MEMORANDUM

To: Board of Directors

Cc: Bill Boyles, Esquire
Joseph Rojas, M.D.

From: George Mikitarian
President/CEO

Subject: Board/Committee Meetings – December 2, 2019

Date: November 25, 2019

The Pension Committee will meet at 10:00 a.m. in the Executive Conference room.

The Investment Committee will meet at 11:00 a.m. in the Executive Conference room.

The Ad Hoc Credentials Review Committee will meet at 11:30 a.m. where the Committee will review credentialing and privileging files as they relate to medical staff appointment/reappointment.

The Quality Committee will convene at 12:00 p.m., which will be followed by the Budget and Finance Committee, and then Executive Committee meetings.

The Board of Directors will meet in executive session no earlier than 1:30 p.m. Following the Board of Directors Executive Session, the Education Committee and Board of Directors regularly scheduled meeting will be held immediately following, however no earlier than 3:00 p.m.

The Planning Committee meeting has been canceled.

Members:
Stan Retz, Chairperson (January 1, 2016 - December 31, 2019)
Michael Allen, Vice-Chairperson (July 1, 2019 – June 30, 2022)
Chris McAlpine (February 4, 2019 – January 31, 2022)
Julia Reyes-Mateo (July 1, 2019 – June 30, 2022)
Dawn Hohnhorst (April 1, 2019 – March 31, 2022)
Warren Berry (January 1, 2016- December 31, 2019)

PARRISH MEDICAL CENTER
PENSION ADMINISTRATIVE COMMITTEE
DECEMBER 2, 2019 @ 10:00 A.M.
EXECUTIVE CONFERENCE ROOM

CALL TO ORDER

I. Public Comments

II. Review and approval of minutes (October 7, 2019).

Motion: To recommend approval of the October 7, 2019 minutes as presented.

III. Quarterly Pension and 403(b) and 457(b) Investment Reports – Anderson Financial Partners

IV. Pension Membership Renewal for Stan Retz – Mr. McAlpine

Motion: To recommend the Board of Directors approve the renewal of membership for Stan Retz for a three-year term from January 1, 2020 through December 31, 2022.

V. Pension Membership Opening

VI. Adjournment

PARRISH MEDICAL CENTER
PENSION ADMINISTRATIVE COMMITTEE MEETING
OCTOBER 7, 2019

The members of the Pension Administrative Committee met in the Executive Conference Room on October 7, 2019 at 11:02 a.m. The following representing a quorum, were present:

Pension Administrative Committee:
- Stan Retz, Chairperson
- Michael Allen, Vice-Chairperson
- Chris McAlpine
- Dawn Hohnhorst
- Julia Reyes-Mateo
- Warren Berry (absent-excused)

Others Present:
- Kent Bailey, VP Finance
- Natalie Sellers, VP Communications, Community and Corporate Services
- Pamela Perez, Recording Secretary
- David Johnson, MetLife
- Ray Abbruzzese, MetLife

Call To Order

The meeting was called to order by the Chairperson at 11:02 a.m.

Review and Approval of Minutes

The following motion was made by Ms. Hohnhorst and seconded by Mr. Mc Alpine and approved without objection.

***Motion:** To approve the PAC minutes of May 06, 2019 and minutes of the July 11, 2019 Special Meeting as presented.*

Public Comments

No public comments presented

MetLife

Mr. Ray Abbruzzese and Mr. David Johnson from MetLife presented an update to the committee on the 403b plan. The following were highlights of the update:

- Executive Summary
- Plan Assets
- Asset Allocation

It was also requested by the committee to have MetLife contact members that are in the Fixed option fund and meet with them to consider reallocating to a different fund manager to better benefit the member. Going forward it was discussed that all new hires would be enrolled under the target date funds investment.

Discussion ensued the following motion was made by Mr. Allen and seconded by Ms. Hohnhorst and approved without objection.

Motion: ***To approve updating the default investment option to target date funds investment option for new employees.***

Pension Investment Assumption Rate

Mr. Bailey explained to the committee that after the actuary presented at the August Investment Committee meeting it was decided to approve reducing the pension assumption rate for the defined benefit plan from 7.6% to 7.35% for the 10/1/2019 valuation.

Other

Ms. Reyes Mateo inquired if the actuary could provide information for the care partners regarding the freeze of the defined benefit plan. It was recommended to review the original correspondence from when the plan was frozen and update accordingly to disburse to plan members.

Adjournment

There being no further business, the meeting was adjourned at 11:47 a.m.

_____

Stan Retz, Chairman

Members:
Jerry Noffel, Chairperson
Peggy Crooks
Stan Retz

TENTATIVE AGENDA
INVESTMENT COMMITTEE
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, DECEMBER 02, 2019, 11:00 AM
EXECUTIVE CONFERENCE ROOM

CALL TO ORDER

I. Public Comment

II. Review and approval of minutes (August 5, 2019 and September 9, 2019)

Motion: To recommend approval of the August 5, 2019 and September 9, 2019 meeting minutes as presented.

III. ROCHE ADR Purchase – Anderson Financial Partners

IV. Adjournment

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
INVESTMENT COMMITTEE
AUGUST 05, 2019

An Investment Committee of the North Brevard County Hospital District Board of Directors met on August 05, 2019 in the Executive Conference Room. The following members, representing a quorum, were present:

Jerry Noffel, Chairperson
Peggy Crooks
Stan Retz

Others present:

Kent Bailey, Vice President-Finance
Pam Perez, Administrative Assistant
Tim Anderson, Anderson Financial Partners
John Anderson, Anderson Financial Partners
Douglas Lozen, Foster & Foster (via phone)

Call to Order

Mr. Noffel called the meeting to order at 10:36 a.m.

Public Comment

No public comments presented.

Review and Approval of Minutes

The following motion was made by Mr. Retz, seconded by Mr. Noffel, and approved without objection.

Action Taken: Motion to approve the minutes of the May 06, 2019 and June 03, 2019 meeting as presented.

Pension Investment Assumption Rate

Mr. Lozen from Foster & Foster explained to the committee the impact of lowering the investment return assumption on GASB liabilities and expense.

Discussion ensued and the following motion was made by Mr. Retz, seconded by Mr. Noffel, and approved without objection.

Action Taken: Motion to approve reducing the pension assumption rate for the defined benefit plan from 7.6% to 7.35% for the 10/1/2019 valuation.

The committee asked that Anderson Financial research an option for an insurance company to buy out the frozen defined benefit plan.

Market Commentary

John Anderson from Anderson Financial gave a brief market commentary.

Adjournment

There being no further business the meeting adjourned at 11:18 p.m.

_____

Jerry Noffel, Chairperson

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
INVESTMENT COMMITTEE
SEPTEMBER 09, 2019

An Investment Committee of the North Brevard County Hospital District Board of Directors met on September 09, 2019 in the Executive Conference Room. The following members, representing a quorum, were present:

Jerry Noffel, Chairperson
Peggy Crooks
Stan Retz

Others present:

Kent Bailey, Vice President-Finance
Pam Perez, Administrative Assistant
Tim Anderson, Anderson Financial Partners
John Anderson, Anderson Financial Partners
Jeff Goolsby, Moore Stephens Lovelace

Call to Order

Mr. Noffel called the meeting to order at 10:44 a.m.

Public Comment

No public comments presented.

Investment Structure Assessment

The Anderson Financial Partners performed a risk analysis of the portfolio. The below were highlights from the analysis that were discussed:

- Overview of Current Portfolio Managers
- Large Cap Growth
- Returns
- Risk/Return
- Large Cap Value
- Large Cap Value Managers
- Asset Allocation Analysis-Operating Funds
- Asset Allocation Analysis-Pension Plan

- Fee Analysis
- Supplemental Manager Materials

The assessment supports the structure we have now. Mr. Bailey asked if the Committee was comfortable moving to a mutual fund with the current managers. Mr. Retz followed with asking that with the results of the assessment did we need to consider a mutual fund option. Out of the current managers, only 5 funds would need to be converted.

It was decided that no further action needed to be taken at this time. Mr. Bailey thanked the Anderson Financial Partners for their work on the assessment.

Mr. Noffel excused himself from the meeting and appointed Ms. Crooks to chair the remainder of the meeting.

Investment Policy Review

A review was completed and no changes needed.

Adjournment

There being no further business the meeting adjourned at 11:47 p.m.

_____

Jerry Noffel, Chairperson

QUALITY COMMITTEE
Herman A. Cole, Jr. (ex-officio)
Peggy Crooks
Billie Fitzgerald
Elizabeth Galfo, M.D.
Robert L. Jordan, Jr., C.M.
Jerry Noffel
Stan Retz, CPA
Maureen Rupe
Ashok Shah, M.D.
Joseph Rojas, M.D., President/Medical Staff
Jeram Chapla, M.D., Designee
Greg Cuculino, M.D.
Christopher Manion, M.D., Designee
Kiran Modi, M.D., Designee
George Mikitarian (non-voting)

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE
MONDAY, DECEMBER 2, 2019
NOON
EXECUTIVE CONFERENCE ROOM

CALL TO ORDER

I. Approval of Minutes

Motion to approve the minutes of the October 7, 2019 meeting.

II. Vision Statement

III. Public Comment

IV. "My Story"

V. Dashboard Review

VI. Other

VII. Executive Session (if necessary)

ADJOURNMENT

NOTE: IF A PERSON DECIDES TO APPEAL ANY DECISION MADE BY THE QUALITY COMMITTEE 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 CONTACT THE ADMINISTRATIVE OFFICES AT 951 NORTH WASHINGTON AVENUE, TITUSVILLE, FLORIDA 32796, AT LEAST FORTY EIGHT (48) HOURS PRIOR TO THE MEETING. FOR INFORMATION CALL (321) 268-6110. 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 EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE. TO THE EXTENT OF SUCH DISCUSSION, A JOINT PUBLIC MEETING OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT, BOARD OF DIRECTORS EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE AND NORTH BREVARD MEDICAL SUUPORT, INC. SHALL BE CONDUCTED.

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE

A regular meeting of the Quality Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on October 7, 2019 in the Executive Conference Room. The following members were present.

Herman A. Cole, Jr., Chairman
Billie Fitzgerald
Robert L. Jordan, Jr., C.M.
Jerry Noffel
Stan Retz, CPA
Joseph Rojas, M.D., President/Medical Staff
Christopher Manion, M.D.
Gregory Cuculino M.D.
George Mikitarian (non-voting)

Members absent:
Peggy Crooks (excused)
Maureen Rupe (excused)
Elizabeth Galfo, M.D. (excused)
Ashok Shah, M.D. (excused)
Kiran Modi, M.D. (excused)
Jeram Chapla, M.D. (excused)

CALL TO ORDER

Mr. Cole called the meeting to order at 12:10 p.m.

VISION STATEMENT

Mr. Loftin summarized the committee's vision statement.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Mr. Jordan, seconded by Ms. Fitzgerald and approved (8 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **APPROVE THE AUGUST 5, 2019 MEETING MINUTES, AS PRESENTED.**

VISION STATEMENT

Mr. Loftin summarized the committee's vision statement.

PUBLIC COMMENTS

There were no public comments.

MY STORY

Mr. Loftin noted that historically, the *My Story* portion has been about patients healing experiences with PMC. Today he wished to add seven examples of those who make up Parrish Medical Center, and explain how these examples, woven together with the patient's stories, make Parrish Medical Center what it is. Mr. Loftin asked the following seven individuals why they choose PMC, why they choose healthcare and why they do what they do. Mr. Cole stated he chooses to be a part of Parrish Medical Center because it allows him to give back to his community. Ms. Fitzgerald stated she chooses to serve on the Board of Directors to serve her community and because she enjoys her service. Dr. Carmona stated he enjoys his work and the people he serves. Dr. Rojas stated he continues to serve his community because he enjoys Orthopedics, PMC and his community. Mr. Fender stated he continues his career in healthcare with PMC because he has the opportunity to do what he loves here. Ms. Leathers stated she chooses healthcare because she wants to help others, and that she stays with PMC because the mission is near and dear to her heart. Ms. Sellers stated she continues her work in healthcare at PMC because she loves what she does. She noted she has always wanted to do something with a greater purpose and is able to offer healing experiences from another side of healthcare.

THE JOINT COMMISSION STROKE RECERTIFICATION

Mr. Loftin noted as mentioned last month Parrish Medical Center was recertified as a Primary Stroke Center by The Joint Commission. Mr. Loftin summarized the letter Mr. Mikitarian received regarding the recertification and noted PMC has maintained this certification continuously since 2004.

QUALITY DASHBOARD REVIEW

Mr. Loftin reviewed the October Value Dashboard included in the agenda packet and discussed each indicator score as it relates to clinical quality and cost. Copies of the Power Point slides presented are appended to the file copy of these minutes.

SEPSIS

Mr. Graybill presented to the committee on Sepsis and the importance of educating the community about the signs and symptoms. Mr. Graybill noted PMC uses flyers, community presentations and social media outlets as aids in raising awareness and educating the Community. Copies of the Power Point slides presented are appended to the file copy of these minutes.

HCAHPS

Mr. Loftin noted there has been considerable improvement in the hospital HCAHPS scores. Copies of the Power Point slides presented are appended to the file copy of these minutes.

OPIOID SAFETY

Dr. Cuculino shared with the committee that PMC will have a Peer Recovery Support Specialist in the Emergency Department in the coming weeks. He noted that PMC will be the first hospital in Central Florida to provide onsite Peer Recovery Support Specialists.

OTHER

There was no other business brought before the committee.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 1:05 p.m.

Herman A. Cole, Jr.
Chairman

FINANCE COMMITTEE MEMBERS:
Stan Retz, Chairperson
Peggy Crooks, Vice Chairperson
Jerry Noffel
Elizabeth Galfo, M.D.
Robert Jordan
Billie Fitzgerald
Herman Cole (ex-officio)
Christopher Manion, MD.
George Mikitarian, President/CEO (non-voting)
Joseph Rojas, M.D., President/Medical Staff

TENTATIVE AGENDA
BUDGET & FINANCE COMMITTEE MEETING - REGULAR
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, DECEMBER 02, 2019
EXECUTIVE CONFERENCE ROOM
(IMMEDIATELY FOLLOWING QUALITY COMMITTEE)
SECOND FLOOR, ADMINISTRATION

CALL TO ORDER

I. Review and approve of minutes (October 7, 2019)

Motion: To recommend approval of the October 7, 2019 minutes as presented.

II. Public Comments

III. Financial Review – Mr. Bailey

IV. Inter-Local Agreement with Halifax Health – Mr. Bailey

Motion: To recommend to the Board of Directors to approve the attached Inter-local Agreements with Halifax Hospital Medical Center Taxing District.

V. Pension Membership Renewal for Stan Retz – Mr. Bailey

Motion: To recommend the Board of Directors approve the renewal of membership for Stan Retz for a three-year term from January 1, 2020 to December 31, 2022.

VI. Disposal

Motion: To recommend to the Board of Directors to declare the equipment listed in the requests for Disposal of Obsolete or Surplus Property Forms as surplus and obsolete and dispose of same in accordance with FS274.05 and FS274.96.

VII. Executive Session (if necessary)

ADJOURNMENT

NOTE: IF A PERSON DECIDES TO APPEAL ANY DECISION MADE BY THE FINANCE COMMITTEE 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 CONTACT MS. LISA CAVALLERO, EXECUTIVE DIRECTOR, AT 951 NORTH WASHINGTON AVENUE, TITUSVILLE, FLORIDA 32796, AT LEAST FORTY-EIGHT (48) HOURS PRIOR TO THE MEETING. FOR INFORMATION CALL (321) 383-9829 (TDD).

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 FINANCE COMMITTEE. TO THAT EXTENT OF SUCH DISCUSSIONS, A JOINT PUBLIC MEETING OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT BOARD OF DIRECTORS FINANCE COMMITTEE AND THE NORTH BREVARD MEDICAL SUPPORT, INC. SHALL BE CONDUCTED.

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
BUDGET AND FINANCE COMMITTEE

A regular meeting of the Budget and Finance Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on October 7, 2019 in the Executive Conference Room. The following members, representing a quorum, were present:

Stan Retz, Chairperson
Jerry Noffel
Robert Jordan, Jr., C.M.
Billie Fitzgerald
Herman A. Cole, Jr.
Joseph Rojas, M.D
Christopher Manion, M.D.
George Mikitarian (non-voting)

Member(s) Absent:
Peggy Crooks, Vice Chairperson (excused)
Elizabeth Galfo, M.D. (excused)

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. Retz called the meeting to order at 12:41 p.m.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Mr. Jordan, seconded by Dr. Manion and approved (7 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **APPROVE THE AUGUST 5, 2019 MEETING MINUTES, AS PRESENTED.**

PUBLIC COMMENTS

There were no public comments.

PENSION DEFAULT INVESTMENT

Mr. Retz noted a motion for approval from the Pension Committee meeting held earlier in the day. Discussion ensued and the following motion was made by Mr. Jordan, seconded by Mr. Cole and approved (7 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO RECOMMEND TO THE BOARD OF DIRECTORS TO APPROVE UPDATING THE DEFAULT INVESTMENT OPTION TO TARGET DATE FUNDS INVESTMENT OPTION FOR NEW EMPLOYEES.**

FINANCIAL REVIEW

Mr. Bailey summarized the August 2019 financial statements. Mr. Noffel noted he would like to further explore referrals from the VA. Mr. Mikitarian noted Mr. McAlpine and Mr. Waterman will look into this.

STERILE PROCESSING CART WASHER

Mr. Graybill summarized the memorandum contained in the agenda packet relative to the Sterile Processing Cart Washer. Discussion ensued and the following motion was made by Mr. Noffel, seconded by Mr. Cole and approved (7 ayes, 0 nays, 0 abstentions).

ACTION TAKEN**: MOTION TO RECOMMEND THE BOARD OF DIRECTORS TO APPROVE THE PURCHASE OF THE REPLACEMENT STERILE PROCESSING CART WASHER AT A TOTAL COST NOT TO EXCEED THE AMOUNT OF $180,360.00.**

STRETCHER REPLACEMENT PROJECT

Mr. Graybill summarized the memorandum contained in the packet relative to the Stretcher Replacement Project. Discussion ensued and the following motion was made by Mr. Jordan, seconded by Mr. Noffel and approved (7 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: MOTION TO RECOMMEND TO THE BOARD OF DIRECTORS TO APPROVE THE PURCHASE OF THE REPLACEMENT STRETCHERS AT A TOTAL COST NOT TO EXCEED THE AMOUNT OF $169,463.00.

PENSION INVESTMENT ASSUMPTION RATE

Mr. Bailey summarized reducing the Pension Investment Assumption Rate. Discussion ensued and the following motion was made by Mr. Jordan, seconded by Mr. Cole and approved (7 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: MOTION TO RECOMMEND TO THE BOARD OF DIRECTORS TO APPROVE REDUCING THE PENSION ASSUMPTION RATE FOR THE DEFINED BENEFIT PLAN FROM 7.6% TO 7.35% FOR THE 10/1/2019 VALUATION.

DISPOSAL OF SURPLUS PROPERTY

Discussion ensued and the following motion was made by Mr. Jordan and seconded by Mr. Cole and approved (7 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO RECOMMEND THE BOARD OF DIRECTORS TO DECLARE THE EQUIPMENT LISTED IN THE REQUESTS FOR DISPOSAL OF OBSOLETE OR SURPLUS PROPERTY FORMS AS SURPLUS AND OBSOLETE AND DISPOSE OF SAME IN ACCORDANCE WITH FS274.04 AND FS274.96.**

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 1:47 p.m.

Stan Retz
Chairperson

PARRISH
MEDICAL CENTER

MEMORANDUM

To: Budget & Finance Committee

From: Kent Bailey
Vice President, Finance

Subject: **Inter-local Agreement with Halifax Health ("Halifax")**

Date: December 2, 2019

Parrish Medical Center ("PMC") has been approached by Halifax for assistance to them in relieving a potential liability for excess Medicaid funding under the Low-Income Pool ("LIP") program for State Fiscal Year 2015. Through an inter-local agreement, Halifax will designate a portion of its LIP payments to PMC. PMC has worked with Tim Wombles and Michael Bittman, attorneys with Nelson Mullins (formerly Broad and Cassel), and Halifax management to develop the appropriate inter-local agreement, which is attached for your reference.

Under the inter-local agreement, PMC will receive a wire transfer from Halifax in the amount of $1,627,500. PMC will then transfer $1,527,500 to an account identified by Halifax. Parrish will retain the difference of $100,000 for providing care to Medicaid, underinsured and uninsured individuals. The arrangement will be submitted to the Florida Agency for Health Care Administration (AHCA) to reflect a formal reallocation of LIP funds between the two organizations. A similar arrangement was entered into between PMC and Halifax in 2017.

The inter-local agreement provides that Halifax will indemnify PMC for any loss associated with the transaction. The risk of loss for this agreement is very low.

Motion: Recommend to the Board of Directors to approve the attached Inter-local Agreement with Halifax Hospital Medical Center Taxing District.

Should you have any questions or concerns, please feel free to contact me at 321-268-6351 or e-mail me at kent.bailey@parrishmed.com.

Attachment

INTERLOCAL AGREEMENT

THIS INTERLOCAL AGREEMENT, pursuant to Section 163.01, Florida Statutes, is made and entered into this ____ day of _____, 2019, by and between the Halifax Hospital Medical Center Taxing District (Halifax), and the North Brevard County Hospital District, d/b/a Parrish Medical Center (PMC).

Background

On October 19, 2005, the Centers for Medicare and Medicaid Services (CMS) approved the 1115 Research and Demonstration Waiver Application for the State of Florida. On December 8, 2005 the Florida Legislature enacted House Bill 3B, authorizing implementation of the Waiver effective July 1, 2006 with subsequent renewals through June 30, 2022. The Waiver Special Terms and Conditions (Waiver) established the Low Income Pool (LIP) to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. During the State fiscal year ended June 30, 2015 (Demonstration Year 9) ("DY 9"), the LIP consisted of a capped annual allotment of $1 billion. CMS increased the LIP cap to $1.5 billion per year for the State fiscal year ending June 30, 2017 (Demonstration Year 11) through the State fiscal year ending June 30, 2022 (Demonstration Year 16).

Funds in the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Social Security Act. These health care expenditures may be incurred by the State, hospitals, clinics, or other providers for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made), may include premium payments for provider access systems and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS.

Local governments, including hospital taxing districts such as Halifax and PMC, provide funding for the non-federal share of the $1.5 billion LIP distributions. No state funds are included in the appropriations.

This Interlocal Agreement is entered into by Halifax and PMC, public agencies as defined in section 163.01(3)(b), Florida Statutes, in pursuance of the provisions of the Waiver, and pursuant to section 163.01, Florida Statutes.

Agreement

In consideration of the matters contained in this Agreement, and other good and valuable consideration acknowledged by the parties, the parties agree as follows:

1. Halifax will designate $1,500,000.00 of its intergovernmental transfers (IGTs) previously paid to the Agency for Health Care Administration (AHCA) for the period covering Waiver DY 9 as intended for PMC.

2. It is intended that the above action by Halifax (the "designation") will result in a reduction in LIP DY 9 payments to Halifax of $1,627,500.00, and an increase in LIP DY 9 payments to PMC of $1,627,500.00. The designation will be accomplished by a letter or other communication acceptable to AHCA.

3. Immediately upon confirmation that the designation is acceptable to AHCA, Halifax will transfer $1,627,500.00 to an account identified by PMC. Immediately upon receipt of the funds transferred by Halifax, PMC will transfer $1,527,500.00 to an account identified by Halifax.

4. Halifax covenants and agrees that to the extent permitted by law, it shall indemnify, defend and hold harmless PMC and its officers, directors, employees and agents from and against any and all losses, obligations, costs, liabilities, damages, actions, suits, causes of action, claims, demands, settlements, judgments or other expenses, including, but not limited to, reasonable attorneys' fees and expenses, which are asserted against, imposed upon, or incurred or suffered by, such indemnified party and which arise out of or result from this Agreement.

5. Each party shall bear its own costs and attorneys' fees.

6. This Agreement shall inure to the benefit of and be binding on each party's successors, assigns, heirs, administrators, representatives and trustees.

7. The signatories to this Agreement, acting in a representative capacity, represent that they are duly authorized to enter into this Agreement on behalf of the respective parties.

8. This Agreement shall be construed in accordance with the provisions of the laws of Florida. Venue for any action arising from this Agreement shall be in Brevard County, Florida.

9. This Agreement is intended by the parties as a final expression of their agreement with respect to the matters specified therein, is intended as the exclusive statement of the terms of this Agreement, and supersedes and replaces any prior agreements between the parties, whether written or oral. No modification or waiver of any provision shall be valid unless a written amendment to the Agreement is properly executed by the parties.

10. The parties agree to execute such documents as may be necessary to carry out the intent and provisions of this Agreement.

11. By signing this Agreement, each party acknowledges receipt of the other party's Arrangements Policies and Procedures, including the Code of Conduct, Physician Referral and Anti-Kickback and Stark Law policies and procedures ("Policies and Procedures"). Each party hereby certifies that they have been provided the Policies

and Procedures. In the event any employee or agent of either party becomes a Covered Person as defined by the Halifax Health Corporate Integrity Agreement, the parties agree such persons will complete the required training. Furthermore, each party agrees not to violate the Anti-Kickback Statute and the Stark Law with respect to the performance of this Agreement.

12. Halifax acknowledges that once this Agreement is fully executed, PMC will file this Agreement with clerks of the circuit courts in Brevard and Volusia Counties pursuant to section 163.01(11), Florida Statutes.

[The remainder of this page intentionally left blank]

HALIFAX HOSPITAL MEDICAL CENTER TAXING DISTRICT

By: _____ Date:_____
Print or Type Name: Eric M. Peburn
Title: Chief Financial Officer

STATE OF FLORIDA)
) ss
COUNTY OF VOLUSIA)

The foregoing instrument was acknowledged before me this _____ day of _____, 2019 by Eric M. Peburn as Chief Financial Officer for Halifax Hospital Medical center Taxing District.

_____
(Signature of the Notary Public

_____
(Print, Type of Stamp Commissioned Name of Notary)

Personally Known _____ OR Produced Identification _____
Type of Identification Produced _____

NORTH BREVARD COUNTY HOSPITAL DISTRICT
D/B/A PARRISH MEDICAL CENTER

By: _____ Date:_____
Print or Type Name: George Mikitarian
Title: President/Chief Executive Officer

STATE OF FLORIDA)
) ss
COUNTY OF BREVARD)

The foregoing instrument was acknowledged before me this _____ day of _____, 2019 by _____ as Chief Executive Officer for the North Brevard County Hospital District, d/b/a Parrish Medical Center.

_____
(Signature of the Notary Public

_____
(Print, Type of Stamp Commissioned
Name of Notary)

Personally Known _____ OR Produced Identification _____
Type of Identification Produced _____

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
TITUSVILLE, FLORIDA

Request for Disposal of Obsolete or Surplus Property

The assets listed below are considered obsolete, inefficient, or have ceased to serve any useful function. Board approval for disposal is requested.

Asset Description	Asset Control KN #	Purchase Date	Purchase Amount	CE #	Reason for Disposal	Net Book Value (Provided by Finance)	Dept. #
HBO Chamber	KN028483	10/25/04	$148,643.52	02876	Retired	$0	1.319
HBO Chamber	KN027948	11/10/03	$197,697.18	02877	Retired	$0	1.319

Requesting Department: 1.319, Wound Care Center _____ Department Director: _____

Net Book Value (Finance): $0.00 _____ EMC Member: Drew Watson 10/29/19

VP Finance: Kurt Bailey 11/12/19 _____ President/CEO: _____ 11/21/19

Board Approval: (Date) _____ VP Finance Signature _____

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

12/19/18

EXECUTIVE COMMITTEE
Robert L. Jordan, Jr., C.M., Chairman
Herman A. Cole, Jr.
Peggy Crooks
Stan Retz, CPA
Elizabeth Galfo, M.D.
George Mikitarian, President/CEO (non-voting)

DRAFT AGENDA
EXECUTIVE COMMITTEE
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, DECEMBER 2, 2019
2nd FLOOR, EXECUTIVE CONFERENCE ROOM
IMMEDIATELY FOLLOWING FINANCE COMMITTEE

CALL TO ORDER

I. Approval of Minutes

Motion to approve the minutes of the October 7, 2019 meeting.

