegacy or transplant teams.
Withdrawal shall occur in the operating room or an area nearby. Healthcare professionals in attendance during the removal of ventilator support shall include, patient's attending/treating physician or physician designee, critical care nurse, respiratory therapist, and organ recovery coordinator. Family members may also elect to attend the withdrawal and be present until death occurs. Utmost attention shall be given to protect the dignity and the rights of the donors and their families.
Comfort care medicines are administered by the physician or hospital staff in accordance with hospital policy. Paralytic agents are prohibited. Neither OurLegacy staff nor any member of the transplant team are involved in the determination, guidance, or administration of comfort care medications.

F. Determination of Circulatory Death

1. The attending/treating physician or physician designee shall be in attendance during the removal of ventilator and all artificial support procedures. Death is pronounced after determining that irreversible cessation of all respiratory and circulatory functions have occurred. After the initial cessation of circulation, 5 minutes waiting period must take place prior to the pronouncement of death. Surgical recovery of organs shall not begin until the pronouncement of death.
    a. The three required elements of the criteria for cardio-pulmonary death are observation for not less than five minutes of simultaneous and irreversible:
        i. Unresponsiveness,

ii. Apnea, and

iii. Absent circulation. Loss of circulation denotes no mechanical circulatory function.

b. The irreversible cessation of circulatory function is recognized by persistent cessation of functions during an appropriate period of observation as demonstrated by one of the following:

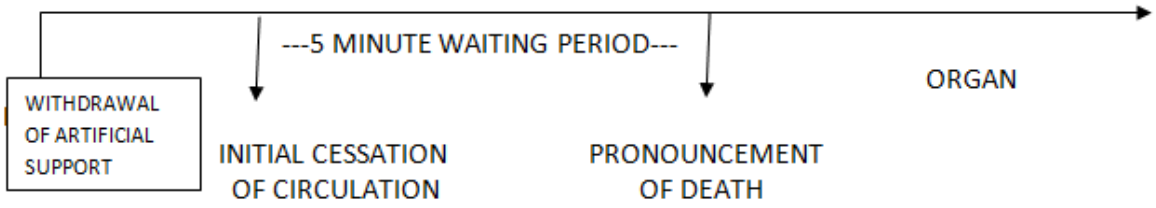
i. Five minutes of ventricular fibrillation, or

ii. Five minutes of electrical asystole (for example, no complexes agonal baseline drift only), or

iii. Five minutes of pulseless electrical as determined by arterial line or Doppler, and noninvasive blood pressure (BP) cuff.

G. Responsibilities

H.



1. OurLegacy:
   a. Medical Screening
   b. Obtains authorization from legally authorized person(s)
   c. Allocates available organs
   d. Collaborates with patient's physician regarding medical management
      Obtains authorization for release of organs, tissues and eyes from Medical Examine (when appropriate)
   e. Supports the donor family throughout the process
   f. Provides all relevant information and timely updates to the respective recovery teams.
2. Patient's Physician or Designee:
   a. Medical management of the patient
   b. Withdrawal of ventilator and all artificial support
   c. Ordering/administering comfort care measures
   d. Determination of death
   e. Administration of anti-coagulant at the time of extubation.
3. Transplant Centers:
   a. Complying with OurLegacy and hospital policies regarding their exclusion from donor management, patient extubation, and determination of death.

I. Donation Process:

1. The attending/treating physician shall document in accordance with hospital policy the basis for the decision to withhold or withdrawal life-sustaining measures in the medical record.

2. Donation option will be presented by a OurLegacy Coordinator following the family's decision to withdraw ventilator and all artificial support.
3. If a reportable medical examiner case, OurLegacy will contact the Medical Examiner to request release for organ, tissue and eye donation.
4. The patient must be maintained on a ventilator and hemodynamically supported for organ perfusion until the withdrawal of support occurs.
5. OurLegacy staff will work collaboratively with the ICU staff, and transplant teams to set up an approximate operating room time that reflects organ placement requirements with the family's wishes.
6. OurLegacy staff will meet with the hospital OR Team (See Department Procedure Organ and Tissue Procurement, 317) to ensure preparedness and smooth process.
7. Patient is transferred to the operating room or nearby area from the ICU with a portable cardiac monitor, arterial pressure monitor, and portable pulse-oximeter under the care of the attending/ treating physician or physician designee and accompanied by a nurse and respiratory therapist after the following issues have been addressed:
    a. Medical suitability for DCDD donation has been determined
    b. Donor authorization has been obtained
    c. OR time is set
    d. Transplant Team is present
8. A DCDD huddle is facilitated by the hospital and OurLegacy staff to ensure:
    a. Confirmation of patient identification
    b. Process for withdrawal
    c. Review of authorization forms
    d. Roles and responsibilities
    e. Discussion regarding outcome plans (pre-determined room)
9. The patient will be surgically prepped and partially draped prior to pronouncement of death if taking place outside the surgical suite.
10. If extubation is to occur in the OR, the transplant center(s) surgical recovery team(s) may be present and drape, but shall not be present in the surgical suite prior to the withdrawal of ventilator support and shall remain outside of the room until death has been declared.
11. If withdrawal occurs outside of the surgical suite, the transplant center recovery team must remain in the surgical suite until the donor is declared and brought into the OR.
12. The withdrawal of mechanical ventilation and the administration of comfort medicines are the responsibility of hospital staff and are performed under the direction of the attending/treating physician or physician designee in accordance with hospital policy.
13. Members of the OurLegacy and transplant teams must not participate in any aspect of the withdrawal process.
14. The OurLegacy Coordinator(s) may remain in the room during withdrawal as a passive observer of the patient's hemodynamics and to:

a. Determine warm ischemic time,

b. Complete organ procurement documentation

c. Make the decision whether to proceed with organ recovery.