II. Reading of the Huddle

III. Public Comment

IV. Managed Care/Lab – Mr. Waterman

V. Metrus Payment –Messrs. Loftin & McAlpine

VI. Attorney Report – Mr. Boyles

VII. Other

VIII. Executive Session –Strategic Planning

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, FORSU CH PURPOSES, MAY NEED TO ENSURE A VERBATIM RECORD OF THE PROCEEDINGS IS MADE AND THAT THE RECORDINCLUDES 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 CONTACT THE ADMINISTRATIVE OFFICES, AT 951 NORTH WASHINGTON AVENUE, TITUSVILLE, FLORIDA 32796, AT LEAST FORTY-EIGHT (48) HOURS PRIOR TO THE MEETING. FOR INFORMATION CALL (321) 268-6110.

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EXECUTIVE COMMITTEE

A regular meeting of the Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on October 7, 2019 in the Executive Conference Room. The following members were present:

Robert L. Jordan, Jr., C.M., Chairman
Herman A. Cole, Jr.
Stan Retz
George Mikitarian (non-voting)

Members Absent:

Elizabeth Galfo, M.D. (excused)
Peggy Crooks (excused)

Also in attendance, and appointed to serve on Executive Committee for this meeting only, were the following Board members:

Billie Fitzgerald
Jerry Noffel

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. Jordan called the meeting to order at 1:49 p.m.

PUBLIC COMMENT

There were no public comments.

RADIOLOGY SERVICES

Mr. Waterman updated the committee on the Request for Information for radiology services, adding that he has had two responses from Alliance and from Radiology Imaging Association. Mr. Waterman noted at this time he would like to explore further discussion with Radiology Imaging Association and that this will not be a replacement for our current radiology service provider, but rather to support them and augment services currently provided.

ATTORNEY REPORT

Mr. Boyles summarized a report he forwarded to committee members regarding CEO Compensation. He noted that Mr. Mikitarian again elected to waive any compensation increase due

this year under the terms of his Employment Agreement. Mr. Cole noted he would like to discuss this further with Mr. Boyles before any final decision is made. Discussion ensued and the following motion was made by Mr. Cole, seconded by Mr. Retz and approved (4 ayes, 0 nays, 0 abstentions). Mr. Jordan recused himself from this vote.

***ACTION TAKEN*: MOTION TO RECOMMEND TO THE BOARD OF DIRECTORS TO ACCEPT THE CEO COMPENSATION REPORT AS WRITTEN.**

OTHER

There was no other business to discuss.

OPEN FORUM FOR PHYSICIANS

No physicians spoke.

ADJOURNMENT

There being no further business to discuss, the committee adjourned at 2:03 p.m.

Robert L. Jordan, Jr., C.M.

Chairperson

EDUCATION COMMITTEE
Billie Fitzgerald, Chairperson
Herman A. Cole, Jr. (ex-officio)
Elizabeth T. Galfo, M.D.
Maureen Rupe
Ashok Shah, M.D.
Joseph Rojas, M.D.
George Mikitarian, President/CEO (Non-voting)

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE
MONDAY, DECEMBER 2, 2019
IMMEDIATELY FOLLOWING EXECUTIVE SESSION
FIRST FLOOR CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Review and Approval of Minutes

Motion to approve the minutes of the October 7, 2019 meeting.

II. Community Health Presentation – Ms. Weaver

III. Other

IV. Executive Session (if necessary)

ADJOURNMENT

NOTE: IF A PERSON DECIDES TO APPEAL ANY DECISION MADE BY THE EDUCATION COMMITTEE 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 CONTACT THE ADMINISTRATIVE OFFICES AT 951 NORTH WASHINGTON AVENUE, TITUSVILLE, FLORIDA 32796, AT LEAST FORTY-EIGHT (48) HOURS PRIOR TO THE MEETING. FOR INFORMATION CALL (321) 268-6110.

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 EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE. TO THE EXTENT OF SUCH DISCUSSION, A JOINT PUBLIC MEETING OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT, BOARD OF DIRECTORS EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE AND NORTH BREVARD MEDICAL SUUPORT, INC. SHALL BE CONDUCTED.

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE

A regular meeting of the Educational, Governmental and Community Relations Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on October 7, 2019, at 3:02 p.m. in the Executive Conference Room, Second Floor. The following members were present:

Billie Fitzgerald, Chairperson
Herman A. Cole, Jr.
Joseph Rojas, M.D.
George Mikitarian (non-voting)

Member(s) Absent:
Elizabeth T. Galfo, M.D. (excused)
Maureen Rupe (excused)
Ashok Shah, M.D. (excused)

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

CALL TO ORDER

Ms. Fitzgerald called the meeting to order at 3:02 p.m.

REVIEW AND APPROVAL OF MINUTES

The following motion was made by Mr. Jordan, seconded by Mr. Cole, and approved (3 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO APPROVE THE MINUTES OF AUGUST 5, 2019 AND JUNE 3, 2019, AS PRESENTED.**

ACHE

Mr. Loftin presented to the committee his ACHE presentation on applying safety across the board. He detailed the Culture of Safety, Transitions in Care and Integrated care with the Joint Commission. Mr. Loftin stated this process begins with the Governance Commitment, continues with the people, process and technology, and must occur throughout the continuum of the person and family health journey.

BOARD ASSESSMENT QUESTIONNAIRE

Mr. Lifton advised that he will be working on the Board Self-Assessment. He distributed questionnaires to the Board and stated he will return in November and share the results of the questionnaire.

OTHER

No other items were presented.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 3:30 p.m.

Billie Fitzgerald
Chairperson

DRAFT AGENDA
BOARD OF DIRECTORS MEETING - REGULAR MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
DECEMBER 2, 2019
NO EARLIER THAN 3:00 P.M.,
FOLLOWING THE LAST COMMITTEE MEETING
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Pledge of Allegiance

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

III. Approval of Agenda

IV. Review and Approval of Minutes (October 7, 2019 Regular Meeting)

V. Recognitions(s)

VI. Open Forum for PMC Physicians

VII. Public Comments

VIII. Unfinished Business

IX. New Business

A. North Brevard Medical Support, Inc, Liaison Report –Mr. Retz

B. Environment of Care Annual Review –Mr. Loftin

Motion: To approve the Annual Environment of Care Report as presented.

C. Motion to Recommend the Board of Directors approve the Organ, Tissue, and Eye Donation policy, as presented.

D. Motion to Recommend the Board of Directors approve Policy 9500-8008, Patient Safety Plan, as presented.

E. Motion to Recommend the Board of Directors approve Policy 9500-2032, Patient Identification Wristbands, as presented.

F. Motion to Recommend the Board of Directors approve the Patients Leaving Against Medical Advice (AMA) policy, as presented.

G. Motion to Recommend the Board of Directors approve Policy 9500-8012, Risk Management Program & Plan, as presented.

H. Motion to Recommend the Board of Directors approve Policy 9500-2035, Ethics, as presented.

X. Medical Staff Report Recommendations/Announcements – Dr. Rojas

Resignations – **For Information Only**

1. **Benjamin Nettleton, DO – Family Medicine**
2. **Laura Costa, APRN – Hospitalist**

XI. Public Comments (as needed for revised Consent Agenda)

XII. Consent Agenda

A. Finance

1. To recommend to the Board of Directors to approve the Inter-local agreements with Halifax Hospital Medical Center Taxing District.

2. To recommend to the Board of Directors to approve the renewal of membership for Stan Retz for a three-year term from January 1, 2020 through December 31, 2022.

3. To recommend to the Board of Directors to declare the equipment listed in the requests for Disposal of Obsolete or Surplus Property Forms as surplus and obsolete and dispose of same in accordance with FS274.05 and FS274.96.

XI. Committee Reports

A. Quality Committee – Mr. Cole

B. Budget and Finance Committee – Mr. Retz

C. Executive Committee – Mr. Jordan

D. Educational, Governmental and Community Relations Committee – Ms. Fitzgerald

E. Planning, Physical Facilities & Properties Committee (Did Not Meet)

XII. Process and Quality Report – Mr. Mikitarian

A. Other Related Management Issues/Information

B. Hospital Attorney - Mr. Boyles

XIII. Other

XIV. Closing Remarks – Chairman

XV. Executive Session (if necessary)

XVI. 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.

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 October 7, 2019 in Conference Room 2/3/4/5, First Floor. The following members were present:

Herman A. Cole, Jr., Chairman
Stan Retz
Jerry Noffel
Billie Fitzgerald
Robert L. Jordan, Jr., C.M.

Member(s) Absent:
Peggy Crooks (excused)
Elizabeth Galfo, M.D. (excused)
Maureen Rupe (excused)
Ashok Shah, M.D (excused)

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 3:30 p.m.

PLEDGE OF ALLEGIANCE

Mr. Cole led the Board of Directors, staff and public in reciting the Pledge of Allegiance.

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 Ms. Fitzgerald and approved (5 ayes, 0 nays, 0 abstentions).

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

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Mr. Jordan, seconded by Ms. Fitzgerald and approved (5 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO APPROVE THE AUGUST 5, 2019 MEETING MINUTES AS PRESENTED.**

RECOGNITIONS

There were no recognitions.

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

Discussion ensued and the following motion was made by Mr. Fitzgerald, seconded by Mr. Jordan and approved (5 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: MOTION TO RECOMMEND THE BOARD OF DIRECTORS APPROVE POLICY 9500-7022, HEALING WORK ENVIRONMENT & STANDARDS OF BEHAVIOR (NON-DISCRIMINATION, ANTI-HARASSMENT & BULLYING, ROMANTIC ASSOCIATIONS), AS PRESENTED.

Discussion ensued and the following motion was made by Mr. Jordan, seconded by Ms. Crooks and approved (5 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: MOTION TO RECOMMEND THE BOARD OF DIRECTORS APPROVE POLICY 9500-165, VEHICLE SAFETY PROGRAM, AS PRESENTED.

Discussion ensued and the following motion was made by Mr. Jordan, seconded by Mr. Retz and approved (5 ayes, 0 nays, 0 abstentions).

MEDICAL STAFF REPORT RECOMMENDATIONS/ANNOUNCEMENTS

Resignations – **For Information Only**

1. Jennifer Ayrey, APRN – AHP/Family Practice
2. Diego Yangco, MD - Hospitalist

PUBLIC COMMENTS

There were no public comments regarding the revised consent agenda.

CONSENT AGENDA

Discussion ensued regarding the consent agenda, and the following motion was made by Mr. Jordan, seconded by Mr. Retz and approved (5 ayes, 0 nays, 0 abstentions).

***ACTION TAKEN*: MOTION TO APPROVE THE FOLLOWING REVISED CONSENT AGENDA ITEMS:**

A. Finance

1. To recommend to the Board of Directors to approve the purchase of the replacement Sterile Processing Cart Washer at a total cost not to exceed the amount of $180,360.00

2. To recommend to the Board of Directors to approve the purchase of the Replacement Stretchers at a total cost not to exceed the amount of $169,463.00.

3. To recommend to the Board of Directors to approve reducing the pension assumption rate for the defined benefit plan from 7.6% to 7.35% for the 10/1/2019 valuation.

4. To recommend to the Board of Directors to declare the equipment listed in the requests for Disposal of Obsolete or Surplus Property Forms as surplus and obsolete and dispose of same in accordance with FS274.05 and FS274.96.

5. **To recommend to the Board of Directors to approve updating the default investment option to target date funds investment option for new employees**.

B. Executive

1. **To recommend to the Board of Directors to accept the CEO compensation report as written.**

COMMITTEE REPORTS

Quality Committee

Mr. Cole reported all items were covered during the meeting.

Budget and Finance Committee

Mr. Retz reported all items were covered during the meeting.

Executive Committee

Mr. Jordan reported all items were covered during the meeting.

Educational, Governmental and Community Relations Committee

Ms. Fitzgerald reported the Education Committee did not meet.

Planning, Physical Facilities and Properties Committee

Mr. Jordan reported the Planning Committee did not meet.

PROCESS AND QUALITY REPORT

No additional information was presented.

Hospital Attorney

Legal counsel had no report.

OTHER

No other business was discussed.

CLOSING REMARKS

Mr. Cole noted that the Foundation Gala will be held Saturday the 12th and that he hoped to see everyone there.

OPEN FORUM FOR PUBLIC

No members of the public spoke.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 3:35 p.m.

Herman A. Cole, Jr.
Chairman

ENVIRONMENT OF CARE

2019

ANNUAL REPORT

By

Lori Thompson, Interim Environment of Care Task Force Chair

December 2, 2019

TABLE OF CONTENTS

I. ENVIRONMENT OF CARE (EOC) EXECUTIVE SUMMARY:

A. Code Purple: Hurricane Dorian skirted the east coast of Florida between September 1 and 4, 2019. Parrish Healthcare (PHC) called a Code Purple effective September 2 and activated incident command. The current Emergency Plan was utilized and appropriate personnel were available throughout the event. At no time was there a need to discuss or activate the evacuation plan. Code Purple was effectively complete on September 4 at 8:00 am with the relief team on duty at 12 noon that day.

Actions Taken:

1. Opened Incident Command
2. Utilized technology available, i.e. cell phones, Tiger Text, iCare for regular updates[3].
4. Explored opportunities for system wide improvements in post event meetings.

B. Code Yellow: PHC's Emergency Plan was partially activated on four (4) occasions for patients arriving via private vehicle to the Emergency Department with gunshot wound(s).

II. EOC SCOPE:

EOC scope includes all PHC inpatient and ambulatory clinical sites. EOC management plans ensure required areas are monitored and evaluated for hazards. EOC Management Plans address issues related to patient, visitor, care partner and medical staff safety. EOC Management Plan Evaluations and Management Plans are annually reviewed and approved by the EOC Task Force, PHC Administration, and the hospital board. Further, the Organization's Emergency Management Plans are reviewed and approved by the Brevard County Department of Emergency Management.

All PHC departments provide EOC services which include but are not limited to:

A. Plant Services (Maintenance)
B. Environmental Services (Housekeeping, Hazardous Waste Pickup)
C. Security
D. Clinical Equipment
E. Food and Nutrition
F. Acute Care Services
G. Other clinical and non-clinical support areas

The EOC Chairman directs the EOC Task Force, a key committee. Improvements and changes are noted in 2019 Management Plan Evaluations, and are incorporated into 2020 Management Plans which will be presented to the Board in early 2020.

Elements of EOC management include:

- **A.** Plans, Evaluations, and Performance Improvement.
- **B.** Orientation & Education for new PHC employees.
- **C.** Annual Education current employees.
- **D**. Employee Health Program and Worker Compensation.
- **E.** Safety & Security Management.
- **F.** Life Safety (Protection of PHC assets from fire and the products of combustion).
- **G.** Emergency Preparedness.
- **H.** Waste Management and Hazard Surveillance.
- **I.** Clinical Equipment including FDA Equipment Recalls, Reporting, and Failure Analysis.
- **J.** Utility Management.

III. STATEMENT OF CONDITIONS:

PHC's Statement of Conditions[1] and The Joint Commission (TJC) electronic Statement of Conditions are maintained, reviewed, evaluated, and revised when necessary by the EOC Task Force Chairman. In 2017, TJC required EOC Life Safety defects to be corrected within 60 days of identification.

IV. MANAGEMENT PLAN OBJECTIVES:

The primary objective of the Parrish Health Care (PHC) EOC program[2] is safe, functional and effective environment for patients, care partners and visitors. The EOC Program encompasses the following seven programs/areas: is to Plan objectives are designed to minimize adverse occurrences through recognition, evaluation, and elimination of workplace safety hazards. The EOC Task Force strives to be proactive in addressing and eliminating safety hazards, and being in compliance.

Evaluation of EOC Management Plan Objectives for 2019 are complete, as follows:

Plan	2019 Objectives	Met/ Not Met	Comments
Employee Safety	1. Minimize safety hazards by continuing EOC rounds at regular intervals	1. Met	
	2. Improve worker safety by continuing to monitor employee health program.	2. Met	
	3. Implement a worker injury prevention and investigation program.	3. Met	
	4. Improve worker safety by comprehensive new-hire and department specific safety hazard job orientation.	4. Met	

Plan	2019 Objectives	Met/ Not Met	Comments
Life Safety	1. Educate Care Partners as to appropriate Life Safety actions with "RACE" and "PASS". 2. Conduct required fire drills and re-drills required by CMS/TJC/AHCA. 3. Ensure PHC are in compliance with 2012 NFPA life safety codes with EOC Rounds. 4. Ensure all Care Partners receive fire prevention education annually. 5. Maintain effective smoke abatement and fire extinguishment equipment.	1. Met 2. Met 3. Met 4. Met 5. Met	
Hazardous Materials & Waste Management	1. Maintain a high level of awareness among Care Partners handling hazardous, chemical, bio-medical, and nuclear waste. 2. Ensure competent Care Partners conduct regular Hazardous Waste, Bio-medical, and Radioactive Holding Room safety inspections.	1. Met 2. Met	
Security Management	1. Conduct regular security patrols throughout all PHC facilities. 2. Identify, develop, educate, and implement security practices. 3. Investigate, manage, and address issues concerning security and safety. 4. Monitor use of identification badges by physicians, care partners, and vendors. 5. Ensure Security Officers responding to hazardous spills are properly trained.	1.Unmet 2. Unmet 3. Unmet 4. Unmet 5. Unmet	1. Unable to verify and no outcome threshold found 2 – 5. Due to departmental changes there is no evidence of compliance with these measures. Further, there are no outcome thresholds defined.

Plan	2019 Objectives	Met/ Not Met	Comments
01Emergency Management	1. Ensure PHC readiness to provide medical support to the community and other healthcare facilities when needed.	1. Met	1. Actual events tested the system that overall worked well.
	2. Maintain communication with Brevard County Emergency Operations Center in Rockledge, Florida.	2. Met	
	3. Ensure that PHC's emergency response plans correspond to the National Incident Management System[3] (NIMS).	3. Met	3. Resources to assure this are unavailable at present
	4. Maintain readiness and effective levels of Care Partner NIMS training to respond to external or internal disasters.	4. Unmet	4. No NIMS training recorded this year
Clinical Equipment	1. Ensure PHC medical equipment is maintained, safe and reliable.	1. Met	
	2. Ensure PHC Care partners safely use Clinical Equipment.	2. Met	2. No known reports of user error in equipment pulled for repair
	3. Ensure PHC Care Partners know whom to report Clinical Equipment problems.	3.Met	
	4. Ensure PHC Care partners know how to determine if Clinical Equipment has been maintained properly.	4. Met	4. Unclear the steps in this process, no outcome threshold determined or measured
Utility Management	1. Ensure PHC utilities are maintained appropriately.	1. Met	
	2. Respond to PHC utility outages in a timely fashion.	2. Met	
	3. Provide reliable utility services to Care Partners and PHC facilities.	3.Met	
	4. Ensure back-up utility equipment is available and maintained correctly.	4. Met	
	5. Ensure adequate potable water is available.	5. Met	

[1] See PHC Policy 9500-4013 for *Statement of Conditions* approval qualifications.

[2] See PHC Policy 9500-4013 for more information.

[3] See PHC Policies 9500-4010 & 9500-4015 for more information

V. MANAGEMENT PLAN STANDARDS:

In addition to the evaluation of EOC Management plans for completing objectives and monitoring performance indicators (PI), an evaluation of meeting standards of acceptable practice was conducted, as follows:

A. EMPLOYEE SAFETY MANAGEMENT

1. EOC Task Force met at least quarterly?	Yes
2. EOC Rounds conducted at least semi-annually for all clinical areas?	Yes
3. EOC Rounds conducted annually for all non-clinical areas?	Yes
4. Employee Safety Plan reviewed by EOC quarterly?	Yes

B. LIFE SAFETY MANAGEMENT

1. PHC Fire Plan approved during 2019 by TFD Fire Marshal?	Yes
2. Required fire drills, one per shift per quarter, completed?	Yes
3. Interim Life Safety Measures were implemented as needed?	Yes
4. Life Safety Plan PI was reviewed by EOC quarterly?	Yes

C. HAZARDOUS MATERIALS AND WASTE MANAGEMENT

1. All policies/programs are up to date?	Yes
2. SDS Information is current and available?	Yes
3. Chemical spills are reported and handled properly?	Yes
4. Hazardous chemicals were disposed of properly?	Yes
5. Hazardous Mat/Waste PI reviewed quarterly by EOC Task Force?	Yes

D. SECURITY MANAGEMENT

1. Safety & Security Management Plans/policies were evaluated and updated?	Yes[1]
2. Care Partners in sensitive areas were educated on the security issues?	Yes
3. Security rounds were conducted at regular intervals?	Yes
4. The Security Plan PI was reviewed by EOC Task Force quarterly?	Yes

E. EMERGENCY MANAGEMENT

1. Emergency Management Plans were evaluated and updated?	Yes
2. Consolidated Emergency Management Plan approved by the B.E.O.C.?	Yes
3. PHC's Emergency Plan was activated at least twice?	Yes
4. Plan activations were critiqued and follow-up actions were addressed?	Yes
5. Management Plan PI's were reviewed by the EOC task force quarterly?	Yes

F. CLINICAL EQUIPMENT MANAGEMENT

1. Preventive maintenance program addresses risk and reliability?	Yes
2. A current list of all clinical equipment is maintained?	Yes
3. Quality Risk Management (QRM) was notified of equipment problems?	Yes
4. Clinical Equipment Plan PI was reviewed by EOC Task Force quarterly?	Yes

G. UTILITY MANAGEMENT

1. *The* Building Maintenance Program addresses risk and reliability? Yes
2. A current list of utilities is maintained by Plant Services? Yes
3. Failure procedures are developed and communicated to Care Partners? Yes
4. Outages and shutdowns are communicated to Care Partners? Yes
5. Utilities Management Plan PI reviewed By EOC Task Force quarterly? Yes

VI. MANAGEMENT PLAN EFFECTIVENESS:

Plan	Discussion	Actions/Follow-up
Worker Safety	**A)** Lost Work Day Rate (LWDR) & Restricted Work Day Rate will continue as performance indicator (PI).	**A)** Reduction in *LWDR* indicators & safety programs continue in an effort to get to Zero for further savings in insurance & worker's comp. costs. Evidence of LWDR is unavailable at this time.
	B) EOC Rounds were conducted on a regular basis in 2019in the hospital	**B)** Weekly EOC Rounds for employee safety will continue in 2020; however, this measure will be retired.
Life Safety	**A)** Review the 2018 fire door assessment and make recommendations for a repair or replacement program	**A)** This item was to be completed in 2019. Full evaluation by the new team will take place in the first quarter of 2020
	B) Revision of the Fire Safety policy will be implemented to address identified failures and overlooked processes to assure employee safety	**B)** Completion of the revision along with staff education begins in January 2020 with completion by February 29, 2020
Hazardous Materials & Waste Management	**A)** Environmental Services (EVS) care partners retrieve hazardous materials & bio-medical waste from regulated (RCRA) areas. In the 2018 evaluation, it was determined that nursing was not appropriately using the correct waste stream. Education was proposed for 2019	**A)** In May 2019, Clinical Education held class(es) for Nurses and CNAs regarding the waste streams. Additionally, new hires are provided education and all are provided with a flow chart of the waste stream process, Assessment of improvement is unavailable at this time.
Security	**A)** All visitors entering the hospital through any door were tracked.	**A)** Change in monitoring to: 1. Assure 100% of staff is trained in the management of aggressive behavior by the end of March 2020 2. Verified rounds to each department in the hospital by one officer once per shift – expected outcome 80%

Emergency Management	**A**) Replacement incident command is in Mission Control	**A**) Use of Incident Command during Hurricane Dorian proved effective, edits to the plan will be reviewed by EOC task force with reported needs for any changes to the plan known by 1/31/2020
	B) If contact with staff is necessary in Code Yellow, Brown, or Purple, decisions on who and when will be made by the respective leaders and the use of telephone trees implemented	**B**) Other technology readily available, specifically Tiger Text, and email were available to the organization. Updated messages were sent vial electronics and a central number for staff to call were available during Hurricane Dorian
Utility Management	**A)** 100% completion of Life Safety preventative maintenance work orders is critical to the EOC.	**A)** 100% completion of preventative maintenance work orders were tracked as a PI. This goal was met in 2019
	B) Utility PI for 2019 will be tracking blocked sewer blockages and RPT in facility	**B)**. No Serious sewage blockages in 2019. New goal to be defined in EOC task Force in January 2020
	C) In 2019 an opportunity was identified for the prevention of Legionnaires	**C)** For 2020: Assess, evaluate, implement procedures and processes to prevent waterborne illness
Clinical Equipment	**A)** Life support completion including but not limited to ventilators defibrillators, anesthesia, etc.is essential	**A)** For 2019, 100% of preventative maintenance was completed for ALL Life Support equipment
	B) PI Monitoring of defibrillator PM battery testing will replace bed repairs for 2019	**B)** No batteries failures for 1st 3 Qtrs. of 2019

VII. EOC ANNUAL PLAN EVALUATIONS AND INDICATORS:

A. Environmental and Worker Safety Management Plan Evaluation 2020

By: Jean Hallett, COHN, Employee Health
December 2, 2019

I PURPOSE

The Environmental and Worker Safety Management plan is based on the mission, vision, and values of PHC and is designed, taught, implemented, measured, assessed for effectiveness, changed and improved to provide a physical environment free of hazards and to decrease the risk of worker injuries.
Consistent with the mission the governing body, medical staff and administration have established and provide ongoing support for the Environmental and Worker Safety Management Plan.

II SCOPE

The Environmental and Worker Safety Management Plan describes the programs used to design, implement and monitor a program to manage safety for staff, visitors and patients.

This program is applied to all PHC personnel and facilities.

III FUNDAMENTALS

Department heads and managers need appropriate information and training to develop an understanding of safe working conditions and safe work practices within their area of responsibility.

Safe working conditions and practices are established by using knowledge of safety principles to educate staff, design appropriate work environment, purchase appropriate equipment and supplies and monitor the implementation of the processes and policies.

Safety is dynamic. Regular evaluation of the environment for work practices and hazards is required to maintain a current relevant safety program. The program should change as needed to respond to identified risks, hazards and regulatory compliance issues.

IV OBJECTIVES

A. Minimize safety hazards by conducting Safety Surveillance Inspections.
B. Improve worker safety through education, which includes general safety topics covered at employee orientation, body mechanics, lifting techniques, safe patient handling with use of equipment, Standard Precautions for infection control, etc. Department specific safety issues and specific job related hazards are covered in the employee departmental orientation.
C. Improve worker safety based on organization experience, applicable laws and regulations, and accepted practice. This includes monitoring the employee health program and implementing a worker injury prevention and investigation program.

V ORGANIZATION AND RESPONSIBILITY

A. It is the responsibility of the Employee Health Nurse and the Safety officer, to monitor the effectiveness of the safety program, in line with organizational experience, applicable laws and regulations and accepted local practice. The Employee Health Nurse responsibilities include maintaining a safe physical environment, reducing the risk of worker injuries during staff activities, monitoring the employee health program and reviewing departmental safety policies and procedures as requested, as well as maintaining an injury prevention and investigation program. The online employee incident form, which is found under RL Solutions, demands more details of the incident and managers will be automatically notified and should investigate each incident along with the Employee health nurse.

B. The objectives, scope, performance and effectiveness of the plan are reviewed annually by the EOC Task Force

VI PERFORMANCE MEASURE/MONITORING

A. The performance measurement process is one part of the evaluation of the effectiveness of the Worker Safety Management Plan. A performance indicator has been established to measure at least one important aspect of the program.

B. The following performance measure will continue to be implemented for CY 2020:

1. Monitor and track employee lost time and restrictive days due to any work related incident or injury.
2. The threshold for lost time days will remain at zero as we strive for zero lost time days.

VII PROCESSES OF THE WORKER SAFETY MANANGMENT PLAN

A. The Environmental and Worker Safety Management Plan provides for reporting and investigating all incidents of occupational illness and personal injury.

All injuries and occupational illnesses are reported through the hospital incident reporting system. Human Resources in collaboration with Infection Control, the Safety Officer and the employee's manager will investigate major incidents and illnesses. The Employee Health Nurse will review incidents or illnesses that result in investigation. It is the responsibility of PHC care partners to report an incident or illness at the time of the occurrence.

B. Safety standards are maintained on all outside PHC grounds equipment used at all PHC facilities. Each PHC department is responsible for maintaining and managing its area and equipment in a safe manner, through preventative maintenance work orders and departmental monitoring.

C. Risk assessment is conducted that proactively evaluates the impact of buildings, grounds, equipment and occupants, and internal systems on patient and public safety.

D. Environmental Tours, Security Rounds, and Maintenance Rounds, proactively monitor and assess buildings, grounds and equipment to reduce risk to the public and workers. Patient Safety is covered under PHC Policy 9500-224.

E. Safety issues are examined by appropriate representatives from administration, nursing, physicians, clinical services and support areas.

The EOC Task Force has representatives from Administration. Appropriate managers represent all areas of the EOC.

F. All incidents of property damage, occupational illness and worker or visitor injury are investigated.

Incidents are reported through the hospital incident reporting system. All worker/visitor incidents are investigated by the Employee Health Nurse, Security Officer, Infection Control or QRM. The Employee Health Nurse and the EOC Committee review incidents that result in an investigation. It is the responsibility of all staff to report incidents to their immediate Supervisor, who reports the incident to the Employee Health Nurse, Security Supervisor, or Infection Control Preventionist as appropriate, as soon as possible after the incident, but no more than 48 hours later.

G. Ongoing hazard surveillance,
Environmental Tours, security rounds, and departmental monitoring of hazards provide a comprehensive and ongoing surveillance program.

For detailed information concerning Policies for Environmental & Worker Safety, see PHC Policy 9500-61

B. 2019 Life Safety Management Plan Evaluation

By: Ted Bryant, Interim Director of Facilities
December 2, 2019

Scope: The PHC Life Safety Management Plan promotes a safe, controlled, healing environment in all Parrish Medical Center's facilities, owned, leased, or rented, and includes all PHC care partners. **The 2019 Life Safety Management Plan was deemed effective by the EOC Task Force.**

The First Objective is to educate all care partners as to actions that must take place when a Life Safety event occurs, as indicated by the acronym, "**RACE**"; Rescue, Alarm, Confine, Extinguish/Evacuate, and "**PASS**": Point, Aim, Squeeze, Sweep. Life Safety education is required during initial orientation with computer based courses for all new care partners. Current care partners are required to annually complete computer-based learning on Life Safety.

The Second Objective is to hold three (3) fire drills per quarter per shift, in rotating areas, in PHC's main hospital. One (1) fire drill per quarter is held in all other PHC buildings. Additional fire drills are held to meet ILSM requirements dictated by construction, equipment or system failures and makeup (learning) drills as dictated by unit performance.

The Third Objective is to ensure the competency of all care partners regarding life safety. New care partners are introduced to Life Safety measures by the Security Manager during general orientation. Additionally, new hires are assigned computer based courses on Life Safety to be completed in the first 90 days of hire. Current PHC care partners must complete a life safety computer-based learning course annually.

Performance Indicator (PI): For 2020 EOC will monitor:

1. The number of medical gas valves blocked – expected outcome: None.
2. RPT safety checks (power strips)To assure electrical safety – expected outcome: no "daisy chaining" or overloading of power strips. No power strips in patient care areas.

2020 Plan Changes: Due to changes in leadership, any changes to the current plan will be presented to the Board not later than the Board's February meeting

C. 2017 Hazardous Materials & Waste Management Plan Evaluation

By: Taylor Ray, Manager
December 3, 2018

Scope: The Hazardous Materials & Waste Management Plan scope, objectives, and performance indicators are reviewed annually, and applied to all facilities owned and operated by Parrish Medical Center (PHC). Plan results provide an indication of plan effectiveness. **The 2019 Hazardous Materials Waste Management Plan was deemed effective by the EOC Task Force.**

It is the intent of the EOC Hazardous Materials Management Plan to promote a safe, controlled, and comfortable environment of care that is compliant with Federal, State, County, and Local regulatory laws. Compliance is mandated by several accrediting agencies, and applies to hazardous materials in use or generated by all facilities owned, operated, or leased by PHC. Hazardous Materials and Waste Management Program responsibilities are divided among the various departments contributing to PHC's waste stream, and the departments that collect the waste stream. Departments who contribute to the PHC waste stream

must appoint Hazardous Waste Material Officers for their departmental waste streams.

The Clinical Laboratory is a major contributor of chemical hazardous waste to PHC's waste stream. The Clinical Laboratory Safety Officer will manage the Clinical Laboratory Chemical Hazardous Waste stream in 2019. To ensure safe storage, the Environmental Services Manager will conduct and document weekly safety inspections of the Chemical Hazardous Waste Holding Room on the hospital's back dock, including the process of storing, labeling, and preparing for shipment of hazardous waste to disposal sites.

Summary reports will be presented at regular intervals to the EOC Task Force, along with problems, solutions, and recommendations.

The First Objective: to ensure annual Department of Transportation Hazardous Materials Safety training for all EVS Care Partners who transport Hazardous Waste at PMC, and is a responsibility of the EVS Hazardous Materials Officer.

The Second Objective: to reduce the amount of waste leaving PHC. This will be accomplished by providing continuing education to all care partners throughout the organization by the Green Team.

The Third Objective: to expand the recycling program to the physician offices, starting with the Port St. John facility.

The Fourth Objective: to reduce the amount of improperly segregated waste in the Sharps, Biomedical, Pharmaceutical, and RCRA Hazardous waste streams from areas all areas of PMC. This responsibility is shared with departmental Hazardous Waste Material Officers.

The Fifth Objective: to audit PHC facilities for Florida Administrative Code 64E-16 compliance.

Program Administration: In 2020 the Security Manager, will continue to oversee and share responsibility for Laboratory chemical hazardous waste, bio-hazardous waste, chemo hazardous waste, and pharmaceutical waste with those PHC departments contributing to the waste. EVS has the responsibility for removal of hazardous materials waste. Radioactive waste is to be removed by the Diagnostic Imaging Department. The compilation of EOC Hazardous Materials Waste Management Plan reports, annual evaluations, and quarterly EOC performance improvement indicators will be the joint responsibility of EVS and those departments contributing to the waste.

The Laboratory Safety Officer, the Manager of EVS, the Diagnostic Imaging Safety Officer, and the Pharmacy Safety Officer represent their respective departments in matters pertaining to Hazardous Materials, including program monitoring objectives from their respective areas. Monitoring includes visits to PHC locations to ensure regulatory compliance. Permitting is done for waste disposal registrations for new facilities as they are transitioned to PMC facilities, and are renewed each August by the Security Hazardous Waste Materials Officer.

2019 Success Items:

1. Transition of the Waste Management program to a PHC program.
2. Increase RCRA/Pharma hazardous waste training for Care Partners.

2019 PI indicators: Perform 95% of the weekly Hazardous material back dock holding room inspections using previous developed checklist as a guideline. Conduct regular inspection of all hazard materials storage spaces during scheduled EOC rounds to insure safe handling equipment is available, correct PPR is available and storage areas is clean orderly and adequate in size.
Outcome: All Indicators were Met

2020 PI Indicators:

Reduce total weight of Bio-Medical Waste by 5%
Measure care partner knowledge of Code Orange. Increase care partner knowledge to assure 95% knowledge of Code Orange
Assess staff knowledge of the presence hazardous in departments
Assess the presence and use of spill kits

SECURITY MANAGEMENT PLAN Evaluation 2019
David Marquez, Security Manager

Scope

The Environment of Care Security Management Plan is based on the mission, vision, and values of Parrish Medical Center (PMC). This is accomplished by using a combination of security officers, electronic security, closed circuit TV systems, policy and procedures, and care partner education and training. This plan applies to the hospital and all buildings on the PMC campus, and all off-campus locations under the cognizance of PMC.

Purpose

The purpose of this plan is designed; in its entirety for the effectiveness in the protection of patients, visitors, and care partners and to continue promoting a safe and secure environment of care.

Objectives

The objective of this plan is to establish and maintain a level of security designed to protect patients, visitors, and care partners from harm, their property from theft or damage and to deter criminal activity and to safeguard the assets of the organization.

- Conduct security and safety patrols throughout the hospital campus, connecting properties and satellite facility locations. These patrols have proved to be an integral and effective element of the security plan. *They have proven to be necessary and effective and continued into 2019*

- Conduct training and improve the level of knowledge, capabilities and performance levels of the Security Department in handling violent situations and de-escalating violent situations. They will be trained/retrained in Taser use, physical and verbal de-escalation, defensive training, complete with certifications in CPI (non-violent crisis intervention. We will continue to expand the knowledge in the department and explore all learning opportunities. *As part of the required knowledge base the continuing increase of violence and threats of violence and to improve effectiveness of the program and the security officers we will continue into 2019.*

• Track and trend safety and security information. Data tracking provides information, accuracy and opportunities to focus on most urgent or changing needs as a part of our daily responsibilities. *This has proven to be highly effective in providing information and will play a major role in the Game Plan as we continue into 2019.*

• Monitor parking areas on campus and areas immediately surrounding the campus. Continue to ensure that ambulance entrance and roadways are kept clear at all times. *This objective is effective and will continue as part of our daily responsibilities.*

• Monitor Physician, care partner, vendor and visitor entry and access to areas afterwards. All care partners must display proper identification at all times and maintain integrity of secured areas. *This objective has proven to be semi effective and going forth is mandatory and will be focused on and closely monitored as part of our security procedures.*

• Continue to improve relationships with local law enforcement and fire department. Plan, train, practice and drill together to improve responses and procedures necessary to provide effective response in a real event. We will be conducting quarterly meetings to maintain continuity. *This objective has proven to be useful and effective and will continue as part of our security procedures*.

Performance Monitoring

Performance measures are selected to monitor actual and/or potential risks related to one or more of the following issues:

- Care Partner knowledge and skills and participation
- Monitoring, inspection and verification of activities
- Emergency and incident reporting

Performance Indicators for 2019

• Track the number of fire drills requiring a need to “do-over” due to incorrect locations or incomplete information. Monitor and log types of extinguishers brought to scene and conducting training and documentation at every drill. Maintain the threshold of 1 drill per shift per quarter. *Successful but will continue with changes and track to ensure effectiveness and improvements in 2019. Performance measure MET*

• Track vendor and visitor badging numbers at main entrance to establish a baseline for entry numbers. At the same time we will be tracking Care Partners access at all badged entrance to establish a baseline number to determine if the need is there for additional lockdowns and reduce entry or failure points. *This was a new data track for the 2019 year. Unclear of performance measure Met/Not Met. Will consider revisit during 2020.*

• Educate care partners in areas of violent situations, active shooters, parking lot vulnerability and security sensitive areas. Continued coordination with the Education Department and Department Directors has a positive impact with care partners. We will continue to have focus on patient violence and confrontations and the potential for active shooters and workplace violence. *As this program grows and expands and as we improve our programs we will be continuing this in 2020*

E. Emergency Management Plan Evaluation

By: Lori Thompson, Risk Manager
December 2, 2019

Scope: The EOC Emergency Management Plan addresses how PMC prepares, responds, mitigates, and recovers from disasters and emergencies, based on an all-hazards approach, and includes all PMC personnel and facilities. **The 2019 Emergency Management plan was judged effective by the EOC Task Force.**

Objectives:

- Annual Hazard Vulnerability Assessments (HVA's) are used to assess the likely impact of emergencies, and to guide the development of PMC's Emergency Management Plan (EMP). HVA's are reviewed annually to determine if circumstances of likely emergencies have changed.

- PHC's EMP clearly defines the process for initiation and activation of emergency plans, including the Incident Command structure, conditions requiring activation of the plan, and the individual(s) responsible for plan activation.

- PHC's EMP includes a current Incident Command chart illustrating how PMC's Incident Command staff is organized, and will work with the Brevard Emergency Operations Center (BEOC) and other community agency Incident Command structures.

- PHC's EMP includes a current list of governmental and commercial organizations that must be notified to effectively implement the emergency plan, and includes the agency or organization name, the basic organization function, the telephone or other contact numbers, and a list of contact personnel.

- PHC's EMP includes a list of key staff needed for scalable plan implementation, and procedures for contacting them. The contact procedure includes on-site and remote contact processes.

- PHC's EMP includes a description of the methods of identification of care partners, facility staff, and community responders. Community responders may include law enforcement, fire service personnel, media, and volunteer organizations.

- PHC's EMP includes a list of critical response requirements. A list of on-duty
- staff that will be assigned (i.e., Job Action Sheets) to critical response positions is included in the Incident Command System.

- PHC's EMP Plan includes processes that address support of staff and staff family members, identifying critical supplies, monitoring consumption, metering supplies to maximize response effectiveness, and a process for re-supply.

Such processes are incorporated into individual department plans as appropriate.

- PMC's EMP includes a list of organizations that can be used as alternate care sites, with current contact information.

- Utility failure response plans are current.

- Backup systems for internal and external communications systems are in place.

- Appropriate facilities for managing biological, chemical, radioactive isolation, and decontamination are in place, and tested as necessary.

- Staff's knowledge of their role in the EMP is evaluated annually. Changes in EMPs are incorporated into the annual mandatory net learning education curriculum.

Performance Indicator (PI) : A minimum of one exercise, drill, or operations training per quarter. Outcome: there were a total of five (5) actual activations of the Emergency Management Plan in 2019 – 4 Code Yellow (2 in 1st quarter, and 2 in the 2nd quarter. Activation of Code Purple occurred in the 3rd quarter. For the 4th quarter, the Security team will have operations training in active shooter scenarios. Such training for the security team to be completed in December 2019.

2020 Plan Changes: PHC's Emergency Management Plan is updated with related policies, procedures, charts, Hazard Vulnerability Assessments, along with the updating and completing of contracts with interlocal agencies and local area facilities to assist PMC in any major disaster will be updated by June 1, 2020.

F. Utility Management Plan Evaluation

By: Ted Bryant, Director of Facilities
December 2, 2019

Scope: The Environment of Care (EOC) 2019 Utilities Management Plan promotes a safe, controlled, healing environment in all of Parrish Medical Center's facilities for all PMC care partners. Original Equipment Maintenance (OEM) requirements are met or exceeded for all PMC and PHC Utility systems. **The EOC Task Force judged the performance of the 2018 Utilities Management plan as effective.**

The First Objective is to maintain and/or increase the operational reliability of all of PMC and PHC's utility systems by performing regular preventative maintenance and testing based on Original Equipment Manufacturers (OEM) requirements, local conditions, equipment condition and age.

The Second Objective is to ensure that updated operational plans and disaster recovery procedures exist for major utility functions when there is a prolonged utility failure. Emergency Operation Plans and Incident Command procedures are revised as necessary.

The Third Objective is to continue compliance with Code and Joint Commission (TJC) requirements. Regular run tests are conducted on all generators with connected loads as required by Code. Emergency generation readiness is demonstrated by successfully completing a full load run when required by Code/TJC.

The Fourth Objective is to address TJC standards regarding nosocomial infections, and elements previously added to the PMC Utilities Management Plan to reduce the possibility of nosocomial infections by cooling tower and domestic water management.

Performance Indicator (PI): PI indicators for 2019 included monitoring pressurization (negative and positive) of critical rooms in the hospital to include quarterly reports of out of compliance rooms. This indicator was Met.

2020 PI indicator: 100% completion of Utility Critical preventative maintenance work orders .

G. Clinical Equipment (CE) Management Plan Evaluation 2020

By: Robert Campbell, Interim Manager of Clinical Equipment
December 2, 2019

I. PURPOSE

The purpose of the **Clinical Equipment Management Plan** is to support a safe patient care and treatment environment at Parrish Medical Center (PMC) by managing risks associated with the use of clinical equipment technology. The program includes processes for selection and maintenance of equipment designed to assure safe and appropriate support of patient care services. The selection and management processes are based on the risks associated with the equipment. The risk management strategies include training, education, and competency evaluation of individuals who maintain and use medical equipment and appropriate inspection, testing, maintenance, and repair of that equipment.

II. SCOPE

The Clinical Equipment Management Program is designed to assure selection of appropriate medical equipment to support the medical care processes of PMC and to assure effective preparation of staff responsible for the use or maintenance and repair of the equipment. Finally, the program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff.

The Clinical Equipment Management Program is applied to all of PHC.

III. FUNDAMENTALS

A. The sophistication and complexity of clinical equipment continues to expand. Selecting new clinical equipment technology requires research and a team approach.

B. Patient care providers need information to develop an understanding of clinical equipment limitations, safe operating conditions, safe work practices, and emergency clinical interventions during failures.

C. Clinical equipment may injure patients or adversely affect care decisions if not properly maintained.

IV. OBJECTIVES

A. The First Objective of the Clinical Equipment Management Plan is to provide a safe environment of care through proper selection, use, testing and maintenance of Medical Equipment.

B. **The Second Objective** is to maintain an accurate Clinical Equipment inventory.

C. **The Third Objective** is to educate users and maintainers of Clinical Equipment to ensure proper use and functioning to identify deficiencies, failures and user errors to prevent unnecessary injury.

D. The Fourth Objective is to ensure Clinical Equipment and care partners perform at an acceptable level to limit the potential for patient injury due to equipment failure or misuse.

E. The Fifth Objective of the Clinical Equipment Management Plan is to verify electrical safety readings on all loaner, rental, physician-owned, and demonstration equipment brought into PMC facilities. Equipment coming into PMC, and its outside organizations, should be sent to the Clinical Equipment Department for an electrical safety check. This objective is measured by the number of items found that does not have an inspection sticker, indicating the item that was safety checked by Clinical Equipment. When equipment is found in the facilities that did not receive an electrical safety inspection, the appropriate department director is informed and the importance of having safety checks completed before their employees come into contact with the equipment is emphasized. **This objective is deemed necessary and effective,** and will continue to be measured during the life of this plan.

The above mentioned objectives, operator error work orders, alerts, recalls, hospital damage, equipment incidents, and emergency equipment repair calls are reported to the Environment of Care Task Force, for action as necessary.

F. The Sixth Objective was to implement and use the Minuteman program **Risk Factor Preventative Maintenance Program (Alternative Equipment Management Strategy).** There are three (3) levels of the program, which are:

1. Equipment that falls under the 95% monthly preventative maintenance completion rate required by TJC.
2. Equipment requiring annual preventative maintenance.
3. Equipment that does not require preventative maintenance.
4. Life Support PM's at 100% completion each month.
5. Other Federal or state law; or hospital Conditions of Participation) require adherence to manufactures' recommendations and/or set specific requirements.

   All imaging/radiologic equipment or medical laser devices must be maintained per manufactures recommendations.

CY2019's Clinical Equipment Performance Indicator (PI) was to reduce the number of battery failures found during routine defibrillator preventive maintenance. Battery failure *Threshold* will be "0". When the *Threshold* is exceeded a review of all PHC defibrillator batteries will be immediately checked to verify condition, failure mode, and next step(s) of action will be recommended to the Environment of Care Task Force Chairman in writing. This measure was Met

2020 Plan PI indicator

CY2020's Clinical Equipment Performance Indicator (PI) will be Electronic and Battery failures of the Baxter Sigma Infusion pumps as well as fluid intrusion into the batteries. Failures will be tracked and reported to the EOC. Outcome measure is Zero.

Parrish Medical Center | North Brevard County Hospital District
Parrish Healthcare Centers
Parrish Medical Group
Parrish Health Network

POLICY TITLE: Organ/Tissue/Eye Donation	**POLICY #:** 9500-2058	**REPLACES POLICY #:** 9500-2011
	EFFECTIVE DATE: 09/01/2017	**Page:** Page 1 of 7
POLICY SCOPE: Parrish Healthcare and Affiliates	**REVIEWED:** N/A	
DEVELOPED BY: Perioperative Services	**REVISED:** N/A	
APPROVALS: Executive Management: _____ Chairperson, Medical Executive Cmte:_____ President/CEO: _____ Chairperson, Board of Directors: _____	**REPOSITORY:** Corporate Compliance iCare	

I. POLICY STATEMENT

Parrish Medical Center (PMC) 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 medical 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.

II. PURPOSE

This policy is to provide a framework for the donation process from the initial identification and timely referral of potential organ, tissue and eye donors; to the evaluation and medical management of potential organ donors; encompassing a uniform structure for the presentation of the donation option to patients and families, and concluding with the OR process.

III. DEFINITIONS

A. **Clinical Triggers**: Mutually established criteria for the referral of "imminent deaths" which ensure timely notification to TransLife of potential organ donors.

B. **Donation After Brain Death**: Organ donation involving a patient whose death is due to neurological criteria, and determination of death is made in accordance with state law and currently accepted medical standards, and for whom medical suitability and authorization for organ donation has been determined by TransLife.

C. **Donation After Circulatory Determination of Death (DCDD)**: Organ donation involving a patient for whom there is a decision to withdraw from ventilator and all artificial support (compassionate extubation), and for whom medical suitability and authorization has been secured by TransLife. Organs are donated following the determination and pronouncement of circulatory death.

D. **Effective Request Process**: A collaborative process between Hospital and TransLife staff that culminates in the donation request to the family using tested and proven methodology incorporating a trained donation agency requestor.

E. **Organ Donation**: Refers to kidneys, heart, liver, lungs, pancreas and intestine.

F. **Tissue Donation**: Refers to cartilage, bone, tendons, ligaments, and soft tissue including skin, heart valves and saphenous veins.

IV. PROCEDURES

Care Partners who fail to comply with this policy will be counseled following the Parrish Healthcare performance and disciplinary counseling guidelines.

A. Donation Agencies
   1. Organ: TransLife Organ & Tissue Donation Services
   2. Tissue: TransLife Organ & Tissue Donation Services
   3. Eye: Keralink

B. Identification of Potential Organ/Tissue/Eye Donors
   Every patient death is to be referred to allow for medical screening by the tissue and/or eye donation agency(s). Every imminent death is to be referred to allow for medical screening for organ donation by TransLife. Referral notification for all potential donors is to occur irrespective of patient's age, medical diagnosis, medical/social history, and Medical Examiner case status.
   1. Potential Organ Donors: Referral of imminent death is defined as a referral of a ventilator-dependent patient meeting and ONE of the following Clinical Triggers for referral of a potential organ donor.
      a. Glasgow Coma Score of 5 or less and any possible neurological insult
      b. Plan to discuss the withdrawal of ventilator and all artificial support with family or legally authorized person(s). Note: Referral must occur prior to withdrawal to allow for the opportunity of organ donation.

c. Absence of TWO or more brainstem reflexes:
   i. no pain response
   ii. no pupillary response
   iii. no corneal reflex
   iv. no cough
   v. no gag
   vi. no eye movement (doll's eyes)
   vii. no response to cold calorics (signs of impending brain death)

d. Family mentions organ donation

Potential Tissue/Eye Donors: Referral of a potential tissue or eye donor is to involve the referral of every patient death, including the deaths of those patients previously referred while on a ventilator and ruled out as potential organ donors. All Hospital referrals will be triaged by the TransLife Call Center to the appropriate tissue/eye donation agency for medical screening. Note: Criteria for organ, tissue and eye donation are quite different, subject to change, and are best addressed directly by experts in these areas.

C. Timely Donor Notification

Potential Organ Donors: The referral of a potential donor should occur ideally within ONE HOUR of a patient meeting a clinical trigger for TransLife notification. Timely notification is further defined as a referral that occurs prior to any measures taken to decelerate treatment of that patient, thus preserving the option of organ donation for patients and families.

Potential Tissue Donors: The referral of a patient death should occur as quickly as possible after the death of a patient, and always within one hour of asystole.

D. How To Make A Referral

A referral is made by calling TransLife's 24-hour line at 1-800-458-7570 and having the following information available:

1. Patient's Name / Unit / Medical Record Number
2. Age / Date of Birth / Gender
3. Admission Date
4. Weight
5. Diagnosis and Pertinent Medical History
6. For tissue and eye referrals made following cardiac death, you may also be asked about lab results and treatment provided.

E. Referral Documentation

Documentation of the Referral Number and instruction from the donation agency shall be made on the following:

1. Deceased Patient Checklist
2. Organ/Tissue/Eye Donation Referral Form (Attachment "A" – Organ/Tissue/Eye Donation Referral Form)

F. Determination of Medical Suitability

The Hospital will provide access to (and when requested copies of) the medical record, including laboratory studies and diagnostic tests to TransLife and donation agencies for the purpose of determining medical suitability, and to ensure patient safety in the release of donated organs, tissue and eyes to transplant patients.

G. Medical Management of a Potential Organ Donor

Hospital staff will provide supportive medical management to the potential organ donor to preserve the opportunity for donation while TransLife determines medical suitability and pursues authorization. TransLife can provide the Hospital with established donor management guidelines as a resource.

1. Physicians may be asked by the TransLife Coordinator to provide consultations necessary to ensure the suitability of the organs for transplant. These may include , but are not limited to bronchoscopy, echocardiograms, central line insertion, cardiac catherizations, chest x-rays, or additional testing to confirm the brain death diagnosis.
2. Following brain death declaration and donor authorization, TransLife assumes the responsibility of maintaining organ viability for transplantation. The TransLife Coordinator will guide the medial management in accordance with TransLife's Medical Director. The hospital will provide a trained ICU Nurse to continue providing supportive care to the donor patient throughout the ICU stay and to order diagnostic tests, etc., as requested by TransLife Coordinator. (1:1 care is preferable when staffing permits.)
3. If a potential DCDD donor, the care and management of the patient will remain under the direction of the attending/treating physician or physician designee. This includes the extubation and the administration of comfort care medications. (See DCDD Policy)

H. Obtaining Donor Authorization

Only trained donation requestors from TransLife or the donation agencies shall offer the option of donation and provide information to the legally authorized person(s) about the donation process. Donation or the donation agency should not be mentioned to families at the time of referral (prior to donor screening) or at any time without prior collaboration with TransLife or authorized requestor from a donation agency.

1. If the patient had previously completed a donor document or online donor registration, this will serve as the legal authorization for the medical record.
2. In the absence of a completed anatomical gift (donor document or online donor registration), the representative from the donation agency is to service in the role of trained requestor. The donation decision for the decedent is to be made in the following order of priority, as defined by state anatomical gift law:
    a. Designated health surrogate
    b. Spouse;
    c. Adult son or daughter;
    d. Either parent;
    e. Adult brother or sister
    f. Adult grandchild
    g. Grandparent
    h. A close personal friend, as defined in §765.101;
    i. A guardian of the decedent at the time of his or her death; or

j. A court appointed representative ad litem

3. If an organ donor, TransLife will provide a signed donor authorization form or copy of the donor document or online registry for inclusion in the patient's medical record.

I. Effective Request Process (ERP) for Potential Organ Donors

Collaboration among Hospital and TransLife staff is to ensure that the donation pathway is always protected on behalf of patients and families and that the request for the donation of organs, tissues and eyes is made in the most sensitive and compassionate manner, both in keeping with federal guidelines and excellent end-of-life care.

Team Huddles are key to the ERP and consist of brief meetings coordinated by the TransLife representative, as follows:

Criteria for Team Huddle

1. After Medical suitability has been determined
2. Shift Change
3. Family/Care Team are discussing withdrawal of ventilator and all artificial support
4. Family brings up donation
5. Brain death has been determined
6. Patient is hemodynamically unstable
7. At the request of either Hospital or TransLife staff

Participants

1. TransLife Coordinator
2. Bedside Nurse
3. Treating Physician
4. Resident
5. Support Staff (when appropriate); pastoral care, palliative care, child life, social work, respiratory care, other

J. Medical Examiner Cases

If the case falls under jurisdiction of the Medical Examiner, the TransLife Coordinator will contact the appropriate person(s) to request authorization for organ donation. A copy of the donor chart and a copy of the donor authorization form, will be prepared for the Medical Examiner by TransLife.