15. Death is pronounced following 5 minutes of observed persistent apnea and non-perfusing rhythm by the attending/treating physician or physician designee, who must not be directly involved with either the OurLegacy or transplant teams. The physician will record the date and time of death in the medical record.
16. Following pronouncement, the donor will be transferred by the OurLegacy team to the OR for organ recovery (if not already in the OR).
17. After pronouncement, the family (if present) will be escorted from the area and critical care staff can leave.
18. If the patient does not arrest within designated time frame, he or she is returned to a predetermined assigned room where comfort measures will be maintained. OurLegacy Coordinator is to notify the Attending/Treating Physician and legal authorizing aurthority of the patient's status.
19. Hospital Reimbursement: All OurLegacy charges incurred following declaration of death and authorization obtained for organ recovery should be billed to OurLegacy. Your OurLegacy representative can provide you with the appropriate mailing address.

REFERENCES

A. Florida Statutes (2014). Title XLIV Health Care Advance Directives. §765.101-113, §765.301-309, §765.401, and §765.404.

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C. Joint Commission Standard, TS.01.01.01

D. Centers of Medicare and Medicaid Services, 42 CFR Part 482

E. Management of the Potential Organ Donor in the ICU: Society of Critical Care Medicine/American College of Chest Physicians/Association of Organ Procurement Organization Consensus Statement: Critical Care Medicine (June 2015)

All revision dates: 12/2019, 11/2017

Attachments

image1.png

Approval Signatures

Step Description	Approver	Date
Board of Directors	Herman Cole: Chairman, Board of Directors	pending
President/CEO	George Mikitarian: President/CEO [AJ]	04/2020

Step Description	Approver	Date
Executive Management Committee	Executive Management Committee [AJ]	04/2020
Medical Executive Committee	Joseph Rojas [EH]	11/2019
Compliance	Corporate Compliance [AJ]	10/2019
Executive Management	Edwin Loftin: SR Vice President/CNO	10/2019
	Matthew Graybill: Executive Director Periop/Diagnostic Services	10/2019

Applicability

North Brevard Medical Support, Parrish Healthcare, Parrish Medical Center

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Areas:	*Risk Management*
Tags:	*9500*
Applicability:	*Parrish Medical Center*

Public Notice of Never Events

~~SERIOUS REPORTABLE EVENTS POLICY~~

SERIOUS REPORTABLE EVENTS POLICY

POLICY STATEMENT

Parrish Medical Center is committed to providing a safe and healing experience for each of our patients, which is exemplified by our values: Compassion, Excellence, Integrity, Safety, Loyalty, and Stewardship. However, in the occurrence of a serious reportable event (~~"~~adverse incident, sentinel event, or never event~~"~~), Parrish Medical Center ~~has agreed to the policy provided by the Leapfrog Group~~will use all best efforts to determine the root cause of such event and implement appropriate actions to eliminate the possibility of another such event.

DEFINITIONS

A. Adverse Incident means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which results in one of the injuries defined by Florida Statute[1].

B. Sentinel Event means a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following injuries or actions as outlined by the Sentinel Event Policy from The Joint Commission[2].

C. Never Event means a serious reportable event as listed by the National Quality Forum[3] and as adopted by The Leapfrog Group[4].

PROCEDURES

A. Parrish Medical Center will:

1. verbally apologize to the patient and/or family affected and provide an explanation of the circumstances of the never event;
2. report to at least one of the following agencies within 10 days of becoming aware that the ~~never~~serious reportable event has occurred:
   a. *The Joint Commission as consistent with their Sentinel Event policy*
   b. *State reporting program for medical errors*

~~*Patient Safety Organization;*~~

3. perform a root cause analysis to identify the basic or causal factors that underlay the never event and to improve our systems and processes;
4. waive all costs directly related to the never event and will refrain from seeking reimbursement from the patient or a third party payer for costs related to it;
5. provide a copy of this policy to the patient(s), patient's family, and payers upon their request.
6. interview patient(s) and/or families who are willing and able to gather evidence for the root cause analysis.

REFERENCES

1. *See* §395.1097(5), Florida Statutes 2019
2. https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event-policy-and-procedures/
3. http://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx
4. https://www.leapfroggroup.org/never-events-report-2019

All revision dates: 04/2020, 06/2013

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board of Directors	Herman Cole: Chairman, Board of Directors	pending
President/CEO	George Mikitarian: President/CEO [AJ]	04/2020
Executive Management Committee	Executive Management Committee [AJ]	04/2020
Medical Executive Committee	Mark Storey [EH]	03/2020
Compliance	Corporate Compliance [NV]	03/2020
Executive Management	Chris McAlpine: Sr V.P. Administration Transformation	02/2020
	Lori Thompson: Risk Manager	02/2020

Applicability

Parrish Medical Center