K. Organ Recovery

The TransLife Coordinator will facilitate communication with all involved parties; i.e. donor family, appropriate hospital staff, medical examiner, tissue and eye programs, and transplant recovery teams.

1. TransLife Coordinator will notify the Hospital Operating Room (OR) as soon as possible after donor authorization is obtained for the organ recovery. Factors affecting OR time include:
    a. Stability of the potential donor and /or potential recipient
    b. Distance of visiting recovery teams
    c. Weather conditions, and
    d. Donor family needs and cultural beliefs
2. Hospital personnel required:
    a. Donation after Brain Death – The Hospital is to provide an Anesthesiologist, circulating nurse and scrub technician. TransLife will provide guidelines to the Anesthesiologist to maintain and monitor the donor's intra-operative perfusion and oxygenation until after the aorta is clamped or until released by the recovery surgeons.
    b. Donation after Circulatory Death – The patient must be maintained on a ventilator and hemodynamically supported for organ perfusion until the withdrawal of support occurs.

The donor is transferred with a portable cardiac monitor, arterial pressure monitor, and portable pulse oximeter from the ICU to the OR or nearby area under the care of the attending/treating physician or physician designee and is accompanied by a nurse and respiratory therapist. (See DCDD Policy)

L. Hospital Reimbursement

The recovery agency will be responsible for all costs related to the evaluation and recovery of organs, tissues and eyes for transplantation.

1. Following organ recovery, the Hospital will provide TransLife with an itemized statement of charges for reimbursement.

M. Quality Improvement

The hospital will provide TransLife with a structured report of all patient deaths and access to the medical record for the purpose of performing retrospective chart review according to a designated schedule, in keeping with the Medicare Conditions of Participation for Hospitals.

The Hospital will work collaboratively with TransLife and donation agencies to ensure ongoing education programs for all staff involved in the donation process.

V. REFERENCES

A. Florida Statutes (2008). Title XLIV Civil Rights. Chapter 765.510-765.546 Anatomical Gifts:§765.512. Persons who may make anatomical gift.

B. Joint Commission Standard, TS.01.01.01

C. Centers for Medicare and Medicaid Services, 42 CFR Part 482

D. Organ Procurement Organization Disclosure under HIPAA §164.512

E. Clarifying Standards Applicability to Organ Procurement Organizations; Joint Commission Perspectives: Volume 34, Issue 5, May 2014

ORGAN/TISSUE/EYE DONATION REFERRAL FORM

CALL 1-800-458-7570 (TransLife 24-Hour Hotline) within ONE HOUR of Clinical Trigger event

VENTILATOR PATIENTS: Potential ORGAN Donors

MUST CALL PRIOR TO EXTUBATION

Date/Time of Referral: _____

Person making Referral: _____

Referral Reference #: _____

Name of Donation Coordinator:_____

Communication from Donation Program:

- TransLife will monitor clinical course by phone.
- TransLife will arrive on-site to further evaluate for organ donation,
- Donor authorization obtained.
- Patient has been ruled out for organ donation.

Must CALL BACK at time of cardiac death to allow screening for tissue and donation, and document referral below.

Clinical Triggers for Organ Donor Referral

Call within 1 HOUR if any ONE of the following occurs for your vent-dependent patient:

- Glasgow Coma Score of 5 or less and any possible neuro insult
- Absence of 2 or more brainstem reflexes:
  - » Pupil Response
  - » Cough
  - » Gag
  - » Response to Painful Stimuli
  - » Eye Movement (Doll's Eyes)
  - » No response to Cold Calorics
- Consideration of withdrawal of ventilator and all artificial support; i.e. plan to discuss with family. Must call prior to withdrawal to allow for the opportunity of organ donation.
- Family asks about donation

Potential TISSUE/EYE Donors

REFER ALL PATIENT DEATHS

Date/Time of Referral: _____

Person making Referral: _____

Referral Reference #: _____

Name of Screener returning Call:_____

Communication from Donation Program:

○ YES ☐ NO The deceased patient is medically suitable for Tissue Donation

○ YES ☐ NO The deceased patient is medically suitable for Cornea Eye Donation

Clinical Triggers for Tissue/Eye Donor Referral

Call ASAP and always within 1 HOUR after a death occurs - prior to release of the body to a funeral home.

1. Obtain a phone number where the family can be reached within the next few hours, i.e. cell phone, neighbor or friend's home phone.

2. Ensure body is refrigerated ASAP to preserve the opportunity for tissue donation.

Refer regardless of patient age, history or diagnosis. Medical Examiner cases should not be excluded from donor referral.
Please refrain from discussing donation with families.

Parrish Medical Center | North Brevard County Hospital District
Parrish Healthcare Centers
Parrish Medical Group
Parrish Health Network

POLICY TITLE: Organ/Tissue/Eye Donation	**POLICY #:** 9500-2058	**REPLACES POLICY #:** 9500-2011
	EFFECTIVE DATE: 09/01/2017	**Page:** Page 1 of 7
POLICY SCOPE: Parrish Healthcare and Affiliates	**REVIEWED:** N/A	
DEVELOPED BY: Perioperative Services	**REVISED:** N/A	
APPROVALS: Executive Management: _____ Chairperson, Medical Executive Cmte:_____ President/CEO: _____ Chairperson, Board of Directors: _____	**REPOSITORY:** Corporate Compliance iCare	

I. POLICY STATEMENT

Parrish Medical Center (PMC) 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 medical 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.

II. PURPOSE

This policy is to provide a framework for the donation process from the initial identification and timely referral of potential organ, tissue and eye donors; to the evaluation and medical management of potential organ donors; encompassing a uniform structure for the presentation of the donation option to patients and families, and concluding with the OR process.

III. DEFINITIONS

A. **Clinical Triggers**: Mutually established criteria for the referral of "imminent deaths" which ensure timely notification to TransLife of potential organ donors.

B. **Donation After Brain Death**: Organ donation involving a patient whose death is due to neurological criteria, and determination of death is made in accordance with state law and currently accepted medical standards, and for whom medical suitability and authorization for organ donation has been determined by TransLife.

C. **Donation After Circulatory Determination of Death (DCDD)**: Organ donation involving a patient for whom there is a decision to withdraw from ventilator and all artificial support (compassionate extubation), and for whom medical suitability and authorization has been secured by TransLife. Organs are donated following the determination and pronouncement of circulatory death.

D. **Effective Request Process**: A collaborative process between Hospital and TransLife staff that culminates in the donation request to the family using tested and proven methodology incorporating a trained donation agency requestor.

E. **Organ Donation**: Refers to kidneys, heart, liver, lungs, pancreas and intestine.

F. **Tissue Donation**: Refers to cartilage, bone, tendons, ligaments, and soft tissue including skin, heart valves and saphenous veins.

IV. PROCEDURES

Care Partners who fail to comply with this policy will be counseled following the Parrish Healthcare performance and disciplinary counseling guidelines.

A. Donation Agencies
   1. Organ: TransLife Organ & Tissue Donation Services
   2. Tissue: TransLife Organ & Tissue Donation Services
   3. Eye: Keralink

B. Identification of Potential Organ/Tissue/Eye Donors
   Every patient death is to be referred to allow for medical screening by the tissue and/or eye donation agency(s). Every imminent death is to be referred to allow for medical screening for organ donation by TransLife. Referral notification for all potential donors is to occur irrespective of patient's age, medical diagnosis, medical/social history, and Medical Examiner case status.
   1. Potential Organ Donors: Referral of imminent death is defined as a referral of a ventilator-dependent patient meeting and ONE of the following Clinical Triggers for referral of a potential organ donor.
      a. Glasgow Coma Score of 5 or less and any possible neurological insult
      b. Plan to discuss the withdrawal of ventilator and all artificial support with family or legally authorized person(s). Note: Referral must occur prior to withdrawal to allow for the opportunity of organ donation.

c. Absence of TWO or more brainstem reflexes:
   i. no pain response
   ii. no pupillary response
   iii. no corneal reflex
   iv. no cough
   v. no gag
   vi. no eye movement (doll's eyes)
   vii. no response to cold calorics (signs of impending brain death)

d. Family mentions organ donation

Potential Tissue/Eye Donors: Referral of a potential tissue or eye donor is to involve the referral of every patient death, including the deaths of those patients previously referred while on a ventilator and ruled out as potential organ donors. All Hospital referrals will be triaged by the TransLife Call Center to the appropriate tissue/eye donation agency for medical screening. Note: Criteria for organ, tissue and eye donation are quite different, subject to change, and are best addressed directly by experts in these areas.

C. Timely Donor Notification

Potential Organ Donors: The referral of a potential donor should occur ideally within ONE HOUR of a patient meeting a clinical trigger for TransLife notification. Timely notification is further defined as a referral that occurs prior to any measures taken to decelerate treatment of that patient, thus preserving the option of organ donation for patients and families.

Potential Tissue Donors: The referral of a patient death should occur as quickly as possible after the death of a patient, and always within one hour of asystole.

D. How To Make A Referral

A referral is made by calling TransLife's 24-hour line at 1-800-458-7570 and having the following information available:

1. Patient's Name / Unit / Medical Record Number
2. Age / Date of Birth / Gender
3. Admission Date
4. Weight
5. Diagnosis and Pertinent Medical History
6. For tissue and eye referrals made following cardiac death, you may also be asked about lab results and treatment provided.

E. Referral Documentation

Documentation of the Referral Number and instruction from the donation agency shall be made on the following:

1. Deceased Patient Checklist
2. Organ/Tissue/Eye Donation Referral Form (Attachment "A" – Organ/Tissue/Eye Donation Referral Form)

F. Determination of Medical Suitability

The Hospital will provide access to (and when requested copies of) the medical record, including laboratory studies and diagnostic tests to TransLife and donation agencies for the purpose of determining medical suitability, and to ensure patient safety in the release of donated organs, tissue and eyes to transplant patients.

G. Medical Management of a Potential Organ Donor

Hospital staff will provide supportive medical management to the potential organ donor to preserve the opportunity for donation while TransLife determines medical suitability and pursues authorization. TransLife can provide the Hospital with established donor management guidelines as a resource.

1. Physicians may be asked by the TransLife Coordinator to provide consultations necessary to ensure the suitability of the organs for transplant. These may include , but are not limited to bronchoscopy, echocardiograms, central line insertion, cardiac catherizations, chest x-rays, or additional testing to confirm the brain death diagnosis.
2. Following brain death declaration and donor authorization, TransLife assumes the responsibility of maintaining organ viability for transplantation. The TransLife Coordinator will guide the medial management in accordance with TransLife's Medical Director. The hospital will provide a trained ICU Nurse to continue providing supportive care to the donor patient throughout the ICU stay and to order diagnostic tests, etc., as requested by TransLife Coordinator. (1:1 care is preferable when staffing permits.)
3. If a potential DCDD donor, the care and management of the patient will remain under the direction of the attending/treating physician or physician designee. This includes the extubation and the administration of comfort care medications. (See DCDD Policy)

H. Obtaining Donor Authorization

Only trained donation requestors from TransLife or the donation agencies shall offer the option of donation and provide information to the legally authorized person(s) about the donation process. Donation or the donation agency should not be mentioned to families at the time of referral (prior to donor screening) or at any time without prior collaboration with TransLife or authorized requestor from a donation agency.

1. If the patient had previously completed a donor document or online donor registration, this will serve as the legal authorization for the medical record.
2. In the absence of a completed anatomical gift (donor document or online donor registration), the representative from the donation agency is to service in the role of trained requestor. The donation decision for the decedent is to be made in the following order of priority, as defined by state anatomical gift law:
    a. Designated health surrogate
    b. Spouse;
    c. Adult son or daughter;
    d. Either parent;
    e. Adult brother or sister
    f. Adult grandchild
    g. Grandparent
    h. A close personal friend, as defined in §765.101;
    i. A guardian of the decedent at the time of his or her death; or

j. A court appointed representative ad litem

3. If an organ donor, TransLife will provide a signed donor authorization form or copy of the donor document or online registry for inclusion in the patient's medical record.

I. Effective Request Process (ERP) for Potential Organ Donors

Collaboration among Hospital and TransLife staff is to ensure that the donation pathway is always protected on behalf of patients and families and that the request for the donation of organs, tissues and eyes is made in the most sensitive and compassionate manner, both in keeping with federal guidelines and excellent end-of-life care.

Team Huddles are key to the ERP and consist of brief meetings coordinated by the TransLife representative, as follows:

Criteria for Team Huddle

1. After Medical suitability has been determined
2. Shift Change
3. Family/Care Team are discussing withdrawal of ventilator and all artificial support
4. Family brings up donation
5. Brain death has been determined
6. Patient is hemodynamically unstable
7. At the request of either Hospital or TransLife staff

Participants

1. TransLife Coordinator
2. Bedside Nurse
3. Treating Physician
4. Resident
5. Support Staff (when appropriate); pastoral care, palliative care, child life, social work, respiratory care, other

J. Medical Examiner Cases

If the case falls under jurisdiction of the Medical Examiner, the TransLife Coordinator will contact the appropriate person(s) to request authorization for organ donation. A copy of the donor chart and a copy of the donor authorization form, will be prepared for the Medical Examiner by TransLife.

K. Organ Recovery

The TransLife Coordinator will facilitate communication with all involved parties; i.e. donor family, appropriate hospital staff, medical examiner, tissue and eye programs, and transplant recovery teams.

1. TransLife Coordinator will notify the Hospital Operating Room (OR) as soon as possible after donor authorization is obtained for the organ recovery. Factors affecting OR time include:
    a. Stability of the potential donor and /or potential recipient
    b. Distance of visiting recovery teams
    c. Weather conditions, and
    d. Donor family needs and cultural beliefs
2. Hospital personnel required:
    a. Donation after Brain Death – The Hospital is to provide an Anesthesiologist, circulating nurse and scrub technician. TransLife will provide guidelines to the Anesthesiologist to maintain and monitor the donor's intra-operative perfusion and oxygenation until after the aorta is clamped or until released by the recovery surgeons.
    b. Donation after Circulatory Death – The patient must be maintained on a ventilator and hemodynamically supported for organ perfusion until the withdrawal of support occurs.

The donor is transferred with a portable cardiac monitor, arterial pressure monitor, and portable pulse oximeter from the ICU to the OR or nearby area under the care of the attending/treating physician or physician designee and is accompanied by a nurse and respiratory therapist. (See DCDD Policy)

L. Hospital Reimbursement

The recovery agency will be responsible for all costs related to the evaluation and recovery of organs, tissues and eyes for transplantation.

1. Following organ recovery, the Hospital will provide TransLife with an itemized statement of charges for reimbursement.

M. Quality Improvement

The hospital will provide TransLife with a structured report of all patient deaths and access to the medical record for the purpose of performing retrospective chart review according to a designated schedule, in keeping with the Medicare Conditions of Participation for Hospitals.

The Hospital will work collaboratively with TransLife and donation agencies to ensure ongoing education programs for all staff involved in the donation process.

V. REFERENCES

A. Florida Statutes (2008). Title XLIV Civil Rights. Chapter 765.510-765.546 Anatomical Gifts:§765.512. Persons who may make anatomical gift.

B. Joint Commission Standard, TS.01.01.01

C. Centers for Medicare and Medicaid Services, 42 CFR Part 482

D. Organ Procurement Organization Disclosure under HIPAA §164.512

E. Clarifying Standards Applicability to Organ Procurement Organizations; Joint Commission Perspectives: Volume 34, Issue 5, May 2014

ORGAN/TISSUE/EYE DONATION REFERRAL FORM

CALL 1-800-458-7570 (TransLife 24-Hour Hotline) within ONE HOUR of Clinical Trigger event

VENTILATOR PATIENTS: Potential ORGAN Donors

MUST CALL PRIOR TO EXTUBATION

Date/Time of Referral: _____

Person making Referral: _____

Referral Reference #: _____

Name of Donation Coordinator:_____

Communication from Donation Program:

- TransLife will monitor clinical course by phone.
- TransLife will arrive on-site to further evaluate for organ donation,
- Donor authorization obtained.
- Patient has been ruled out for organ donation.

Must CALL BACK at time of cardiac death to allow screening for tissue and donation, and document referral below.

Clinical Triggers for Organ Donor Referral

Call within 1 HOUR if any ONE of the following occurs for your vent-dependent patient:

- Glasgow Coma Score of 5 or less and any possible neuro insult
- Absence of 2 or more brainstem reflexes:
  - » Pupil Response
  - » Cough
  - » Gag
  - » Response to Painful Stimuli
  - » Eye Movement (Doll's Eyes)
  - » No response to Cold Calorics
- Consideration of withdrawal of ventilator and all artificial support; i.e. plan to discuss with family. Must call prior to withdrawal to allow for the opportunity of organ donation.
- Family asks about donation

Potential TISSUE/EYE Donors

REFER ALL PATIENT DEATHS

Date/Time of Referral: _____

Person making Referral: _____

Referral Reference #: _____

Name of Screener returning Call:_____

Communication from Donation Program:

○ YES ☐ NO The deceased patient is medically suitable for Tissue Donation

○ YES ☐ NO The deceased patient is medically suitable for Cornea Eye Donation

Clinical Triggers for Tissue/Eye Donor Referral

Call ASAP and always within 1 HOUR after a death occurs - prior to release of the body to a funeral home.

1. Obtain a phone number where the family can be reached within the next few hours, i.e. cell phone, neighbor or friend's home phone.

2. Ensure body is refrigerated ASAP to preserve the opportunity for tissue donation.

Refer regardless of patient age, history or diagnosis. Medical Examiner cases should not be excluded from donor referral.
Please refrain from discussing donation with families.

Origination:	*11/2001*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/2019*
Next Review:	*3 years after approval*
Areas:	*Quality*
Tags:	*9500, TJC*
Applicability:	*Parrish Medical Center*

Patient Safety Plan, 9500-8008

Replaces Policy: # 9500-224

POLICY STATEMENT

This Patient Safety Program is based on the mission, vision, and values of Parrish Medical Center (PMC). It is designed to identify and reduce the risks to PMC patients in an integrated, organization-wide approach that focuses on processes and systems. The Patient Safety Program is non-punitive. The Patient Safety Program is part of an on-going process to analyze potential error points, actual errors, and 'near miss' events (do not reach the patient). In addition it is to create and share knowledge as well as implement and recommend strategies to improve PMC's current and future health care delivery.

PURPOSE

A. The objectives of the Patient Safety Program are:

1. Ensure that the National Patient Safety Goals are continuously updated, addressed and integrated into all of PMC services; Current National Patient Safety Goals (NPSG) can be found on iCare. The material found at iCare is hereby incorporated by reference into this Patient Safety Plan and Policy.
2. To create a culture that encourages the reporting of "near miss" and actual patient care errors. The "Good Catch" program was established to recognize care partners who prevent "near miss" events from occurring and reaching a patient. More information can be found in the Risk Management policy #9500-8012.
3. To select one high risk process for proactive risk assessment and to analyze using the Failure Mode and Effects Analysis (FMEA). The process will be selected based on internal reporting, or TJC safety initiatives. More information can be found in the Risk Management policy #9500-8012.
4. To review all TJC Sentinel Event Alerts proactively. A thorough review of all sentinel "near miss" events (e.g. do not reach the patient) will be performed.
5. To perform a root cause analysis on all Sentinel Events to determine the underlying factors, and take action to establish procedures to prevent future occurrences. More information can be found in the Risk Management policy #9500-8012.

B. Disclosure:

To support and facilitate the disclosure of adverse patient outcomes resulting from healthcare errors, PMC's "Risk Management Program & Plan" Policy # 9500-8012.

SCOPE:

This policy applies to all PMC departments, services, facilities and future PMC healthcare services as they are implemented and added. Patient safety as well as overall safety is a key value of PMC. It is supported within every level of the organization from the Board of Directors to frontline staff. Leadership provides the necessary resources for the Patient Safety Program. Safety is everyone's responsibility. PMC's Patient Safety Officer coordinates all patient safety-related activities/issues. Oversight ranges from no-harm, frequently occurring "slips" to sentinel events with serious adverse outcomes.

Clinical Alignment Team

A. The Clinical Alignment Team Membership/Composition:

   Membership of the Clinical Alignment Team is multi-disciplinary hospital committee to promote a collective and collaborative perspective for identified improvement opportunities for patient care. Membership is comprised of at least the following:

   - Physician Leadership
   - Quality Resource Management Staff
   - Directors of Clinical Departments
   - Community Representative
   - Director, HIM
   - Director of Case Management
   - Executive Leadership
   - PI/Patient Safety Coordinator

B. Responsibilities

   1. The Clinical Alignment ~~team~~Team is responsible for reviewing and coordinating activities that address health care system and individual outcomes, process improvements, process concerns, errors, "near Miss" events (e.g. do not reach the patient), and sentinel events.
   2. The Clinical Alignment Team will recommend and where necessary implement changes to processes and procedures to improve outcomes, improve safety and reduce risk to patients, staff, and visitors, to improve existing processes, or when appropriate, design new processes.
   3. Such review, coordination, and changes shall include patient care and patient safety related issues that are communicated and/or coordinated through the Clinical Alignment Team.
   4. See also Policy 9500-1032, PMC's "Quality Improvement Performance Plan."

C. The Clinical Alignment Team will meet at least bi-weekly, and is chaired by members of the Executive Leadership Team.

D. Reporting:

   1. The Clinical Alignment Team provides a summary report to the Medical Executive Committee and the Board of Directors.
   2. The Environment of Care (EC) Task Force will report a summary of its activities to the Clinical Alignment Team.

CONFIDENTIALITY, IMMUNITY FROM LIABILITY AND INDEMNIFICATION

All activities set forth in this Patient Safety Plan, including information collected by any medical staff committee, administrative committee, team, or hospital department in order to evaluate the quality of patient care and identified patient safety issues, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure consistent with the PMC confidentiality policies and procedures. Per Florida Statute 395.0197, no individual reporting, providing information, opinion, counsel or services to a medical or incident review committee or any other medical staff administrative or governing body committee that evaluates quality of care issues, or as a part of the Medical Staff Review Committee program, shall be liable in a suit for damages based on such reporting, providing information, opinion, counsel or services provided that such individual or institution acts in good faith and with reasonable belief that said actions are warranted in connection with or in furtherance of the functions of North Brevard County Hospital District dba Parrish Medical Center. The Parrish Medical Center agrees to indemnify and hold harmless from all claims against any member of the Medical Staff and North Brevard County Hospital District ~~dba Parrish Medical Center agrees to indemnify and hold harmless from all claims against any member of the Medical Staff and all~~dbaall other healthcare/administrative staff for activities, conducted in good faith and without malice, in support of committee participation in working together on opportunities to improve patient care delivery, treatment and outcomes.

LEADERSHIP SUPPORT

Leadership is responsible for adopting patient safety as a strategic goal and initiative. This includes supporting the risk reduction efforts of the Clinical Alignment Team through the following:

- Allocation of adequate resources
- Assign staff as necessary to participate in risk reduction activities
- Allocation of adequate time for staff participation
- Adequate information/data management systems support
- Ensure that all staff receives patient safety education

STAFF RESPONSIBILITIES

Medical Staff and hospital employees are responsible for participating in patient safety reduction activities. Any employee or medical staff member may identify a process(s) and/or system(s) that may lead to a patient safety issue. Issues may be communicated directly to the Patient Safety Coordinator, or the QRM Department.

A. When a medical error or near miss occurs, a staff member who is aware of the occurrence shall complete an Incident Report, as described in PMC's "Risk Management Program & Plan," Policy # 9500-8012.

B. In response to a health care process error, appropriate steps should be taken in the care of patients to minimize negative outcomes. Appropriate steps that will decrease the possibility of the error occurring again, or that will protect others from the risk, should be implemented immediately.

C. The Risk Manager, in conjunction with the Director or Unit Manager where the error or near miss occurred will coordinate the analysis. All information obtained during the analysis will be reported to the Clinical Alignment Team.

D. Depending on the severity of the medical error, the appropriate external authorities will be notified of the medical error as outlined in the PMC's "Risk Management Program & Plan," Policy # 9500-8012.

LEGIBILITY, DOCUMENTATION, COMMUNICATION

To prevent errors from occurring, PMC, its medical staff, and its healthcare staff support the legible handwriting initiative. Also addressed in this documentation initiative, is the use of "unacceptable" abbreviations, acronyms and symbols, a write down and read back requirement for all verbal/telephone orders that are taken, as well as communication with respect to patient "Hand over" to other staff members, and timely reporting of critical values (e.g. lab results, diagnostic test results).

A. **DEFINITIONS**

1. ***Legible documentation*** – Person(s) unfamiliar with the handwriting can read it with little or no need to resort to context to determine what is written.
2. ***Decipherable documentation*** – Person(s) familiar with the handwriting determines the actual content of the writing with the aid of the context implied in the rest of the documentation, e.g. the rest of the medical record. For instance, nurses familiar with an individual's handwriting, given the patient clinical situation, conclude what they think is being stated in the respective documentation.
3. ***Illegible documentation*** – Person(s) unfamiliar with the handwriting cannot read it.
4. ***Unacceptable abbreviations, acronyms and symbols*** – those that have been identified as having the potential to cause errors to occur; and **are not to be used**. Refer to PMC's "Unacceptable Abbreviations" in iCare which is incorporated by reference in the Patient Safety Plan and Policy.

   If it is deemed that an abbreviation is needed, reference Medical Abbreviations manual in Health Information Management.
5. ***Read back of verbal/telephone orders*** –
   Verbal Orders - A Verbal Order is a verbal request for care activities from a provider who is physically present in the care area and is rendering emergency care, is performing an operative procedure, or unable to access the EMR in a timely fashion.

   Telephone Orders: A Telephone Order is a verbal request for care activities from a provider who is not physically present, but is necessary to provide urgent care when a provider is not physically present in the facility and/or when a provider is unable to access the EMR in a timely fashion.

   Read back of verbal/telephone orders is required of any healthcare professional who is allowed within the scope of their license and in accordance with hospital policy to take a verbal/telephone order. That individual must write down and read back the verbal/telephone order that they have taken to ensure accuracy of the order and to avoid potential patient safety issues. This must be annotated in the medical record.
6. ***"Hand over" communications*** – the requirement that patient care information that is given/ delivered is understood by the receiver who not only fully understands, comprehends the message, but whom also, where/when required, will follow through. This strategy is to prevent patient safety errors. "Hand over" communications should be both verbal as well as written in the majority of situations. Pertinent information should be addressed in the communication (e.g. if the patient is in isolation, if the patient is at risk for falls, what the physician consultant's findings and recommendations are). This includes but is not limited to shift changes, patient transports, patient multi-disciplinary rounds, reporting critical values, and attending physician – consulting physician

communication. (The following does not represent an appropriate patient "Hand over": a physician writes an order such as "may discharge if ok with Dr. X". This places a third party in the middle to deliver the message and may create a patient safety issue. Physicians should communicate to one another when they are both involved in the treatment and care of a patient(s)). Finally, interruptions during Hand over are limited to prevent the potential of errors.

7. ***"Critical Value(s)" Communications*** – to ensure timely reporting of critical values, these values are identified so that they will be reported anytime a patient exhibits said value. Critical values are called to the respective healthcare provider/staff member to ensure they are addressed in a timely manner and to prevent patient safety issues. The receiver must 'read back' the critical value(s) to the person who is delivering the information. The receiver also must receive confirmation from the person who gave the order or provided the test result. For Radiology, this would apply to significant abnormalities found with the potential for significant patient morbidity if they are not addressed immediately. Some examples would be findings of deep vein thrombosis, fetal demise, pulmonary embolus, cerebral hemorrhage, pneumo-thorax, testicular torsion, retained foreign body. Please refer to the Critical Results Policy, Policy # 9500-2033, for the procedures to be followed with respect to Critical Values.

PROCEDURE

Identified documentation issues related to illegibility, the use of unacceptable abbreviations, acronyms, symbols, verbal/telephone orders taken without being read back, "Hand over" communication issues, or critical values not communicated timely, will be reported to the Risk Manager, who will monitor to ensure corrective actions are implemented to reduce and ultimately eliminate issues associated with the above. Identified documentation issues involving physicians will be referred by the Risk Manager to the MEC for review and action in executive session according to the process below.

A. MEC CORRECTIVE ACTION FOR PHYSICIAN ILLEGIBLE CHART ENTRY ISSUES

1. Upon identification of the first illegible incident the offending physician will receive a written warning specifying the corrective action which will be taken should another illegible incident occur.
2. If the physician again writes an illegible chart entry within three months of the first infraction after having received the written warning outlined above, he/she will be required to print all chart entries until he/she has completed ~~an~~a handwriting course approved ~~handwriting course~~by the MEC and Risk Manager (at their own expense) and has provided documentation of successful completion of such a course to the ~~risk manager~~Risk Manager and to MEC. At this time he/she may again write his/her chart entries.
3. If after completing the handwriting course the physician again writes an illegible chart entry, he/she will be required to again print all chart entries for a period of three months or to use a scribe or other acceptable method of recording documentation. The responsibility for providing and funding any such alternative will be solely ~~the~~ on the physician. After this three-month period, the physician will again be allowed to write chart entries if he/she chooses, but any subsequent violations will be grounds for permanently requiring him/her to use an alternate method.
4. If an illegible incident occurs while a physician is under the requirement to print chart entries, he/she will be required to review all written orders with the nurse responsible for the patient's care.
5. Failure to comply with the above requirements, or the demonstration of chronically recurring illegible documentation, will result in the physician facing disciplinary actions imposed by the MEC, in accordance with the Medical Staff Bylaws and Medical Staff Rules and Regulations, which may include suspension of privileges.

6. Any order containing an ***Unacceptable*** abbreviation will be handled according to the Medical Staff Rules and Regulations, Section II, MEDICAL ORDERS, General Requirements. Documentation that contains an abbreviation located on the **"DO NOT USE"** listing will be confirmed with the ordering physician. This action is coordinated by the nursing/pharmacy staff calling the appropriate physician for clarification at the time of their review of the documentation. If a physician continues to be non-compliant, their Department Chair will be contacted to become involved with the corrective action plan. Ongoing clinical pertinence reviews of the medical records, both concurrent and retrospective will review for these types of issues as well as other required indicators for complete medical records.

B. ACCURATE PATIENT IDENTIFICATION

To promote patient safety, PMC requires at least two patient identifiers to identify patients prior to providing care, treatment, and services, for example when performing high risk functions (e.g. administering medications, administering blood products, taking specimens) and any treatment with direct patient impact. The first step is to ask the patient to state their name and date of birth.

1. Inpatients, Emergency Department patients, and Perioperative patients should have an identification wristband on before care is provided. Registration or Nursing is responsible for identification and the placement of the identification band.
2. Outpatients with no wristband will be asked their name, birth-date, and the name of the ordering physician.
3. Once wristbands are attached the medical record number and account number can also be used as the second identifier.
4. For emergency situations with newborns that have not received a medical record number, this policy does not apply. The baby's name along with the mother's information will be accepted.

Registration staff uses the patient's name and date of birth as the initial two patient identifiers. They may validate asking the patient for a photo identification card (e.g. driver's license). With respect to ID bracelets, staff shall verify the correct name on patient's ID bracelet (located on the patient's wrist or ankle if unable to use wrist). The medical record number, the account number, the date of birth, or the patient's address in the case of Home Health, may be used as the second identifier.

If patients are unable to ~~verbalize or are obtunded~~self-identify, registration staff ~~may~~should identify patients using the patient's ~~drivers~~driver's license (or other government issued identification on their person if available) and should never rely solely on the EMS and/or police transport information. Patients that are too young or incapable of speaking to staff must rely on a relative, care giver, or friend to verbally identify the patient.

~~Remove all~~

Any patient who has no proof of identification ~~bracelets from other organizations~~(i.~~ Ornamental~~e. photo identification card) and/or ~~other colored bracelets shall~~is unable to self-identify will be ~~removed upon a~~registered as a Jane Doe (female) or John Doe (male). Registration staff will work with nursing staff, friends and family to assure proper identification of any Jane Doe or John Doe as quickly as possible.

"Labeling of specimens" – Labeling of any patient~~'s admission. These items may~~ specimen is to be

~~provided to the family or significant other accompanying the patient or may be placed in safe-keeping as valuables.~~

~~*"Labeling of specimens"* - Labeling of any patient specimen is to be~~ done at the **point of care** (e.g. for inpatients this would be at the bedside or location; for outpatients this would be at the laboratory/draw station/location where it is completed), **in front of the patient**. Staff will circle the patient's medical record number on the label as documentation that the patient has been positively identified and the wristband information matches the specimen label. Every specimen submitted to the laboratory must ~~havthis~~have this documentation. It is the policy of Parrish Medical Center to promote patient safety by standardizing patient identification ~~writstbands~~wristbands with the State of Florida and Brevard County.
Reference Patient Identification Wristband policy # 9500-2032

C. 'TIME OUT' PROCEDURES

~~Universal Protocol focuses on safety for all procedures that expose patients to more than minimal risk by eliminating wrong site, wrong procedure, and wrong person surgery:~~

1. Pre-procedure verification process

   Purpose: To ensure that all of the relevant documents and related information or equipment are available prior to the start of the procedure and that they are:

   a. Correctly identified, labeled, and matched to the patient's identifiers.
   b. Have been reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site.
   c. Pre-procedure assessment completed.
   d. Consent signed, dated and timed.
   e. Missing information or discrepancies are addressed before starting the procedure.

2. Process: An ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the pre-procedure preparation of the patient, up to and including the "time out" just before the start of the procedure.
3. Marking the operative site
   a. Purpose: To identify unambiguously the intended site of incision or insertion.
   b. Process: For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site must be marked with a "YES" and must be visible after the patient has been prepped and draped. **The site is to be marked directly by the LIP (Licensed Independent Practitioner) who is performing the procedure.**
   c. **No site marking is required for :**
      i. **Emergency procedures, if delay may risk life or limb,**
      ii. **Interventional procedure for which there are alternative catheter/instrument insertion sites (eg, cardiac catheterization, central line placement, peripherally inserted central catheter(PICC), cardiac device insertion, epidural/spinal anesthesia, dialysis catheter)**

iii. **Midline, single organ procedures (eg, liver biopsy, circumcision, Caesarean section, PEG placement**

iv. **Endoscopic procedures without intended laterality (eg, colonoscopy, bronchoscopy, cystoscopy)**

v. **Premature infants (<37 weeks), for whom the mark may cause a permanent tattoo**

vi. **Cases in which it is technically or anatomically impossible or impractical to mark the site (e.g., mucosal surfaces, perineum)**

vii. **Teeth, for which the operative tooth name (s) and number (s) are indicated on documentation or the operative tooth (teeth) is marked on the dental radiograph or dental diagram. The documentation must be in the procedure room prior to the start of the procedure.**

viii. **ECT procedures**

ix. **Obvious sites such as lacerations and abscesses unless there is more than one site and not all are being treated.**

x. **When the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure.**

d. The patient always has the right to refuse site marking. The patient must be educated about the purpose of site marking, including the safety implications/risks of refusing the site marking. An alternative to site marking may be offered. The procedure may then proceed only after the attending physician fully documents in the medical record the patient's informed refusal of site marking. When a wrist-band is used as an alternative to site marking, the entire procedure name must be on the band.

e. An alternative method to site marking should be used when marking cannot be performed or is impractical. The alternative method to site marking is by a wrist-band. The wrist band will be labeled with the side (right/left), structure (finger/toe), spinal level, or surface (flexor/extensor) and will be applied prior to transferring the patient to the location where the procedure will be performed. Examples include, but are not limited to, ophthalmic procedures and craniotomy. If it is not visible during the Time Out, the wrist band should be removed prior to prepping and draping and referred to during Time Out.

4. **"Time out" immediately before starting the procedure**

a. Purpose: To conduct a final verification of the correct patient, procedure, site and position, as applicable, all relevant documents, consent form completed, signed, dated and timed, related information and necessary equipment.

b. Process: Active communication includes at a minimum the correct patient identity, the correct site, and the procedure to be done. The communication is among all members of the surgical/ procedure team, consistently initiated by a designated member of the team, conducted in a "fail-safe" mode, i.e. the procedure is not started until any question or concerns are resolved. The "time out" procedure must be completed anywhere there are invasive procedures, identified by the hospital, being performed. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated. The following is a list of common bedside procedures (not limited to) where a "time out" procedure should be performed.

√ Amniocentesis	√ Epidural catheter	√ Sigmoidoscopy
√ Biopsy	√ Intrauterine Device insertion	√ Thoracentesis
√ Bone Marrow	√ LEEP	√ Tracheostomy
√ Bronchoscopy	√ Line insertion	√ Unit-specific procedures
√ Chest tube insertion	√ Lumbar puncture	√ Ventilator Assist Device
√ Endometrial biopsy	√ Paracentesis	(VAD) insertion
√ Gastric tube	√ Proctoscopy	√ Ventriculostomy

D. Universal Protocol focuses on safety for all procedures that expose patients to more than minimal risk by eliminating wrong site, wrong procedure, and wrong person surgery:

FALLS PREVENTION PROGRAM

Parrish Medical Center strives to reduce patient falls and potential harm resulting from falls. Parrish Medical Center staff is educated on the Fall Reduction Program and observes patients for unsteady gait, balance, coordination or weakness. Immediate assistance is provided as needed.

In-patients receive a Fall Risk Assessment by the Nurse. Patients and/or families are notified when they are at increased risk for falls and educated on the Fall Prevention Program and any individual fall prevention interventions. Yellow wristband and yellow door magnet indicates fall risk. All staff participates in observing these patients and reporting unsafe behaviors, such as attempting to get out of bed alone or walking without assistance or an assistive device to Nursing.

Out-patients observed to have mobility problems are encouraged to discuss fall risk with their primary care physician.

Fall risk screening, assessment and prevention programs services are available through Parrish Out-Patient Rehabilitation, Parrish Sports Medicine and PMC Senior Consulting Services.

The effectiveness of the Fall Prevention Program is monitored through measurement of the number of falls and the number of injuries and changes are made as warranted.

ANNUAL EVALUATION

The Patient Safety Program will be evaluated annually, by the Clinical Alignment Team. The objectives, scope, performance and effectiveness of the program will be assessed, and revisions made to the Program, as appropriate.

Related Policies

A. *Allergy Bracelet Nursing Procedure 18.1.02*

B. *Patient Identification Wristband policy # 9500-2032*

C. *Critical Values #9500-2033*

D. *Quality Improvement Performance Improvement Plan #9500-1032*

E. *Risk Management Plan #9500-8012*

References

A. 2015 Medical Staff General Rules and Regulations pgs. 6,9,14

B. The Joint Commission Hospital NPSG 2015

All revision dates: 11/2019, 04/2015, 07/2014, 02/2013, 09/2011, 01/2011, 09/2010, 09/2009, 10/2008, 01/2008, 07/2007, 03/2007, 01/2007, 10/2006, 07/2006, 06/2006, 12/2005, 08/2005, 07/2004, 03/2003, 07/2002

Attachments:

Approval Signatures

Step Description	Approver	Date
Board of Directors	Herman Cole: Chairman, Board of Directors	pending
President/CEO	George Mikitarian: President/CEO [AJ]	11/2019
Executive Management Committee	Executive Management Committee [AJ]	11/2019
Medical Executive Committee	Joseph Rojas [EH]	11/2019
Compliance	Corporate Compliance [NV]	09/2019
Executive Management	Edwin Loftin: SR Vice President/CNO	09/2019
	Lori Thompson: Risk Manager	08/2019

Applicability

Parrish Medical Center

Origination:	*11/2008*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/2019*
Next Review:	*3 years after approval*
Areas:	*Acute Care Services*
Tags:	*9500*
Applicability:	*Parrish Medical Center*

Patient Identification Wristbands, 9500-2032

POLICY

It shall be the policy of Parrish Medical Center to promote patient safety by standardizing patient identification wristbands.

PURPOSE

Color wristbands are used to alert care partners to specific risk factors for inpatients and certain outpatients.

SCOPE

This policy addresses patients that are provided wristbands in all clinical areas of the organization.

PROCEDURE

A. The following are the standardized wristband colors used at Parrish Medical Center:
   1. White – admission wristband with patient information to include name, date of birth and medical record number
   2. Red – allergy alert (specific allergies written on wristband with indelible marker)
   3. Yellow – fall risk
   4. Purple – Do Not Resuscitate (DNR)
   5. Green – isolation alert
   6. Pink – lymphedema alert (placed on affected arm)

B. Patients transferred or incoming from other facilities or providers will have wristbands removed at time of admission. Ornamental and/or other colored wristbands of any kind will also be removed. These items should be returned to the family or significant other accompanying the patient or may be placed in safe-keeping as valuables.

C. Wristbands will be applied upon admission, upon changes in condition, or when pertinent information is available during the hospital stay.

D. Care partners will educate the patient and their family members ~~as to~~concerning the purpose of the wristbands.

E. All wristbands will be verified during initial assessment, during hand-off of care, as care is provided, and

during facility-to-facility transfer.

F. Care partners will verify the use of specific wristbands (including color and purpose) with the patient, upon review of the medical records, and upon review of any other relevant resources or information to identify accuracy. For example, if a care partner sees a patient with a purple wristband, the existence of the DNR order on the chart should be verified.

RESPONSIBILITY

All care partners are responsible for determining the need and accuracy of colored wristbands. All care partners are also responsible for ~~checking~~verifying each patient's wristband in order to promote patient safety and abide by the patient's desires regarding resuscitation.

REFERENCES

Joint Commission 2015 Hospital Accreditation Standards NPSG 1

All revision dates: 11/2019, 09/2015

Attachments:

Approval Signatures

Step Description	Approver	Date
Board of Directors	Herman Cole: Chairman, Board of Directors	pending
President/CEO	George Mikitarian: President/CEO [AJ]	11/2019
Executive Management Committee	Executive Management Committee [AJ]	11/2019
Medical Executive Committee	Joseph Rojas [EH]	11/2019
Compliance	Corporate Compliance [NV]	09/2019
Executive Management	Edwin Loftin: SR Vice President/CNO	09/2019
	Edwin Loftin: SR Vice President/CNO	09/2019

Applicability

Parrish Medical Center

Origination:	*12/1997*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/2019*
Next Review:	*3 years after approval*
Areas:	*Risk Management*
Tags:	*9500*
Applicability:	*Parrish Medical Center*

Patients Leaving Against Medical Advice (AMA)

POLICY STATEMENT

Against Medical Advice ~~is a term used in the hospital when a patient leaves against the advice of their doctor. Data suggests that in general, patients discharged Against Medical Advice have an increased risk of hospital readmission, and potentially death. Although a competent adult patient has the right to decide whether or not to submit to medical treatment, patients leaving against medical advice~~ (AMA) is a term used when a patient leaves the hospital against the advice of their doctor. Data suggests that in general, patients discharged Against Medical Advice have an increased risk of hospital readmission, and potentially death. Although a competent adult patient has the right to decide whether or not to submit to medical treatment, patients leaving against medical advice may present a risk to themselves and others, particularly if they must drive a motor vehicle after leaving the hospital. Action must be taken to minimize the possibility of harm to themselves or others, and a discussion with proper documentation must occur. This discussion which includes disclosure of the risks, benefits, and alternatives to hospitalization, as well as the patient's understanding, should be documented in the patient's chart

PROCEDURES

A. When a patient indicates that he/she wants to leave the hospital AMA:
   1. Staff shall immediately notify the attending physician.
   2. Staff shall try to determine why he or she insists on leaving,
   3. Staff shall identify family members or friends who might be persuasive and might help eliminate the need for an AMA discharge.
   4. If the attending physician and the hospital staff are still unable to make the patient reconsider, the attending physician may need to determine whether the patient has the capacity to make the decision to leave AMA. A detailed description of the patient's mental status and overall appearance, including inappropriate actions the patient has taken, should be included in the chart.

B. Encourage the patient to remain until the attending physician can discuss the risks and consequences involved in leaving the hospital.
   1. If the patient attempts to leave before the physician arrives, request the assistance of another physician, if appropriate, or arrange for a telephone conversation between the attending physician and the patient.
   2. A telephone call must be witnessed by a R.N. who can verify and document the conversation.

C. If all efforts to persuade the patient to stay fail, it is important to ask the patient to sign the AMA form. If family members are present, they should also be asked to sign the form.

1. If ~~family members are present, they should also be asked~~the patient refuses to sign ~~the form.~~

   ~~If the patient refuses to sign~~ the form, note "Patient refuses to sign" in the space provided for patient's signature. Document a brief note concerning the circumstances of the refusal. Other care partners present when the form was offered and refused may also sign as witness to the refusal.

2. Inform the patient that if he/she changes his/her mind and wants to receive treatment, they will not be denied treatment because of leaving AMA.

D. Minors who lack the legal authority to make healthcare decisions, or lack the capacity to make healthcare decisions, ~~the patient has~~have the right to have a legal representative make the decision to stay or leave for her or him.

E. Documentation of Leaving Against Medical Advice

1. In the medical record document the discharge instructions provided.
2. A signed AMA form is acknowledgement that a discussion with the patient of the risks of discharge has occurred.
3. The recommendations for care, the mental capacity assessment, the patient's reasons for refusing investigation or treatment, and the follow-up and discharge instructions should be documented in the medical record.

F. If the patient has received an analgesic or tranquilizing medication within the previous four hours, an assessment must be made regarding the effects of the medication:

1. By a member of the medical staff, or
2. By a nurse caring for that patient, and who is familiar with the patient's specific condition.

G. If the patient is determined to be possibly impaired due to medication, the following alternatives may be presented:

1. Take proper precautions to see that the patient leaves the hospital in a safe manner.
2. Advise the patient that he/she should not drive a vehicle because the medication received may impair their judgment or coordination, and request they remain until the effects of the medication have fully worn off.
3. If the patient still insists on leaving, it may be appropriate to provide them a ride home at the hospital's expense via either a taxi cab or the Healing in Motion van.
4. If the patient is determined to be significantly impaired by medication and still insists on leaving, inform them that it may be necessary to:
   a. Notify the police department that they will be driving under the influence of a medication. (Hopefully, this will be an adequate deterrent to them leaving and driving).
   b. If the patient insists on leaving despite the warning, request that they sign the appropriate portion of the form : "AMA: Leaving Against Medical Advice" (Attachment 'A' OR Form ~~P-526 (Patient Consent of Admission and/or Medical Treatment~~E711 in Form Fast) indicating that they have been advised against leaving.

H. As a last resort, where there is significant indication that the patient is impaired by medication, notify the TPD that the patient insists on leaving, and intends to drive a motor vehicle.

1. Because notification of the TPD may be considered a violation of patient confidentiality, a final decision for this action must be made by one of the following:
    a. the Medical Director of a department/unit,
    b. the attending physician or consulting physician, or
    c. appropriate administrative representative

I. If the patient has been admitted under a "Form ~~52-A~~E1334a" (Baker Act), the patient may be physically restrained, if possible, until a physician determines the requirements for a "Form ~~52-A~~E1334a" are no longer met.
    1. If a patient leaves AMA while a "Form ~~52-A~~E1334a" is in effect, the Titusville Police Department (TPD) must be notified.

J. If the patient is exhibiting behavior which indicates he/she is incompetent due to a medical condition, effect of medication, or other substances a "Form ~~52-B~~E1334a" (Baker Act) may be initiated by a:
    1. Physician
    2. Psychiatric nurse (an MSN with a minimum of two years experience)
    3. Licensed clinical social worker (LCSW)

K. The patient under a Baker Act may ~~then~~ be physically released from the hospital if:
    1. At any time a patient is found to no longer meet the criteria for involuntary placement, the attending physician shall:
        a. Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer;
        b. Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge or adjudicated incapacitated;
        c. Place improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

L. Documentation of Event:
    1. Complete an Incident Report documenting the AMA event.

All revision dates: 11/2019, 04/2014, 12/2008

Attachments:

AMA: LEAVING AGAINST MEDICAL ADVICE FORM

Approval Signatures

Step Description	Approver	Date
BOD	Herman Cole: Chairman, Board of Directors	pending
President/CEO	George Mikitarian: President/CEO [AJ]	11/2019
MEC	Joseph Rojas [EH]	09/2019
Compliance	Corporate Compliance [NV]	09/2019
Executive Management	Chris McAlpine: Sr V.P. Administration Transformation	05/2019

Step Description	Approver	Date
	Lori Thompson: Risk Manager	05/2019

Applicability

Parrish Medical Center

PARRISH
MEDICAL CENTER

AMA: LEAVING AGAINST MEDICAL ADVICE

Patient Name: _____ *(Place patient label or print name)*

I am voluntarily leaving the hospital against the advice of Dr. _____ and/ or a hospital representative.

I have been told by my doctor about the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternative, if any, to continued treatment and hospitalization.

I hereby release my doctor, any other doctors involved in my care, the hospital and its employees and agents from all responsibility for any injury or ill effects which may result from this action.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/ parent/ conservator/ guardian)

If signed by other than patient, indicate relationship: _____

Witness: _____

I declare that I have personally explained to the patient the risks and consequences involved m leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

Remarks: _____

Date: _____ Time: _____ AM / PM

Signature: _____
(physician or hospital representative)

Origination:	*08/1996*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/2019*
Next Review:	*3 years after approval*
Areas:	*Risk Management*
Tags:	*9500, TJC*
Applicability:	*Parrish Medical Center*

Ethics, 9500-2035

Statement of Organizational Ethics

It is the responsibility of every member of the organization--board of directors, management staff, physicians, auxilians, and employees to act in a manner that is consistent with the organizational objectives and its supporting policies. This policy applies to all PMC facilities.

Guiding Principles

All patients, employees, physicians, auxilians, and visitors will be treated with dignity and respect. We will fairly and accurately represent PMC's capabilities to all. We will provide services to meet identified needs of PMC patients in the North Brevard County area and will constantly seek to avoid provision of those services that are unnecessary. To avoid compromising quality of care, we will not make contractual agreements that may create conflicts in the relationship between the use of services or supplies and financial incentives. We recognize that the potential for conflict of interest exists for decision-makers at all levels within the organization. It is our policy to require the disclosure of potential conflicts of interest so that appropriate action may be taken to ensure that such conflict will not inappropriately influence important decisions.

We will adhere to a uniform standard of care and quality throughout the organization and will consistently follow standards of care based upon the needs of the patient regardless of the patient's financial status. We will not turn away patients in urgent need of care because of their inability to pay or any other factor that is substantially unrelated to patient care. We will maintain sensitivity to the human dignity of all persons, regardless of their disability, race, ethnicity, culture, religion, gender, age, lifestyle diversity, or financial status, and will treat all with fairness and respect.

Respect for the Patient (Attachment "A")

We will seek to preserve the dignity, self-respect and rights of every patient in an environment of care and concern that also gives reasonable consideration to background, culture, religion and heritage. We will seek to provide this care in a patient-centered approach where the total health care needs of the patient and family are met. We will involve the patient and family in decisions regarding the care that we deliver and will seek to assure they receive information about the benefits, risks, treatment, alternatives and outcomes associated with the care they are receiving. We will respect the wishes of patients, families, and health care professionals regarding withholding or withdrawing of life sustaining treatment. The Institutional Ethics Committee is available as a resource and mechanism for conflict resolution.

We will endeavor to understand, respect, and comply with their wishes informing patients, families/significant

others, physicians and other clients of the availability of the Ethics Committee as a resource and mechanism for conflict resolution. In addition, the Western Institutional Review Board (WIRB), will review, approve, and monitor any investigational studies or clinical trials involving patients. We will assure the patient is informed of the risks, benefits, and alternatives prior to consenting to participate in any study.

Resolution of Conflicts

We recognize that from time to time conflicts may arise among those who participate in organizational and patient care decisions. Regardless of the source or participants, we will seek to resolve all conflicts fairly and objectively. In cases where mutual satisfaction cannot be achieved, it is the policy to involve appropriate administrative personnel regarding organizational matters and the Institutional Ethics Committee to facilitate resolution of patient care issues. Other staff and second opinions will be involved as needed to pursue a mutually satisfactory resolution.

Admissions, Discharges, and Transfers

Parrish Medical Center is committed to be in full compliance with ~~Section VI~~Section VI, Civil Rights Act of 1964, ~~Civil Rights Act of 1964~~Section 504 of the Rehabilitation Act of 1973, ~~Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975~~and the Age Discrimination Act of 1975. The health care services at Parrish Medical Center are available to all persons without regard to race, color, religion, sex, national origin, disability, age or medical status. While providing emergency services, no person is denied services because of their inability to pay or demands of third party payors such as Health Maintenance Organizations (HMOs). Treatment or admission will be provided based solely on clinical needs, and not managed care requirements. We will make and accept referrals in the best interest of patients.

Parrish Medical Center will provide the address and phone number of each state agency responsible for responding to patient complaints about the provider or facility's noncompliance with licensing requirements. This facility ensures that inpatients are provided the opportunity during admission to receive information regarding their rights and how to file complaints with the facility and appropriate state agencies.

Parrish Medical Center and Medical Staff will comply with Federal Statutes and Regulations written by CMS (Centers for Medicare/Medicaid), and enacted by Congress, regarding Emergency Medical Treatment and Active Labor Act. Any patient presenting to the hospital for examination of a medical condition will be provided with a medical screening exam within the hospital's Emergency Department capability, including ancillary services routinely available to the Emergency Department to determine whether or not an emergency condition exists.

Patient safety and medical stability is of prime concern, and all transfers shall be in the patient's best interest, or at their request. And, unless the transfer is necessitated for immediate life sustaining treatment, all patients will be stabilized prior to transfer.

All patients are discharged upon achieving recognized discharge criteria or are safely transferred or diverted to another hospital or other health care provider for continuum of care.

Patient Responsibilities

In providing care, hospitals have the right to expect behavior on the part of patients, their relatives, and, their friends, that is reasonable and responsible. A patient has the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints (e.g. reason(s) that brought them to the hospital), past illnesses, hospitalizations, medications, and other matters relating to their health. They have

the responsibility to report unexpected changes in their condition to their responsible practitioner(s). A patient is responsible for reporting whether they clearly comprehend and understand the contemplated course of action and what is expected of them.

A patient is responsible for following the treatment plan recommended by their practitioner primarily responsible for their care. This may include following the instructions of nurses and allied health personnel as they carry our the coordinated plan of care, implement the attending or consulting physician's orders and enforce the applicable hospital rules and regulations. The patient is responsible for keeping all appointments and, when they are unable to do so for any reason, they should notify their physician and/or the hospital.

The patient is responsible for their actions if they refuse treatment or do not follow their practitioner's instructions. Any patient leaving against medical advice shall sign a statement to this effect to release the hospital and their practitioner from any responsibility for their health or well-being.

The patient is responsible for their financial obligations of the healthcare treatments provided to them once they have been fulfilled unless advance alternate arrangements have been made. The patient is responsible for following hospital rules and regulations affecting patient care and conduct. The patient is responsible for being considerate of the rights of other patients and hospital personnel and for assisting in the control of noise, the number of visitors and in abstinence of smoking in any of the facilities. There are designated smoking areas where they may go to smoke if their physician allows them to. The patient is responsible for being respectful of the property of other persons and of the hospital and its facilities.

Competency

We are committed to maintain the highest level of competency, skill and expertise among staff and auxilians in our delivery of care. We will ensure competency, based upon identified position descriptions, in our recruitment, selection, orientation, training and periodic evaluations of every employee; appreciate cultural, religious and life-style diversity among staff and auxilians; support, affirm and empower staff and auxilians in the delivery of quality care; expect all personnel to measure and assess their continuous improvement in how they perform what they do; recognize the stress factors inherent in health care services and provide access to ongoing support, assistance and opportunities for personal and professional development.

End of Life Care for the Terminally Ill

Care of the terminally ill patient focuses on the comfort, dignity, psychological, social, emotional, spiritual, and cultural concerns of the patient and the family. The patient is observed for physical signs of impending death. The patient's ability to fulfill basic needs without help will be monitored so that assistance can be provided when necessary. Appropriate pain management is critical. The degree and nature of pain intensity as well as relief will be assessed and re-assessed at regular intervals. Patient preferences used for pain management will be respected when determining what methods will be used.

The patient and family's psycho-social condition will be observed for:

A. Support needs through establishing relationships

B. Stages of grieving and associated needs during the process

C. Needs to express feelings, concerns, fears, spiritual issues

Institutional Ethics Committee Composition, Responsibilities, Education

The Institutional Ethics Committee is a multi-disciplinary, voluntary committee comprised of the following members:
Medical Staff members (5): (1) Chair, 2 Physicians,
(1) Hospice and one other*
Community Clergy (1)
Hospital Chaplain (1)
Community Attorney (1)
Nurses (3): (1) ICU Nurse and two others
Senior ~~V.P. Professional Services~~Vice President Administration/CTO
Designee, Quality Resource Management/Risk Management
Case Manager
Customer Relations Coordinator
Patient Safety Officer

The Institutional Ethics Committee meets quarterly to discuss ethical consults requested by healthcare staff during the quarter. Any member of the healthcare team may request an ethics consult. This is done through the QRM Department who coordinates the meetings. For ethics consult meetings, the nurse caring for the patient, the attending physician and members of the Institutional Ethics Committee will be contacted to meet. All information discussed during ethics consult meetings will be kept confidential. The purpose and objectives of the Institutional Ethics Committee is:

A. To provide a forum to listen to and review concerns of the patient or their designated representative, family members, physician(s), and hospital staff when ethical issues or conflicts arise.
B. To carefully and compassionately clarify, discuss, evaluate, and mediate the issues and individual rights.
C. To ensure that a supportive, courteous, and helpful attitude is conveyed without judgment or criticism when differing views emerge.
D. To offer a recommendation that imposes no obligation for acceptance.
E. To protect the patient's, or their legal representative, legal right to refuse or request treatment.
F. To encourage and strengthen rapport among all members of the healthcare team by providing a forum for airing differences, defusing frustrations, and resolving conflict when ethical issues are presented.
G. To promote and facilitate communication of information so mutual understanding between healthcare providers and recipients is achieved.
H. To recommend policy or policy development to the Board of Directors, Administration and the Medical Staff.
I. To provide educational opportunities for patients, family members, medical staff, and hospital staff.

Members of the Institutional Ethics Committee will receive 'just in time' education at their first meeting. Additionally, the QRM Department will coordinate at least one Ethics Educational session annually. Ethics is included during the QRM portion of hospital orientation.

Confidentiality, Immunity from Liability and

Indemnification

All activities set forth in this Ethics Policy, including information collected by any medical staff committee, administrative committee, team, or hospital department in order to evaluate the ethical issues, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure consistent with the PMC confidentiality policies and procedures. Per Florida Statute 395.0197, no individual reporting, providing information, opinion, counsel or services to a hospital or medical staff committee or any other administrative or governing body committee that evaluates ethical concerns, conflicts or quality of care issues, or as a part of the Medical Staff Review Committee program, shall be liable in a suit for damages based on such reporting, providing information, opinion, counsel or services provided that such individual or institution acts in good faith and with reasonable belief that said actions are warranted in connection with or in furtherance of the functions of Parrish Medical Center. The North Brevard County Hospital District dba Parrish Medical Center agrees to indemnify and hold harmless from all claims against any member of the Medical Staff and all other healthcare/ administrative staff for activities, conducted in good faith and without malice, in support of committee participation in working together on opportunities to resolve conflicts, resolve ethical issues/dilemmas, improve patient care delivery, treatment and outcomes.

Please see the attached A: A Patient's Bill of Rights and Responsibilities

Please see the attached B: Apnea Test Protocol for Determination of Brain Death

REFERENCES

~~Advance Directives Policy No. 9500-2048~~Advance Directives Policy No. 9500-2048

~~Organ/Tissue Donation for Transplantation; Brain Death Protocol Policy No. 9500-2011~~Organ/Tissue Donation for Transplantation; Brain Death Protocol Policy No. 9500-2011

~~TJC Standards: RI.01.01.01, RI.01.05.01, LD.02.02.01, LD.02.02.01~~TJC Standards: RI.01.01.01, RI.01.05.01, LD.02.02.01, LD.02.02.01

All revision dates: 11/2019, 10/2014, 03/2013, 02/2011, 11/2009, 09/2007, 10/2006, 12/2005

Attachments:

A: A Patient's Bill of Rights and Responsibilities
B: Apnea Test Protocol for Determination of Brain Death

Approval Signatures

Step Description	Approver	Date
BOD	Herman Cole: Chairman, Board of Directors	pending
President/CEO	George Mikitarian: President/CEO [AJ]	11/2019
MEC	Joseph Rojas [EH]	11/2019
Compliance	Corporate Compliance [NV]	09/2019
Executive Management	Chris Mcalpine: Sr V.P. Administration Transformation	09/2019
	Lori Thompson: Risk Manager	08/2019

Applicability

Parrish Medical Center

Origination:	*08/1979*
Effective:	*Upon Approval*
Last Approved:	*N/A*
Last Revised:	*11/2019*
Next Review:	*3 years after approval*
Areas:	*Risk Management*
Tags:	*9500*
Applicability:	*Parrish Medical Center*

Risk Management Program & Plan, 9500-8012

BOARD, ADMINISTRATIVE ENDORSEMENT

In accordance with the corporate and medical staff bylaws of Parrish Medical Center, the Board of Directors (Board), Administration, and Medical Staff shall continue to provide quality health care within accepted standards of medical/professional care, as well as provide for the safe delivery of this care to the sick of every race, color, creed, national origin, and economic condition. The Hospital will also continue to provide a safe environment for all patients, visitors and employees and insure adequate precautions against potential disasters.

Problems related to the safe delivery of medical/professional care and to the environment, which pose actual or potential injury to patients, visitors and employees will be evaluated and acted upon through the Safety Committee and/or the Patient Care Improvement Committee, and when appropriate, the Hospital's Risk Management program.

The Board, Administration and Medical Staff will work to establish, maintain and support this comprehensive Risk Management program. Each will insure the institution of effective mechanisms for assessing and appropriately responding to Risk Management findings and recommendations.

PURPOSE

The Risk Management program's specific purpose is to reduce, and/or eliminate, practices and/or conditions, that are likely to give rise to patient, employee or visitor injury, thereby placing the assets of the organization at risk of loss."

GOALS AND OBJECTIVES

It shall be the goal of the Board, Administration and Medical Staff to establish a formal risk management program that:

A. Strives to provide the safe delivery of quality health care within reasonable financial/ resource limits.

B. Facilitates the timely identification and resolution of risk in an effort to reduce or prevent the potential for injury and/or loss.

C. Fosters effective patient/family/caregiver communication on patient care and safety problems.

D. Enhances organizational relations, community image and consumer confidence.

E. Works to continually improve the ongoing delivery of health care services and strengthen the organization.

~~Gives the organization the ability to exercise internal controls over:~~

- ~~Reducing financial losses associated with claims experience.~~
- ~~Decreasing the number, frequency and severity of claims.~~

In order to accomplish these goals, the following objectives have been established:

~~Demonstrate a commitment by the Board of Directors to support the desired risk management activities by providing resources, both manpower and financial, necessary for implementing the daily functions of the program.~~

~~Maintain an incident reporting system with specific reporting procedures to facilitate prompt administrative notification of all patient, visitor, employee and product incidents.~~

F. ~~Establish an~~Gives the organization~~-wide patient complaint system that communicates potential liability issues to the Risk Manager~~ the ability to exercise internal controls over:

- Reducing financial losses associated with claims experience.
- Decreasing the number, frequency and severity of claims.

In order to accomplish these goals, ~~and provide quarterly reports to the Joint Risk Management Committee. The patient complaint system will include an analysis of patient grievances that relate to patient care and the quality of medical services.~~the following objectives have been established:

1. Demonstrate a commitment by the Board of Directors to support the desired risk management activities by providing resources, both manpower and financial, necessary for implementing the daily functions of the program.
2. Maintain an incident reporting system with specific reporting procedures to facilitate prompt administrative notification of all patient, visitor, employee and product incidents.
3. Establish an organization-wide patient complaint system that communicates potential liability issues to the Risk Manager, and provides quarterly reports to the Joint Risk Management Committee. The patient complaint system will include an analysis of patient grievances that relate to patient care and the quality of medical services.
4. Centralize risk management data collection in the Quality & Resource Management office.
5. Develop regular risk management reporting and accountability mechanisms for hospital and medical staff departments.

~~Centralize risk management data collection in the Quality & Resource Management office.~~

~~Develop regular risk management reporting and accountability mechanisms for hospital and medical staff departments.~~

ACCOUNTABILITY AND AUTHORITY

The authority and responsibility for the establishment, maintenance, support and evaluation of the risk management program is vested in the Board of Directors. The Board delegates the responsibility for the implementation of risk management functions to the President/Chief Executive Officer of the organization and the Risk Manager. The coordination of all risk management activities is assigned to the Director of Risk Management, who shall report directly to the President/Chief Executive Officer or their designee.

RESPONSIBILITY:

A. **ORGANIZATION**

The Risk Management Program will be the administrative responsibility of the Risk Manager and President/Chief Executive Officer or designee as delegated by the Board of Directors. The Risk Manager/ Director of the Quality & Resource Management Department will be responsible for the coordination of all risk management investigation, review, and reporting activities.

B. **CLAIMS SCREENING PROCESS**

Claims screening will be performed by the Risk Manager, Sr. Vice President, Professional Services/ Administration, and the President/Chief Executive Officer. Claims will be forwarded to PMC's defense legal counsel upon the agreement of the Risk Manager, Sr. Vice President, Professional Services/ Administration, and the President/Chief Executive Officer. When an incident in the Hospital may have the potential for litigation or potential payment by the Hospital to an injured patient or visitor, or beneficiaries and/or heirs, the Risk Manager will confer with the Sr. Vice President, Professional Services/Administration and the President/Chief Executive Officer.

Specific responsibilities for actual claim screening as well as potential claim screening includes:

1. Review of adverse patient incident(s) per protocol described in **Attachment "A"**.
   Review of allegation of sexual misconduct per protocol described in **Attachment "B".**
2. Secure those third-party consultative services that will assist in determining an equitable settlement. Those services may include additional expert review and/or insurance adjusting expertise, as needed.
3. Make recommendations to the President/CEO for settlement payments up to $50,000.
4. Make recommendation to the Board of Directors through legal counsel for settlement payments in excess of $50,000.

C. **JOINT RISK MANAGEMENT COMMITTEE**

This Committee, appointed by the Board of Directors, meets quarterly and more often as needed. This committee is coordinated by the ~~risk manager~~Risk Manager, and chaired by a member of the medical staff. Specific responsibilities are:

1. Review and evaluate incidents or actions of the organization and its employees which may result in a claim against the organization regarding the treatment of any inpatients or outpatients of the organization.
2. Review medical records of the organization or other information furnished to the committee from third parties relating to a potential claim against the organization.
3. Interview persons having any knowledge or information that would assist the committee in carrying out its duties hereunder as necessary.
4. The members of the committee shall prepare, when requested by the organization's Defense Counsel, the summary of committee conclusions, degree of liability, and suggestions as to strategy that could be utilized by the organization in defending against any potential claim. The report shall be prepared exclusively for any threatened or anticipated litigation or legal proceeding against the organization.

5. Make recommendation to the President/Chief Executive Officer as to specific actions to be taken on an individual case.
6. Review regular summary reports on organization's Department/Medical Staff Risk Management activities submitted by the risk manager. Monitor satisfactory resolution to any identified problems.
7. Monitor organization and Medical Staff compliance with risk management program objectives and regulatory requirements.
8. Review of adverse patient incidents to determine if they meet State of Florida criteria for reporting to the Agency for Health Care Administration (AHCA). **Attachment "C".**
9. Sentinel events as defined by The Joint Commission (TJC) require root cause analysis. **Attachment "D."**

Committee membership includes:

1. Chair (Medical Staff Member)
2. President/CEO
3. Vice President – Nursing
4. Senior Vice President – Professional Services
5. Risk Manager
6. Medical Staff Representatives (2)
7. Board Member

JOINT RISK MANAGEMENT COMMITTEE, IMMUNITY FROM LIABILITY

Per paragraph 766.101(3)(a), Florida Statue (2008), there is no monetary liability on the part of, and no cause of action for damages against, any Joint Risk Management Committee member, or any physician furnishing any information to the Committee, or any person, including any person acting as a witness, incident reporter to, or investigator for, the Joint Risk Management Committee, for any act or proceeding undertaken or performed within the score of the Committee's functions, if the person acts without intentional fraud and/or malice.

INDEMNIFICATION

The North Brevard County Hospital District d/b/a Parrish Medical Center, to the extent allowed by law, agrees to indemnify and hold harmless from all claims against any member of the Medical Staff and all other healthcare/administrative staff for activities, conducted in good faith and without malice, in support of committee participation, investigations or where they are acting as agents of the hospital. These activities include but are not limited to participating in credentials review/privileging, peer review, Joint Risk Management Committee, claims screening, and disciplinary action recommendations/taken. To the extent allowed by law, the North Brevard County Hospital District shall provide legal counsel to defend any civil action brought against a staff member so engaged, and may obtain insurance for such purpose at its ~~opinion~~option.

CONFIDENTIALITY

Per Florida Statutes 395.0191, 395.0193, 395.0197, 766.101, and 768.28, any and all documents and records that are a part of the Claims Screening process, Joint Risk Management Committee, executive sessions of

committee meetings, in addition to the proceedings, reports, and records from any of the above shall be confidential, considered part of the peer review process, and not subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding, except for disciplinary and/or review action of any professional and requests made under Fla Const. Art. X, section 25.

POST-TRIAL AUTHORITY OF THE PRESIDENT/ CHIEF EXECUTIVE OFFICER OF THE ORGANIZATION

To the extent of the organization's applicable sovereign immunity limitations, the President/Chief Executive Officer shall have the authority to approve and authorize payment of any Court awarded amounts, including costs and post-judgment interest.

To the extent of the foregoing sovereign immunity limitation, the President/Chief Executive Officer shall have the further authority upon recommendation of defense legal counsel to waive any rights of appeal and/or post-trial motions.

INSURANCE

Parrish Medical Center covers employed staff and auxilians from liability under the Florida Statute 768.28, Sovereign Immunity, in the course of their employment and while working in a PMC facility. This also includes organization personnel who accompany a PMC patient via helicopter or other emergency vehicle under the direction of their supervisor or administrator on call while working at PMC. Organization employees who accompany patients while working for other employers are not covered by the organization's sovereign immunity protection.

A. **Sovereign Immunity**

Parrish Medical Center is a state entity having public accountability and responsibility. Meetings and records are open to the public so that the public can have a say in how PMC is operated. The public not only has input into the organization's operations, but also has a voice in how funds are used in addition to what research the organization may undertake. Under the doctrine of sovereign immunity, limitations on claims or judgments that are brought against the organization exist.

B. **Professional Liability**

Each licensed physician, dentist, or member of the Medical Staff of Parrish Medical Center, as well as doctoral scientists who are members of the Associate Professional Staff and Allied Health Professionals, shall be required to conform to the applicable Florida statutes regarding liability insurance coverage. This condition not only exists for licensure in their respective disciplines but includes liability insurance coverage for payment of patient liability claims. Each practitioner and Allied Health Professional shall notify the organization and furnish proof in the form of a certificate of insurance or other satisfactory written evidence of compliance with state law. Such proof shall be furnished upon admission to the medical staff and renewal certificates shall be provided not less than ten (10) days prior to the expiration of current certification. Proof of insurance coverage shall also include written confirmation that all privileges granted are included and addressed in the insurance coverage. Each practitioner and Allied Health Professional shall **immediately** notify the organization, in writing, of any modification or termination of their insurance coverage. If the practitioner participates in the Florida Birth-Related Neurological Injury Compensation

Association, the practitioner must also provide written proof to the organization. Compliance with this policy is required for all categories of the Medical Staff and is a condition of admission to, and continued membership on, the Medical Staff where there is any privilege granted to admit, attend, manage, treat and/or consult any patient in the hospital. Policies are renewed annually.

The Physicians Professional Liability Risk Retention Group, Inc. formed through AON Risk Services of Florida, can assist medical staff members with medical professional liability insurance coverage. There are specific criteria that must be met in order for medical staff members to participate. This program provides claims-made coverage with specific retroactivity allowances.

C. **General Liability**

PMC purchases general liability insurance to protect the assets of the organization when it is sued for something that is alleged as having been done or not done to the injured party or having caused property damage. Under a general liability insurance policy, the insurer is obligated to pay the legal costs of the organization in a covered liability claim or lawsuit. Covered liability claims include bodily injury, property damage, personal injury and advertising injury (damage from slander or false advertising). There are limits and exclusions to these policies that are spelled out in the agreement. The policies are renewed annually.

D. **Property/Casualty**

Property insurance covers Parrish Medical Center's buildings and their contents such as money and securities, accounts-receivable records, inventory, furniture, machinery, supplies and even intangible assets such as trademarks when damage, theft or loss occurs. Included in PMC's property/casualty overage is business-interruption insurance. Business-interruption insurance provides payments for expenses such as salaries, taxes and debts, as well as any loss of profit due to the interruption of business (e.g. hurricanes).

E. **Workers' Compensation**

Parrish Medical Center and its facilities are self-insured for Workers' Compensation claims that are managed by a third party payer. PMC's Workers' Compensation Program includes a Return to Work Program for employees with limited duty requirements. Employees who injure themselves while on the job should report directly to their supervisor and then the Employee Health Nurse for evaluation.

F. **Directors & Officers (D & O)**

Directors & Officers insurance is purchased to protect the organization's leaders from suits arising from allegations of mismanagement of operations or organization assets, conflicts of interest, acts beyond authority granted in by-laws, violation of certain state and federal laws, and, breach of fiduciary responsibilities. Surety bonds are also purchased for each Board of Director member to sign as a guarantee of faithful performance in their positions of public trust with a proper accounting of any and all public funds they would handle in their roles.

INCIDENT/VARIANCE REPORTING & COMMUNICATIONS

An incident is any unusual event or circumstances that are not consistent with the normal operation of the organization or outcome of a procedure. It may be an error, poor outcome or accident that could have or did

result in injury or loss. A "near miss" incident is an event that would have caused an adverse outcome but was intercepted before it reached the patient.

Incidents and "near miss" events are documented by the person involved in or first observing, discovering or having special information about the event in rLsolutions located on ICARE. These reports will be assigned to the Risk Manager in QRM and those who need to be involved with the incident; and also the Chief Transformation Officer will be made aware of incidents that require legal action or insurance coverage settlement. If the legal matter requires financial settlement, then the Chief Financial Officer will also be made aware. All transmission within the facility using rLsolutions will be considered **Privileged and Confidential, unless subject to a proper request under Fla. Const. Art. X, Section 25.** Once entered in to rLsolutions the Risk Manager will review the report to guarantee proper notification of the incident and will re-assign or "task-out" to another department. The ~~risk manager~~Risk Manager, in conjunction with the department coordinator or director will do their investigation and will report their findings to the proper vice president for review. If there is a potential for litigation, the report will be filed with counsel in anticipation of litigation. In the event of rLsolutions downtime paper incident reports will be available in their department or in Meditech (form E149-Risk Management Incident Report **Attachment "E**", Behavioral Report **Attachment "G"**, and form E159-Medication Error/Adverse Drug Reaction (ADR) **Attachment "F"**). The report will be completed and your supervisor will send the paper form to risk management for processing. Once the report is closed in rLsolutions, the name of the Risk Manager will be recorded in the closed name field and will be the electronic signature of the Risk Manager. Report of a variance or concern or a memorandum for the record may be used as an internal process improvement communication for issues concerning quality, risk ~~manager will~~management, patient safety or standards of care, **Attachment "H."** These reports must be ~~recorded in the closed name field and will~~completed and received by the Risk Manager within 72 hours. All fields on the form need to be ~~the electronic signature of the risk manager~~filled in as appropriate. ~~Report of a variance or concern or a memorandum for the record~~The investigation and corrective action plan may ~~be used as an internal process improvement communication for issues concerning quality, risk management, patient safety or standards of care, **Attachment "H."** These~~take longer than 72 hours to report to Risk Management. Incident reports ~~must be completed and received by the Risk Manager within 72 hours. All fields on the form need to be filled in as appropriate. The investigation and corrective action plan may take longer than 72 hours to report to Risk Management. Incident reports~~ are not to be copied unless legally required.

Adverse events as defined by AHCA and TJC are to be reported to Risk Management as soon as possible, ensuring that the appropriate chain of command for the reporter is also aware. An investigation will be undertaken as soon as practicable. A root cause analysis is performed for adverse and sentinel events. **Refer to Attachments "A," "B," "C," and "D."**

To ensure that members of the medical staff receive information regarding process improvement efforts in response to incident reports they themselves have requested, a written response should be sent to the physician within two (2) weeks with a copy of the response forwarded to the Risk Manager. The response should be written by the Department Director or Manager after the investigation with the development of a corrective action plan.

Disclosure to the patient, parent, or legal guardian occurs promptly when information is obtained, and will be carried out by the physician involved in the patient's care. The goal of the disclosure process is to provide factual information about the event. The following basic information will be communicated:

A. Acknowledgement of the event

B. Data known to date

C. Assurance that a full analysis will take place

D. What we are doing about it (additional information on an ongoing basis)

E. Measures taken to prevent recurrence

F. Apology that the event occurred

The Senior Vice President of Professional Services or designee is responsible to ensure the communication process occurs.

Disclosure criteria include but may not be limited to the following:

A. Any iatrogenic injury as a result of care and treatment of the patient

B. Any medication error or significant adverse drug reaction that causes moderate temporary effect to the patient as in a change in vital signs that requires increased monitoring, significant temporary effect where drug treatment is required to reverse the effects or where the patient has to be transferred to a higher level of care (e.g. ICU), permanent harm to the patient as in hearing loss or kidney damage requiring dialysis treatments, or death of a patient.

C. A wrong site surgery or a wrong procedure

SAFE MEDICAL DEVICES ACT & USE OF TEMPORARY EQUIPMENT

Under the Safe Medical Devices Act (the "Act"), health care facilities must report serious or potentially serious device-related injuries or illness of patients and/or employees to the manufacturer of the device, and if death is involved, to the Federal Food and Drug Administration ("FDA").

All employees who are involved with patient care, review patient care, repair devices or provide device preventative maintenance have a duty under the Act to report device- related incidents (*e.g.*, device failure, device malfunction, inadequate design or labeling and user error). This duty extends to physicians, nurses, allied health professionals, students, volunteers and all other persons affiliated with the facility. Basically, anything that is not a drug is considered a device under the Act. Examples include, but are not limited to, a(n): anesthesia machine, pacemaker, heart valve, suture, surgical sponge, wheelchair, hospital bed or gurney, catheter, infusion pump, dialysis machine and artificial joint. **Attachment "E"** **and Attachment "I"**

"GOOD CATCH" PROGRAM

The "Good Catch" Program was established to recognize employees who prevent "near miss" events from occurring and reaching a patient. The "Good Catch" Program includes a card that is signed by the Risk Manager and the employee's supervisor. The card and a "Star Buck" will be presented to the employee during a department meeting so that the employee is recognized by their colleagues as having preventing an event from occurring and promoting patient safety. **Attachment "J"**

INAPPROPRIATE CHART COMMENTS

Inappropriate comments are not to be documented in medical records or any other organizational documents. **Attachment "K"** provides the corrective action plan to be taken regarding documented inappropriate comments in medical records on in other hospital documents.

SERVICE OF LEGAL NOTICE AND RESPONSE TO SUBPOENAS

Legal notices may include a legal summons where a plaintiff has the intent to initiate a lawsuit against the hospital or it may include a subpoena, requesting a copy of a patient's medical record. All legal notices should be served to the President/Chief Executive Officer or the Administrator on call. These documents are time-sensitive so it is important that they reach the President/CEO or Administrator on call immediately by the server.

Additionally, when a governmental agency requests patient health information for an investigation they are conducting (e.g. AHCA), or when a plaintiff's attorney requests records either with a release of information consent signed by the patient or their power of attorney, **or**, with a subpoena for the records, only the individuals identified in A or B below may expedite the requests.

The process for subpoenas served on employees involving a PMC patient are to be brought to the Risk Manager as noted under "B" who will receive them and take the appropriate action. After hours, the Administrator on call would be contacted. The Risk Manager will review the employee summons in Human Resources. After review, the employee will be called and server will deliver the summons to the employee in Human Resources only. If the employee is not working we will ~~obtain~~determine a day when they are working and notify the server.

A. **For specific patient records:**
   1. Director of Health Information Management (Medical Records)
   2. Director, Business Office (Billing)
   3. Director/Manager, Diagnostic Imaging (Films)
   4. Director, Community Clinic (Medical Records pertaining to the Community Clinic)
   5. Risk Manager
   6. Human Resources Director (Personnel files)

B. **All other requests:**
   1. Risk Manager

INFORMED CONSENT, INFORMED REFUSAL, OTHER TYPES OF CONSENTS

A. To comply with the Florida Statute 766.103 Medical Consent Law, any elective, invasive medical/ surgical operative or diagnostic procedure performed at a PMC facility, requires that an informed consent be completed, **Attachment "L"** by the respective physician. A patient, however, may refuse recommended treatment as per a patient's rights.

B. It is the physician's responsibility to obtain the patients informed consent, **Attachment "M,"** by providing the patient sufficient information to enable the patient to make an informed decision. The type of information that should be disclosed to the patient during the informed consent process includes:
   1. The nature of the patient's condition and purpose for the procedure that is to be performed.
   2. The benefits that a patient may reasonably expect.

3. The nature and probability of significant or material risks and complications that may be involved.
4. The medically acceptable alternatives that is available, including the likely results if the patient does not have the proposed treatment or procedure.
5. The inability of the physician to predict or guarantee results.
6. Irreversibility of the procedure where this may be the case.
7. Practitioners other than the primary surgeon who will be performing important parts of the proposed procedure and specific tasks that will be performed by the other practitioners.
8. Observers who may be present during the proposed procedure (e.g. vendors, students) – a patient may refuse to have observers present.

C. The consent form must be completely filled out prior to the patient's signing and should not contain any medical abbreviations. The guidelines for the informed consent process include:

1. A valid patient signature where the patient has the mental and physical capacity to give their consent or refusal, or, it may be their appointed representative, **Attachment "N"**. If the patient does not have the mental capacity to give their consent (e.g. is determined through a psychiatric evaluation to not be competent) and there is no appointed representative present, the appointed representative/one with legal authority, may provide consent via the telephone. This requires two witnesses to hear the representative provide the consent and this is then documented on the consent form. In an emergency situation it is ~~the~~a matter of discretion for the treating physician to determine if consultation is advisable to confirm the existence of the emergency. The medical determination that an emergency exists should be documented by the physician in the medical record.

   The consent will be valid until there is significant change in the condition of the patient or procedure to be performed since the patient's consent was obtained (e.g. if there is a change in the history and physical, then a new consent is required). In general, consent should not be considered valid after discharge from the hospitalization for which the consent was given, unless it was clearly for continuing treatment. The patient can revoke consent at any time, either orally or in writing.
2. If the treatment requires a number of procedures (e.g. electro-convulsive therapy), and there are no significant changes in the condition of the patient or procedure to be performed, one consent form may be used that specifies the number of procedures to be performed for the patient's particular treatment. The number of procedures to be performed is explained to the patient or appointed representative during the informed consent process. The care partners shall have the responsibility on behalf of Parrish Medical Center to make certain the appropriate consent form has been completed with signatures, date and time correctly and placed in the patient's chart prior to commencement of the procedure.
3. In the absence of a properly executed informed consent, the procedure shall be cancelled or postponed until one is obtained.

STAFF WITNESSING FORMS

Members of Parrish Medical Center staff may be requested from time-to-time to sign as witnesses for various documents (e.g. Power of Attorney forms, Healthcare Surrogate forms). There should be no legal liability associated with signing as a witness to a form. By signing as a witness, an employee is in no way attesting to the legality of the document. An employee is only signing as a witness to the signatures of the person or persons who are involved. Additionally, there is no obligation assigned to an employee to serve as a witness of

a non-hospital related document.

HANDLING LAW ENFORCEMENT ISSUES & BAKER OR MARCHMAN ACT PATIENTS

Parrish Medical Center, its staff, and the medical staff are responsible for providing emergency medical treatment to all persons regardless of their legal status or ability to pay. Additionally, they must protect staff, patients and visitors by maintaining a safe environment.

The local and county law enforcement departments and agencies are responsible for protecting the law-abiding citizens within their jurisdiction to include those persons who are in their custody and who they present to PMC for emergency medical treatment or non-emergent care.

All patient-prisoners who are being treated at a PMC facility must be guarded at all times by the law enforcement staff responsible for them. Law enforcement staff will be oriented by PMC's security staff to the PMC facilities in which the patient-prisoner is receiving care.

Law enforcement staff will be oriented as to the Patient Bill of Rights, how to interact with patients, procedures for responding to unusual clinical events, incidents, emergency codes, communication channels for clinical, security and administration, seclusion and restraining administrative and clinical issues. PMC Security Officers will provide law enforcement staff with a copy of the contact telephone numbers and orientation guide pamphlet they will need as well as any other pertinent information. PMC's Security Officers will provide for an introduction to the Nurse Manager or designee of the area where the patient-prisoner is being treated. (Refer to **Attachment "O"**, for Brevard County procedures Imposition of disciplinary restrictions).

A. **Patients Presented With Law Enforcement Assistance Only**

   Patients presented to PMC for emergency medical treatment with only the assistance of law enforcement officers and not by reason of such patient's prior arrest, involuntary custody, and current incarceration or with the stated or apparent intent of any law enforcement agency to later arrest that patient, shall be the responsibility of Parrish Medical Center. Any law enforcement officer providing such assistance shall be relieved of responsibility upon transfer to and accepted by PMC emergency care personnel. PMC shall have no responsibility thereafter to provide any law enforcement agency with information regarding the medical condition or discharge status of such patients.

B. **Patients Presented Under Law Enforcement Arrest Custody**

   Any patient presented to PMC for emergency or non-emergency medical treatment that is then under arrest, involuntary custody, current incarceration or with the stated or apparent intent of any law enforcement agency to later arrest such patient, shall be required to remain at PMC under the continuous security and control of the law enforcement officer or responsible law enforcement agency. This will be until all necessary medical treatment is provided and such patient is discharged back into the custody of the law enforcement agency.

   Any such patient as noted above and who is subsequently "un-arrested," released on such patient's own recognizance or whose custody, security and control is then or later relinquished shall remain the financial responsibility of such law enforcement agency for all medical treatment provided.

   Patient-prisoners must be admitted to a private room with law enforcement staff providing the custodial-

related services. The law enforcement staff will remain in close physical proximity to the patient-prisoner at all times. An exception to this is when a patient-prisoner requires surgery and is transferred to the Operating Room. For isolation patient-prisoners, the law enforcement staff may take a position directly outside of the patient room.

The use of Seclusion and restraint for non clinical purposes - Patient-prisoners are to be shackled to the bed at all times, unless this is medically contraindicated and ordered by the attending physician. PMC Security Officers will communicate continuously with law enforcement staff as to patient-prisoners' needs (e.g. removal of shackles to transport to diagnostic testing or to surgery).

No photographs or video-taping of patient-prisoners is allowed without a written court order. Patient-prisoners and law enforcement staff are **only** to be supplied with plastic utensils and disposable plates for meals. For hygiene purposes, a patient-prisoner may only be supplied with an electric razor. Access to telephone services is not permitted by patient-prisoners.

C. **Enforcement of Financial Responsibility**

When medical treatment has been provided by PMC to patients presented under current or prior arrest, involuntary custody, incarceration or control of any law enforcement agency, that agency shall be notified of its financial responsibility and billed for all medical treatment and protective services provided to such patients.

D. **Notices to Law Enforcement Agencies and Patients**

Length of Stay - For patients presented to PMC for treatment who are then under current or prior arrest, involuntary custody, incarceration or is otherwise released with the express or apparent intent of future arrest following discharge, the Watch Commander of the law enforcement agency will be promptly notified by PMC personnel. PMC personnel will request 24-hour security and control from the law enforcement agency while the patient remains at PMC. PMC personnel shall not be responsible to accept the substitute judgment of any law enforcement officer as to whether or not such patient presents a threat, but shall presume in all instances that law enforcement custody should be maintained in order to protect staff, patients, and other persons who are present at PMC.

Plan of discharge and continuing care, treatment and services - Any patient released from or not maintained under the custody or control of the law enforcement officer or law enforcement agency or such patient's representative shall be notified by PMC personnel that such patient is free to leave PMC as soon as medically appropriate. PMC shall have no responsibility to notify any law enforcement agency either before or after such patient's departure or discharge.

E. **Requests by Law Enforcement Officers – Constitutionally Permissible Searches**

If a patient refuses to consent to medical procedures (other than blood tests) requested by law enforcement officers, the hospital should not permit the performance of any procedures, other than visual evaluation of the patient, unless the procedures will be performed under the officer's limited authority to conduct constitutionally permissible searches.

Law enforcement officers may conduct constitutionally permissible searches pursuant to a valid search warrant. However, the procedures may be performed only if the warrant:

1. States a finding of probable cause

2. Specifically describes the person and the procedures to be performed

Hospital personnel should inspect the warrant to see that it contains the above information before performing the requested procedures.

A search may not be conducted without a valid warrant **unless**:

1. The subject has been lawfully arrested or detained; and,
2. The evidence sought relates to the crime for which the patient is detained; and,
3. There is "probable cause" (if non-intrusive procedures will be performed) or a "clear indication" (if intrusive procedures will be performed) that evidence relating to the crime will be found; and
4. Exigent circumstances exist which require that the tests or procedures be performed without the delay required to obtain a warrant (e.g. the evidence would be destroyed during the delay required to obtain the warrant); and
5. The tests or procedures are "reasonable" in view of the totality of the circumstances.

Warrant-less searches should not be conducted unless the law enforcement officer acts pursuant to these strict constitutional requirements that they validate as being met to hospital personnel.

Communications and disclosure of medical information that may accompany law enforcement requests for physical items or samples from patients must comply with HIPAA privacy regulations and applicable Florida Statutes concerning confidentiality.

Law enforcement officers may request permission to interrogate a patient in the hospital. For these issues, the Administrator on call and the Risk Manager must be contacted to intervene on behalf of the hospital to ensure that the patient's rights are protected. The attending physician is to be consulted prior to any interrogation taking place to ensure that the patient is medically stable for this to occur.

F. **Marchman Act and Baker Act Patients**

The Marchman Act is the Florida Statute, Chapter 397, and Substance Abuse Impairment Act that was enacted in 1993. It encourages persons with substance abuse impairment to seek treatment voluntarily; however, there are some involuntary provisions that permit a law enforcement officer, a physician, or a judge to put a person in a licensed substance abuse facility for assessment and stabilization. Should a Marchman Act patient be presented or present to PMC's Emergency Department, they must be screened, assessed, evaluated, and medically stabilized before they can be transferred to a licensed substance abuse facility.

The Baker Act is the Florida Statute, Chapter 394, and Mental Health Act that addresses the treatment of mental illness in Florida. PMC will provide for the screening, assessment, treatment for emergency medical conditions, and stabilization of patients covered by the Florida Baker Act statute prior to transferring them to a licensed mental health facility. The Safety and Security Department shall be notified regarding the arrival of any patient covered under the Baker and/or Marchman Acts. If accompanied by a law enforcement officer, the law enforcement officer may remain in attendance. For patients exhibiting violent tendencies, Safety and Security personnel who have been trained to de-escalate violent behaviors, will respond to assist the Emergency Department with these patients. Safety and Security officers may leave once the patient is no longer violent, is restrained, or is sleeping.

Once these patients are medically stabilized and can be transferred to a designated receiving facility, the appropriate forms must be completed to accompany the patient. Approved transportation shall be arranged to transport the patient to the nearest Receiving Facility.

EMTALA

Any patient who comes to PMC's emergency department, as defined under the Emergency Medical Treatment and Active Labor Act ("EMTALA") or for whom a request is made for emergency services and care pursuant to Florida law, will be provided with a medical screening examination within the hospital's Emergency Department in compliance with EMTALA and Florida law to determine the presence of an emergency medical condition. If an emergency medical condition is determined to be present, the patient will receive stabilizing treatment and such other treatment as required by EMTALA and Florida law, within the capability and capacity of PMC. Patient safety and medical stability is of prime concern. All transfers of patients having been determined to have an emergency medical condition shall be made in accordance with EMTALA and Florida law.

Stabilized generally means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from PMC. A woman in labor is considered stabilized only if the baby and placenta are delivered. If a physician certifies that the labor is what is commonly known as false labor or Braxton Hicks contractions, the woman will not be considered to have an emergency medical condition, absent any other indications of an emergency medical condition. Any woman in active labor is generally considered as having an emergency medical condition under EMTALA, preventing discharge or transfer, unless there is absolutely no capability to deliver the baby safely. Under this circumstance, an appropriate transfer is permitted when the benefits of the transfer outweigh the risk to the woman or unborn child, or when the woman or a legally responsible person acting on the patient's behalf requests in writing the transfer after being informed of PMC's obligations under EMTALA and Florida law and the risk of transfer .

A screening examination, stabilization treatment, and reason for transfer will not be dependent on or affected by the ability to pay, method of payment, amount of time required for emergency services, prognosis, immigration status, sex, race, ethnicity, religion, national origin, citizenship, age, preexisting medical condition, physical or mental handicap, insurance status, economic status, or criminal status, except to the extent that a circumstance such as age, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient

PMC shall maintain all appropriate logs, provide all required signage, and carry out all required activities as delineated by EMTALA and Florida law. Qualified medical persons who may conduct a medical screening examination will be designated by PMC's Board in its Bylaws or Rules and Regulations. Specific departments, e.g. Emergency Department, Obstetrics/Gynecology Department, shall make recommendations to PMC's Board as to who shall be qualified to perform a medical screening examination. Standard department procedures should specify a "reasonable fixed time" beyond which a medical screening exam will not be delayed awaiting the arrival of a private physician, the procedures by which patients are to receive this exam, and a detailed transfer procedure. The procedures shall be updated to ensure ongoing compliance. **Attachment "P."**

250-yard rule and EMTALA

Attachment "T" is a map that reflects a 250-yard campus radius around the main Hospital. Designated members of the Code Blue Team to include Security will respond to Code Blue emergency situations in Parrish Medical Center's parking lots, Wound Center/North Building, and South Building. Other identified properties (e.g. US-1, Brevard Community College's adjacent road) within the 250-yard radius, the Emergency

Management System (911) will be initiated for response. Procedures will address the designated members who will respond, what equipment they will bring with them to the location, what they are responsible for, how they will manage the emergency and how they will transfer the patient to the Emergency Department.

STAT, URGENT, ROUTINE PHYSICIAN ORDERS

The terms 'stat', 'urgent', and 'routine' may be defined based on service(s) ordered and a patient's situation:

A. **STAT**

◦ **X-ray**	**Within 1 hour**
◦ **Lab**	**Within 1 hour**
◦ **Nursing**	**Within 30 minutes**
◦ **Pharmacy/Other ancillaries**	**Within 30 minutes**

B. **URGENT**

◦ **X-ray**	**Within 4 hours**	
◦ **Lab**	**Within 4 hours**	
◦ **Nursing**	**Within 1 hour**	**Also called orders**
◦ **Pharmacy/Other ancillaries**	**Within 1 hour'NOW'**	

C. **ROUTINE**

◦ **X-ray**	**Within 8 hours**
◦ **Lab**	**Within 8 hours**
◦ **All other clinical depts**	**Per Dept. schedule as approved By Medical Staff**

D. **TRAUMA & CODE TYPE SITUATIONS**

All orders are to be responded to and implemented as fast as humanly possible to preserve life and limb.

CONFLICT RESOLUTION & USE OF CHAIN OF COMMAND

As a culture of choice, PMC expects that all patients, employees, members of the Medical Staff and other persons within PMC facilities will be treated with respect and dignity. This means that all staff will conduct themselves professionally and courteously.

Abusive, disruptive and derogatory behavior is not tolerated at PMC. In maintaining good order and discipline, it is important for everyone to cooperate with each other in rendering quality care to the community PMC and its staff serves. Disruptive behavior can be demoralizing, having a direct impact on the involved staff and patients. Disruptive behavior that occurs out in the open for others to witness negatively reflects on the organization's reputation as well.

Conflicts among staff may occur in the day-to-day operations. It is important to resolve these conflicts at the lowest level of occurrence whenever and wherever possible. When this is not possible, staff should utilize their respective chains of command. The conflict is raised to the next level and continues up the chain until it is resolved or the involved parties come to a mutual understanding and agreement.

The following types of behavior are likely to be considered disruptive:

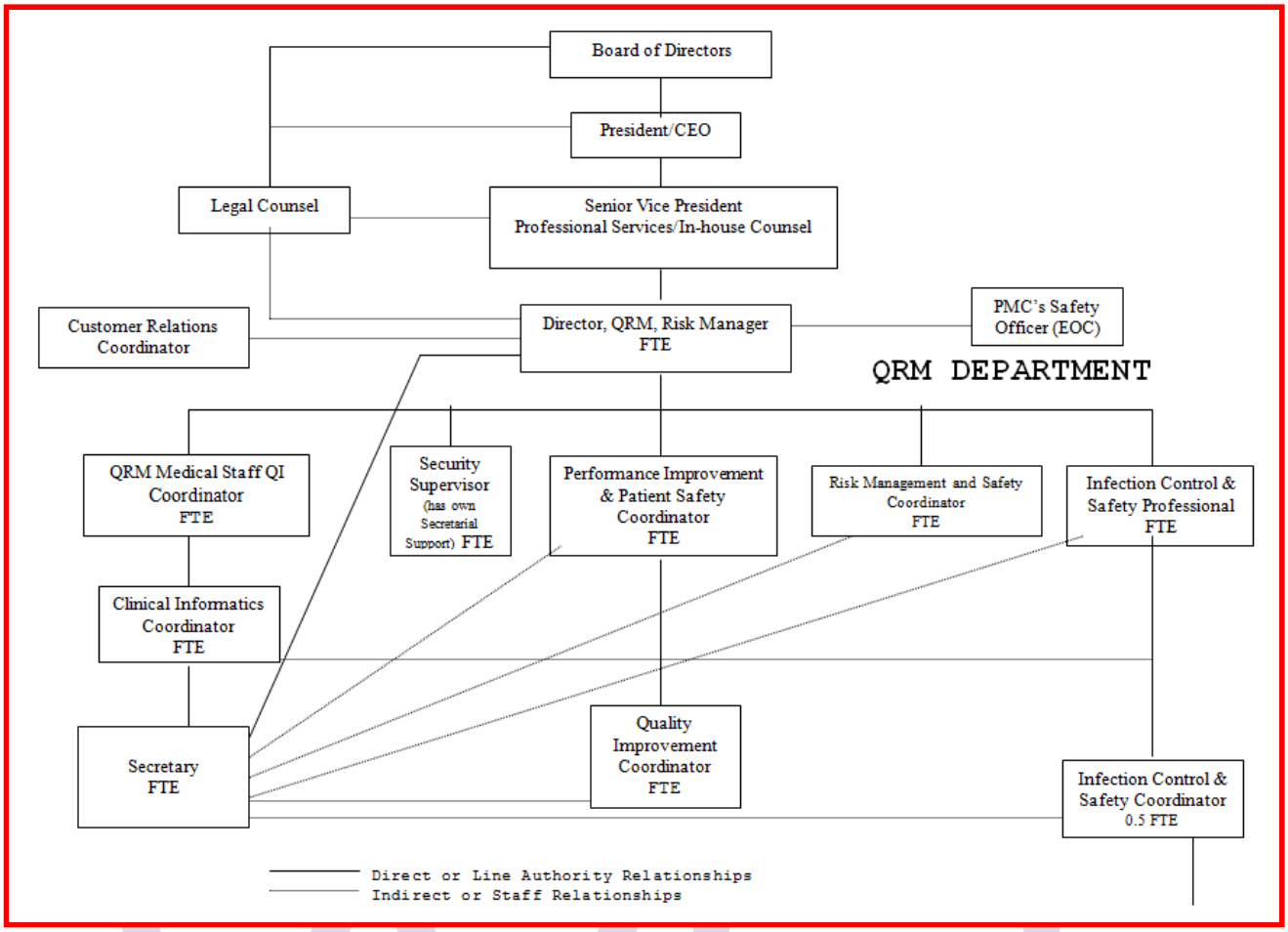
A. Intentional physical or verbal abuse
B. Sexual harassment
C. Abusive and demeaning treatment by means of:
    1. Threats
    2. Intimidation
    3. Obscene and/or profane gestures and/or language
D. Dishonest, malicious, inappropriate or unsubstantiated comments in patient charts or other documents without good faith, legal or medical justification, that can reasonably be expected to cause harm to others and seemingly intended not to correct a problem. Extreme caution should be exercised in applying this to a physician making comments or corrections in order to protect himself, the patient, the organization, or others.

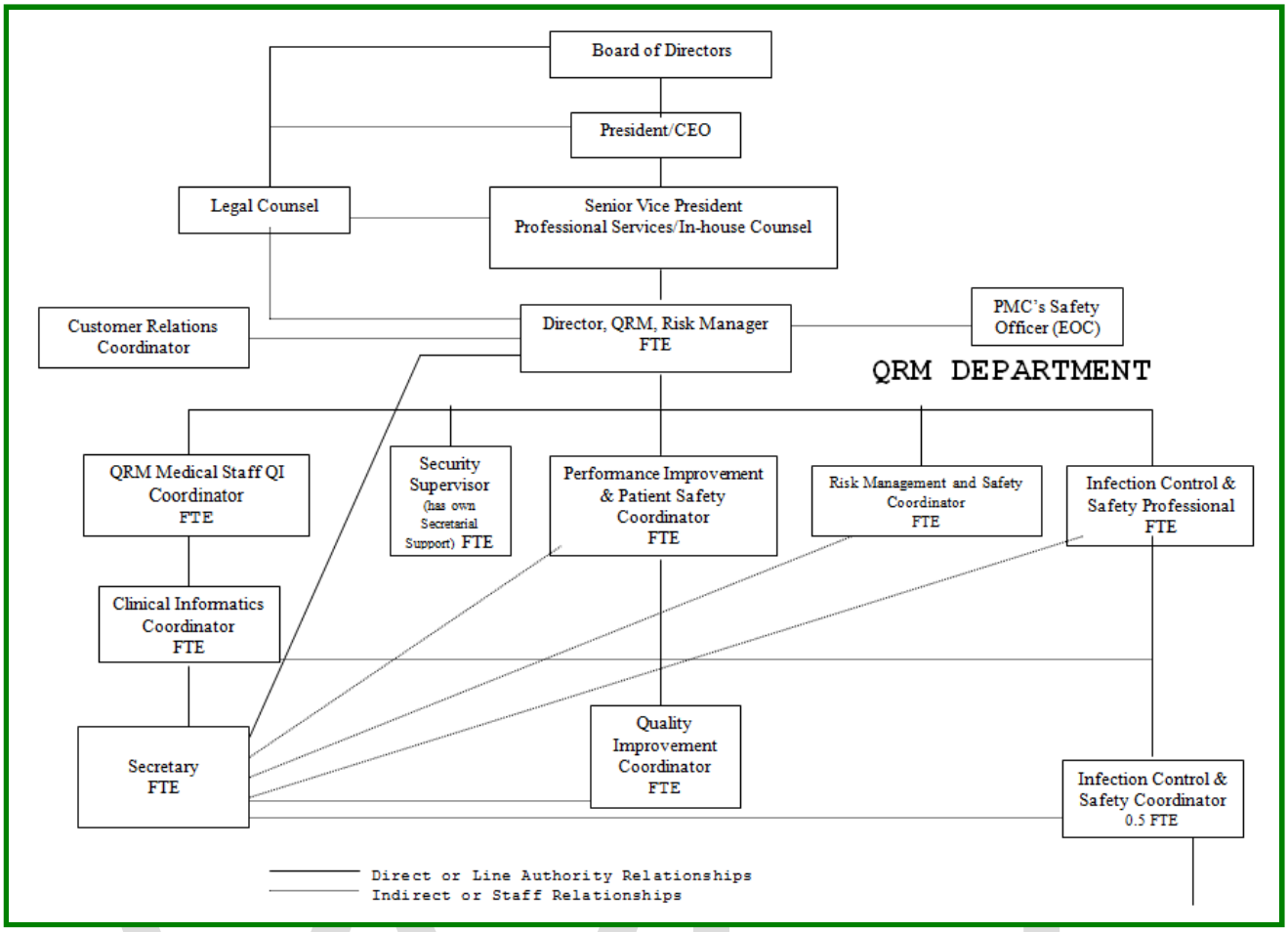
Violations will be investigated and judged in accordance with existing policies, including without limitation: (i) for members of the Medical Staff, the Medical Staff Bylaws and the Medical Staff General Rules and Regulations, specifically section VI; (ii) for patients and visitors, administrative policies 9500-24 (Patient Relations Program), 9500-2035 (Ethics – p. 5 on Patient Responsibilities and Attachment A on Patient Rights and Responsibilities), and (iii) for staff, administrative policy 9500-214 (Standards of Behavior) and the PMC Employee Handbook, or any other policies to the extent applicable.

NOTARY PUBLIC SERVICES

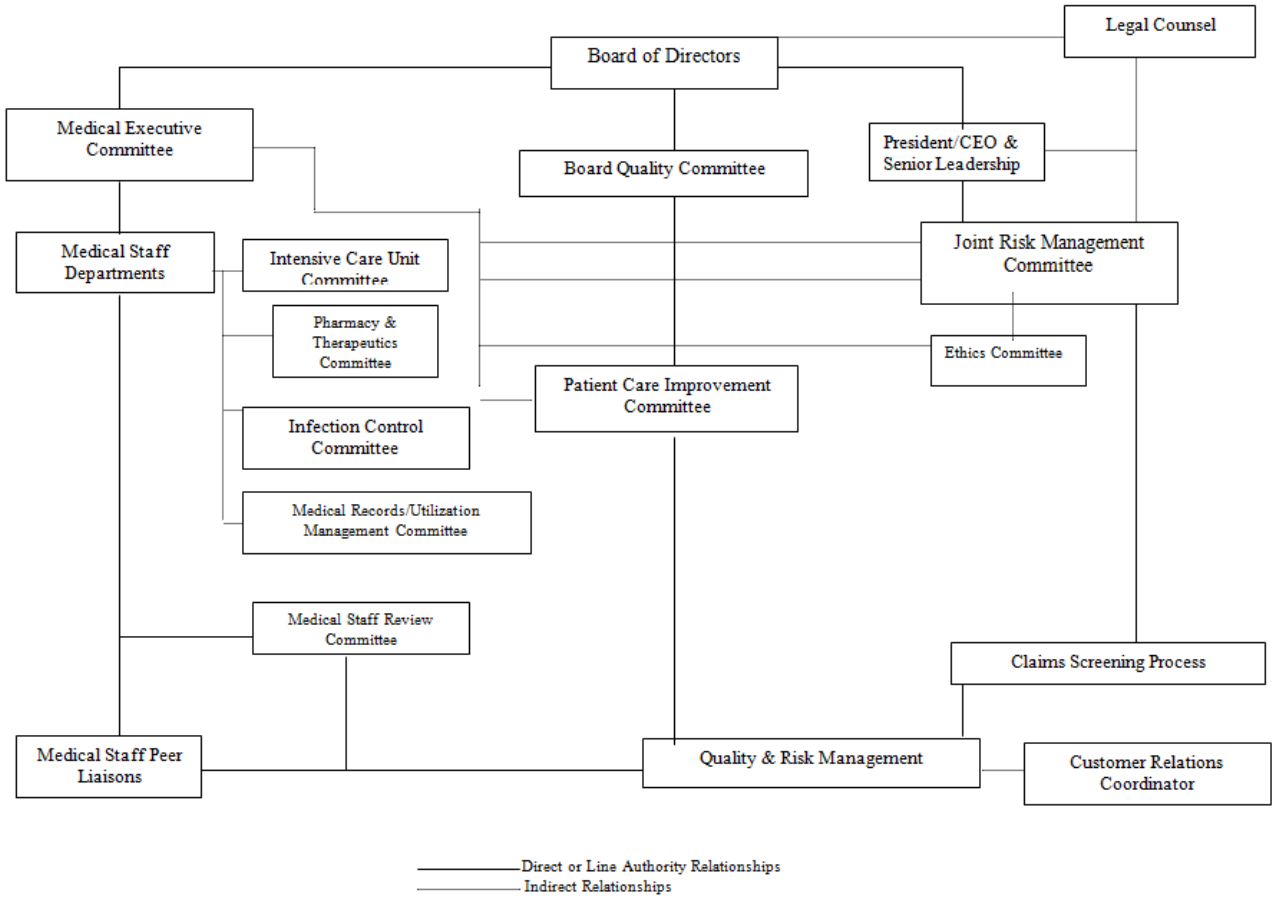
Notary Public Services are available through the hospital for patients, physicians, and employees. Notary services are available by contacting any of the following areas:

A. Administration
B. Patient Registration
C. Business Office
D. Emergency Department
E. Health Information Services
F. Human Resources
G. Medical Staff Services.


Board of Directors
President/CEO
Legal Counsel
Senior Vice President
Professional Services/In-house Counsel
Customer Relations
Coordinator
Director, QRM, Risk Manager
FTE
PMC's Safety
Officer (EOC)
QRM DEPARTMENT
QRM Medical Staff QI
Coordinator
FTE
Security
Supervisor
(has own
Secretarial
Support) FTE
Performance Improvement
& Patient Safety
Coordinator
FTE
Risk Management and Safety
Coordinator
FTE
Infection Control &
Safety Professional
FTE
Clinical Informatics
Coordinator
FTE
Secretary
FTE
Quality
Improvement
Coordinator
FTE
Infection Control &
Safety Coordinator
0.5 FTE
Direct or Line Authority Relationships
Indirect or Staff Relationships


Board of Directors
President/CEO
Legal Counsel
Senior Vice President
Professional Services/In-house Counsel
Customer Relations
Coordinator
Director, QRM, Risk Manager
FTE
PMC's Safety
Officer (EOC)
QRM DEPARTMENT
QRM Medical Staff QI
Coordinator
FTE
Security
Supervisor
(has own
Secretarial
Support) FTE
Performance Improvement
& Patient Safety
Coordinator
FTE
Risk Management and Safety
Coordinator
FTE
Infection Control &
Safety Professional
FTE
Clinical Informatics
Coordinator
FTE
Secretary
FTE
Quality
Improvement
Coordinator
FTE
Infection Control &
Safety Coordinator
0.5 FTE
Direct or Line Authority Relationships
Indirect or Staff Relationships

PMC ORGANIZATIONAL RELATIONSHIP CHART RELATIONSHIPS CHART



All revision dates: 11/2019, 02/2015, 12/2014, 11/2013, 07/2013, 01/2013, 07/2012, 09/2011, 03/2011, 01/2010, 04/2009, 11/2008, 05/2008, 06/2007, 12/2006, 08/2006, 08/2005, 10/2004, 08/2003, 10/2002, 10/2001

Attachments:

A: Adverse Incident Review Procedure
B: Allegations of Sexual Misconduct
C: Reporting “Code 15” Events
D: TJC’s Sentinel Event (SE) Definition
E: Risk Management Incident Report
F: Medication Error Data Collection Form Flowchart
G: Risk Management Behavioral Report
H: Report of a Variance or Concern Draft
I: Safe Medical Devices Act
J: Good Catch Acknowledgement Card
K: Corrective Action Plan for Inappropriate Chart Comments
L: Consent for Medical or Radiological Invasive

Diagnostic Procedure
M: Other Consents Authorizations
N: Qualifications for Signing Consent for Treatment
O: Brevard County Association of Chiefs of Police and Sheriffs Office Imposition of Disciplinary Restrictions
P: Emergency Transfers
PMC Organizational Relationship Chart
Q: Parrish Medical Center
R: Chain of Command Process for Conflict Resolution

Approval Signatures

Step Description	Approver	Date
BOD	Herman Cole: Chairman, Board of Directors	pending
President/CEO	George Mikitarian: President/CEO [AJ]	11/2019
MEC	Joseph Rojas [EH]	11/2019
Compliance	Corporate Compliance [NV]	09/2019
Executive Management	Chris Mcalpine: Sr V.P. Administration Transformation	09/2019
	Lori Thompson: Risk Manager	08/2019

Applicability

Parrish Medical Center

ATTACHMENT "A"

PARRISH MEDICAL CENTER
Titusville, Florida

ADVERSE INCIDENT REVIEW PROCEDURE

In accordance with Florida Statute 395.0197, the term "***adverse incident***" means an event over which healthcare 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 following injuries: death, brain or spinal damage, permanent disfigurement, fracture or dislocation of bones or joints, a resulting limitation of neurological, physical or sensory function which continues after discharge from the facility, any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention (other than an emergency medical condition) to which the patient has not given their informed consent, **or** any condition that required the transfer of the patient (within or outside of the facility) to a unit providing a more acute level of care due to the adverse incident rather than the patient's condition prior to the adverse incident, a condition that resulted in the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition, required surgical repair of damage resulting to a patient from a planned surgical procedure (where the damage was not a recognized specific risk) as disclosed to the patient and documented through the informed consent process **or** was a procedure to remove unplanned foreign objects remaining from a surgical procedure.

The President/CEO or in his absence the Senior Vice President of Professional Services/ Administrator on-call, along with the Vice President of Nursing, and the Risk Manager shall immediately or within 24 hours of an adverse incident initiate the following steps:

- Assess the liability exposure associated with serious incidents, and patient, visitor injuries when they occur.
- Determine the appropriate hospital and medical staff actions needed to insures proper patient/family disclosure communication.
- Determine steps necessary to reduce or minimize financial losses.
- Review steps taken by the Risk Manager to properly secure the medical records and associated case evidence (e.g. equipment, supplies used during procedure).
- Determine proper public relations responses to any media/external inquiries into the incident.
- Institute measures to prevent and/or reduce the potential for similar incidents.
- Allegations of sexual misconduct reporting are outlined in **Attachment "D."**
- If preliminary investigation by the Risk Manager determines this may be a "Serious Adverse Incident" as defined by 395.0197 of the State of Florida mandated Risk Management Program, a defined procedure will be followed to verify the incident meets requirements of a "Code-15" incident as outlined in **Attachment "E."**
- If the incident meets the definition of a TJC "sentinel event", a root cause analysis will be coordinated by the Risk Manager as per **Attachment "F."**

QRM - 10/97
Revised: 10/01, 10/02, 10/04, 08/05, 5/08

ATTACHMENT "B"

PARRISH MEDICAL CENTER
Titusville, Florida

ALLEGATIONS OF SEXUAL MISCONDUCT

Risk Management will:

1. Investigate every credible allegation of sexual misconduct which is made against a member of the facility's personnel who has direct patient contact, when the allegation is that the sexual misconduct occurred at the facility or on the grounds of the facility.

2. Report every credible allegation of sexual misconduct to the President/CEO or Administrator on call of the facility.

3. Notify the family or guardian of the victim, if a minor, that credible allegation of sexual misconduct has been made and that an investigation is being conducted.

4. Report to the Department of Health every allegation of sexual misconduct, as defined in Chapter 456 and the respective practice act, by a licensed healthcare practitioner that involves a patient.

Any witness who witnessed or who possesses actual knowledge of the act that is the basis of an allegation of sexual abuse will:

1. Notify Risk Management and the President/CEO or Administrator on call of the facility.

2. Risk Management or the Administrator on call will coordinate with the Witness to ensure notification to the Titusville Police Department by the Witness.

Sexual abuse means acts of a sexual nature committed for the sexual gratification of anyone upon, or in the presence of, a vulnerable adult, without the vulnerable adult's informed consent, or a minor. ***Sexual abuse*** includes, but is not limited to, the acts defined in Florida Statute 794.011(1)(h), fondling, exposure of a vulnerable adult's or minor's sexual organs, or the use of the vulnerable adult or minor to solicit for or engage in prostitution or sexual performance. ***Sexual abuse*** does not include any act intended for a valid medical purpose or any act which may reasonably be construed to be a normal care-giving action.

A person who, with malice or with intent to discredit or harm the hospital or any person, makes a false allegation of sexual misconduct against a member of the hospital's personnel is guilty of a misdemeanor of the second degree, punishable as provided in Florida Statute 775.082 or 775.083.

The hospital will provide AHCA with a written plan of correction. If the hospital does not comply, AHCA may impose an administrative fine.

ATTACHMENT "C"

PARRISH MEDICAL CENTER
Titusville, Florida

REPORTING "CODE 15" EVENTS

Any of the following adverse incidents, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, shall be reported by the facility to the Agency for Health Care Administration (AHCA) **within 15 calendar days** after its occurrence:

- Death of a patient
- Brain or spinal damage to a patient
- Performance of a surgical procedure on the wrong patient
- Performance of a wrong-site surgical procedure
- Performance of a wrong surgical procedure
- Performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition
- Surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed consent process
- Performance of procedures to remove unplanned foreign objects remaining from a surgical procedure

AHCA may grant extensions to the 15-calendar day reporting requirement upon justification submitted in writing by the hospital's President/Chief Executive Officer. AHCA may require an additional final report. These reports shall not be available to the public pursuant to Florida Statute 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by AHCA or the appropriate regulatory board, or pursuant to Fla. Const. Art. X, Section 25, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by AHCA or the appropriate regulatory board. AHCA or the appropriate regulatory board, however, shall make available, upon written request by a healthcare professional against which probable cause has been found, any such records which form the basis of the determination of probable cause. AHCA may investigate any such incident and prescribe measures that must or may be taken in response to the incident. AHCA will review each incident and determine whether it potentially involved conduct by the healthcare professional that is subject to disciplinary action. If this is the case, then the provisions of Florida Statute 456.073 shall apply.

AHCA will trend the adverse event reports for all Florida facilities and will publish the data analysis on its website on a quarterly basis. The data will be de-identified as to facility, patient, or healthcare practitioners involved. AHCA will also publish an annual summary of the reports, also de-identified as to facility, patient, or healthcare practitioners involved, on their website. This information may be used to prevent further similar events from occurring and reduce morbidity and mortality.

PMC does not report adverse events or sentinel events to the TJC. However, when TJC surveyors are onsite, they may review the information in the presence of the Risk Manager.

TJC's SENTINEL EVENT (SE) DEFINITION:

A ***"sentinel event"*** is an unexpected occurrence involving death or serious injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcome. Sentinel events include but are not limited to the following:

- Unanticipated death caused by significant deviation from usual hospital healthcare processes or associated with healthcare acquired infection
- Major permanent loss of function
- Abduction
- Infant discharged to the wrong family
- Rape by another patient or a staff member
- Hemolytic transfusion reaction due to mis-matched blood
- Surgery on the wrong patient or wrong body part

TJC's ROOT CAUSE ANALYSIS CHARACTERISTICS

The root cause analysis should be completed within 45 days of the event.

For a *thorough* root cause analysis:

- The proximate cause of the sentinel event is determined and the process(es) and systems related to its occurrence are identified
- Related systems and processes are analyzed
- Possible common causes and their relative potential contributions to the event are identified
- Potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future is identified; or, after analysis, a defensible determination is made that no such improvement opportunities exist
- A plan to address identified opportunities for improvement or formulation of a rationale for not undertaking such changes is established
- Where improvement actions are planned, the following are identified:
    - Who is responsible for implementation
    - When the actions will be implemented, including any pilot testing
    - How the effectiveness of the actions will be evaluated

In a *credible* root cause analysis:

- The organization's leadership and the individuals most closely involved in the processes and systems under review participate in the analysis
- The analysis is internally consistent
- The analysis includes consideration of any relevant literature

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or listed) should be conducted as appropriate to the specific event under review.

PARRISH MEDICAL CENTER
Titusville, Florida

Root Cause Analysis Matrix

	Suicide (24-Hour Care)	Medication Error	Procedural Complication	Wrong-Site Surgery	Treatment Delay	Restraint Death	Elopement Death	Assault/Rape/ Homicide	Transfusion Death	Patient Abduction	Unanticipated Death of Full-Term Infant	Unintended Retention of Foreign Body	Fall Related
Behavioral assessment process (1)	X					X	X	X					
Physical assessment process (2)	X	X	X	X	X	X	X				X		X
Individual identification process		X		X					X				
Individual observation procedures	X				X	X	X	X	X		X		X
Care planning process	X		X			X	X				X		X
Continuum of care	X	X			X	X							X
Staffing levels	X	X	X	X	X	X	X	X	X	X		X	X
Orientation and training of staff	X	X	X	X	X	X	X	X	X	X	X	X	X
Competency assessment/credentialing	X	X	X	X	X	X	X	X	X	X	X	X	X
Supervision of staff (3)	X	X	X		X	X			X			X	
Communication with individual/family	X	X		X	X	X	X			X			X
Communication among staff members	X	X	X	X	X	X	X	X	X	X	X	X	X
Availability of information	X	X	X	X	X	X			X		X		X
Adequacy of technological support		X	X										
Equipment maintenance/management		X	X		X	X					X		X
Physical environment (4)	X	X	X	X		X	X	X	X	X			X
Security systems and processes	X						X	X		X			
Medication management (5)		X	X		X				X		X		X

1. Includes the process for assessing individual's risk to self (and to others, in cases of assault, rape, or homicide where an individual is the assailant).
2. Includes search for contraband.
3. Includes supervision of physicians-in-training.
4. Includes furnishings: hardware (for example, bars, hooks, rods); lighting; distractions.
5. Includes selection and procurement; storage; ordering and transcribing; preparing and dispensing; administration and monitoring.

3/1/10

Root Cause Analysis Matrix

Privileged/Confidential

	Findings/Conclusions	Recommendations	Action Plan	Responsible Entity	Target Date for Completion
Behavioral assessment process(1)					
Physical assessment process (2)					
Individual identification process					
Individual observation procedures					
Care planning process					
Continuum of care					
Staffing levels					
Orientation & training of staff					
Competency assessment/credentialing					
Supervision of staff (3)					
Communication with Individual/family					
Communication among staff members					
Availability of information					
Adequacy of technological support					
Equipment maintenance/management					
Physical environment (4)					
Security systems and processes					
Medication Management(5)					
Other					
Literature Search					

ROOT CAUSE ANALYSIS
ACTION PLAN TO ADDRESS RISK REDUCTION STRATEGIES

For each of the risk reduction strategies identified, indicate the steps needed to accomplish the action, the expected implementation date, and the associated measurement plan. Improvements to reduce the risks may include policy development or revision, education and training, and/or procedural changes. Include processes that will force the action steps to occur as planned before the next step can be taken. The measurement plan must provide data that will allow evaluation of the effectiveness of the actions taken.

Root Cause Findings	Risk Reduction Strategies/ Actions	Implementation Plan and Timeline	Areas for Implementation	Responsible Person(s)by Title/Dept.	Monitoring Effectiveness Timeframes

ATTACHMENT "E"

DO NOT PHOTOCOPY FOR ANY REASON

CONFIDENTIAL & PRIVILEGED (FS395.041)

NOT PART OF THE MEDICAL RECORD

SEND BOTH PAGES TO RISK MANAGEMENT WITHIN 72 HOURS

Use the E159 Form for Medication Events. Use the E148 for Adverse Drug Reactions

NORTH BREVARD HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
TITUSVILLE, FLORIDA 32796

Events involving serious patient injury must be reported to Risk Management immediately.

For reporting actual and "near miss" events.

RISK MANAGEMENT INCIDENT

DATE OF REPORT / /	TIME OF REPORT (Use 24 hr clock)	DATE OF INCIDENT / /	TIME OF INCIDENT (Use 24 hr clock)	INCIDENT LOCATION	STATUS ☐Inpatient ☐Outpatient ☐ Visitor ☐Other: _____
TIME PT LAST SEEN PRIOR TO FALL?		DIAGNOSIS		PT. ROOM NO.	PHYSICIAN
ENVIRONMENTAL FACTORS AT TIME OF FALL? (e.g., wet floor, obstacles, etc.)		IAN NOTIFIED: ☐ Yes ☐ No Time: _____		Physician Comments Made: ☐ Yes ☐ No	
		IAN RECOMMENDATIONS MADE:			

An incident is defined as any unexpected event or unintended act which caused, or may cause an adverse effect on patient care, the safety or well being of a patient, staff, or visitor, or loss/damage to property or resources.

PLEASE CHECK ALL APPROPRIATE ITEMS – PROVIDE DETAILS IN COMMENTS SECTION

FALLS

☐ From Bed ☐ From Chair
Type of Bed: ☐ While Walking
Mattress: ☐ From Wheelchair
Specialty: ☐ In Crib
☐ From Stretcher ☐ Other:
☐ Found on Floor _____
☐ From BSC
Injuries Observed ☐ Yes ☐ No
Explain Injury:
X-Rays Ordered ☐ Yes ☐ No
Treatment Required ☐ Yes ☐ No
Patient's Family Notified ☐ Yes ☐ No

PATIENT / ENVIRONMENTAL FACTORS RELATED TO FALL

"Fall" Protective Protocol: ☐ Yes ☐ No

☐ Oriented ☐ Unsteady Gait
☐ Disoriented ☐ Blind
☐ Dementia ☐ Aphasic
☐ Sedated ☐ Non-compliant
☐ Cognitive Impairment: ☐ Other:
_____

On Falls Precautions? ☐ Yes ☐ No
Bed Alarm Device Used? ☐ Yes ☐ No
Shirt Alarm Device Used? ☐ Yes ☐ No
Orange Armband? ☐ Yes ☐ No
Orange Door Magnet? ☐ Yes ☐ No

Physician Restraint Order: ☐ Yes ☐ No
Type: ☐ Jacket ☐ Four-Point
☐ Soft Wrist ☐ Waist
In Use: ☐ Yes ☐ No
☐ Bed Up ☐ Bed Down
☐ Two SR Up ☐ Four SRUp
Call Bell Reach: ☐ Yes ☐ No
Red Socks: ☐ Yes ☐ No
Assistive Device: _____
☐ Complete Bed Rest ☐ Up W/Assist
Activity Order:
☐ Up Ad Lib ☐ No Orders Written

COMPLICATIONS FROM INVASIVE PROCEDURES / OTHER INJURIES

☐ Burn
☐ IV Infiltration/Other
☐ Wound Disruption
☐ Unplanned Return to Surgery
☐ O.R.: Retained Iatrogenic Foreign Body
☐ Wrong Site, Surgery/Invasive Procedure Performed on Extremity, or Organ
☐ Laceration/Perforation/Tear or Puncture of Body Part During a Procedure
☐ Unplanned Removal of an Organ or Body Part During an Operative Procedure
☐ Pneumo / Hemothorax
☐ Other:

EQUIPMENT FAILURE/MALFUNCTION, OR DISCONNECTION

Type of Equipment: _____ ☐ Equipment Failure Pertaining to Patient Care
Describe Problem: _____
Describe Adverse Effect on Patient/Staff: _____

CE #: Sent to CE: ☐ Yes ☐ No CE Findings: _____

LOST OR DAMAGED PROPERTY

☐ Money ☐ Jewelry ☐ Eye Glasses ☐ Hearing Aid ☐ Dentures ☐ Other:

PROCEDURE / MISCELLANEOUS

☐ Wrong Test/Procedure Ordered	☐ Omitted	☐ Lost/Mislabeled Specimen
☐ Wrong Priority/Time/Date	☐ O.R.: Incorrect Count	☐ Patient Left AMA
☐ MD Not In Attendance At Delivery	☐ Other	

☐ **Supporting Documents**

NAME & TITLE OF PERSON(S) COMMITTING VARIANCE (Please Write Clearly)	REPORT COMPLETED BY: (name and title)	SUPERVISOR SIGNATURE (name and title)

PATIENT LABEL OR VISITOR INFORMATION

RISK MANAGEMENT USE ONLY

CRITERION NO.	INJURY: ☐ Yes ☐ No	INJURY CODE	REPORT STATUS:☐ Code – 15 ☐ Annual ☐ SMDA ☐ S.E.
EVENT CODE	PROCEDURE CODE	SEVERITY CODE	
DISPOSITION: ☐ DNE ☐ Trend ☐Peer Review ☐ File ☐ Refer To:			

CONFIDENTIAL & PRIVILEGED (FS395.041)

PARRISH MEDICAL CENTER
TITUSVILLE, FLORIDA 32796

SEND BOTH PAGES TO RISK MANAGEMENT WITHIN 72 HOURS

MEDICATION ERROR DATA COLLECTION FORM

EVENTS INVOLVING SERIOUS PATIENT INJURY MUST BE REPORTED TO RISK MANAGEMENT IMMEDIATELY.

DATE OF REPORT / /	TIME OF REPORT (Use 24 hr clock)	DATE OF ERROR / /	TIME OF ERROR (Use 24 hr clock)	ERROR LOCATION
PT. ROOM NO.	ADMISSION DIAGNOSIS:		PRESCRIBING PHYSICIAN:	

ICIAN NOTIFIED:
s ☐ No

ician Comments Made:

Physician Recommendations Made:

This is a requirement of PMC Corporate Compliance. Complete for ALL actual or potential medication variance events.

Reported by:_____
(Please Print Name and Title)

PHYSICIAN ORDER INFORMATION:

Medication **Ordered**:

(Medication) (Dose) (Route) (Rate) (Frequency)

Medication **Given**:

(Medication) (Dose) (Route) (Rate) (Frequency)

ERROR CLASS: (Check one)
☐ ACTUAL - Dose(s) of medication(s) or diagnostic agent(s) that were received by patient, or were omitted when scheduled to be received, that deviates from the prescribed order intent.
☐ POTENTIAL- A medication event that is detected and corrected before administration ("Near Miss").

MEDICATION SOURCE: ☐ 20 After Hours from Pharmacy ☐ 21 Stock, Non-Pyxis ☐ 22 Sent by Pharmacy ☐ 23 Floor/Department Stock ☐ 24 "Borrowed" ☐ 25 Pyxis ☐ 26 Respiratory Therapy

MEDICATION ERROR CLASSIFICATIONS (Check all that apply):

☐ Ordering / Prescribing
☐ Inappropriate Med(s) ☐ Inappropriate Dose ☐ Illegible
☐ Duplication ☐ Order not dated/timed ☐ Wrong Chart
☐ Contraindication ☐ Verbal order misunderstood
☐ Other: (explain)

☐ Transcription Error(s)
☐ Wrong Medication ☐ Wrong Time ☐ Wrong Dose
☐ Wrong Frequency ☐ Wrong Patient ☐ Wrong Chart
☐ Verbal order not in the chart ☐ Verbal order misunderstood
☐ MAR Reconciliation ☐ Pharmacy Order Entry ☐ Wrong Duration
☐ Other: (explain)

☐ Monitoring
☐ Failure to Act on Lab/Clinical Information
☐ Other (Explain)

☐ Preparation / Dispensing Error(s)
☐ Inaccurate Labeling ☐ Wrong Quantity ☐ Wrong Medication
☐ Wrong Dose ☐ Delay in Delivery ☐ Pyxis Refill Error
☐ Other: (Explain)

☐ Administration Error(s)
☐ Wrong Patient ☐ Wrong Dose ☐ Wrong Time
☐ Wrong Medication ☐ Wrong Route ☐ Omission
☐ Wrong Rate IV ☐ Extravasation
☐ Unauthorized Dose ☐ Failure to Use IV Pump Library
☐ Other (Explain)

☐ Miscellaneous Error(s)
☐ Equipment Problems ☐ Packaging Design Problem
☐ Patient/Family Compliance ☐ Interruptions/Distractions
☐ Other (Explain)

SUPERVISOR SIGNATURE
(Name and title)

A patient note is required.

Patient Label:

RISK MANAGEMENT USE ONLY

CRITERION NO.	INJURY: ☐ Yes ☐ No	INJURY CODE	REPORT STATUS: ☐ Code – 15 ☐ Annual ☐ SMDA ☐ S.E.
☐ Error ☐ Incident	PROCEDURE CODE	SEVERITY CODE	
EVENT CODE	DISPOSITION: ☐ DNE ☐ QA Review ☐ File ☐ Refer To:		

NORTH BREVARD HOSPITAL DISTRICT

OPERATING
PARRISH MEDICAL CENTER
TITUSVILLE, FLORIDA 32796

X. TYPES OF MEDICATION ERRORS

Type of Error	Definition
1. Wrong Patient	One patient receiving medication(s) intended for another patient. If this results in the intended patient not getting their medication(s), then a second medication event report (omission) will need to be completed.
2. Wrong Dose	Administration to the patient of a dose that is greater than or less than the amount ordered by the prescriber.
3. Wrong Time	The failure to administer a medication dose within a predefined interval from its scheduled administration time.
4. Wrong/Unauthorized Medication	Administration to the patient of a dose of medication not authorized by a legitimate prescriber for the patient (this would include a dose given to the wrong patient, unordered medications and doses given outside a stated set of clinical parameters.
5. Wrong Route	Administration to the patient of a medication by a route other than that ordered by the physician.
6. Transcription	Event resulting from the failure to transcribe the physician's original order correctly.
7. Omission	The failure to administer an ordered dose to a patient (assumes no prescribing event).
8. Extra Dose	Administration of duplicate doses to a patient (i.e., one or more dosage units in addition to those that were ordered).
9. Wrong Dosage-Form	Administration to the patient of a medication product in a different dosage form than was ordered by the prescriber.
10. Failure To Act On Lab Or Clinical Information	Improper administration or failure to administer a medication based on relevant available laboratory and/or other clinical information.
11. Wrong Rate	Incorrect rate of administration of a medication product to the patient.
12. Prescribing	Inappropriate medication selection (based on indications, contraindications, known allergies, existing medication therapy and other factors), dose dosage form, quantity, route, concentration, rate of administration or instructions for use of a medication product ordered or authorized by physician (or other legitimate prescriber).
13. Wrong Medication – Preparation	Medication product incorrectly formulated or manipulated before administration.
14. Compliance	Inappropriate patient behavior regarding adherence to a prescribed medication regimen.
15. Wrong Administration-Technique	Inappropriate procedure or improper technique in the administration of a medication.
16. Other Medication Error	Any medication error that does not fall into one of the above predefined categories.

DO NOT PHOTOCOPY **FOR ANY REASON** **DRAFT**	**CONFIDENTIAL PRIVILEGED (FS395.041)**	**NOT PART OF THE MEDICAL RECORD** **DRAFT**

PARRISH MEDICAL CENTER - TITUSVILLE, FL 32796

SUSPECTED ADVERSE DRUG REACTION (ADR)
DATA COLLECTION FORM

ADR Definition: A significant ADR is any response to a medication agent that is undesired, unintended, excessive, or unexpected in doses recognized in acceptable medical practice that: requires the dis-continuance or change in the dose of a medication; requires treatment of the reaction with a medication; requires the initial or prolongation of hospitalization; results in permanent disability; or results in death.

Date of Report / /	Time of Report (Use 24 hour clock)	Patient Location	Status: ☐ Inpatient ☐ Outpatient

Reported by:
(Please print)

Suspected Medication(s) Agent(s):

(Medication) (Dose) (Route) (Rate) (Frequency)

Medication Order:

(Medication) (Dose) (Route) (Rate) (Frequency)

If yes, Preventability Class:

Medication given without review of allergies:
☐ Yes ☐ No

Type of Reaction:

☐ Allergic Reaction
☐ Cardiovascular
☐ Central Nervous System (Describe Below)
☐ Other (Describe Below)
☐ Of Skin
☐ Of Respiratory System
☐ Gastrointestinal System (Describe Below)

Description of reaction:

Treatment Required:
☐ Yes ☐ No
If yes explain:

Any other treatments used:

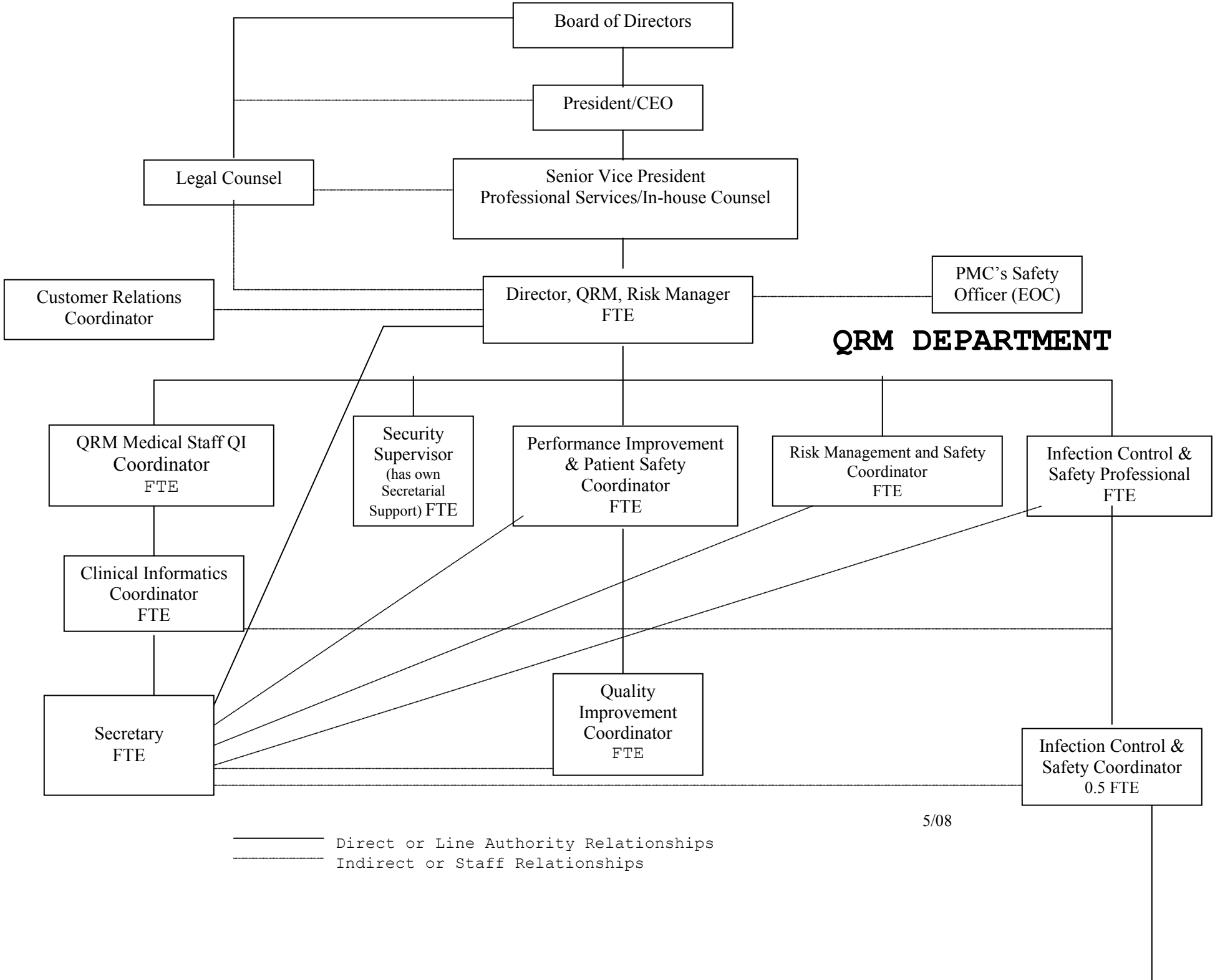
Medication(s) used to treat event:

A patient note is required.

PHARMACY USE ONLY

ADR TYPE:	**SEVERITY:**	
DRUG:	**DRUG CLASS:**	
Preventable? ☐ Yes ☐ No If Yes, Date to P&T:	P&T Agreed? ☐ Yes ☐ No	If yes, Preventability Class:
(Patient Information/Label)		

REV. 11/2008 FORM E-148


Board of Directors
President/CEO
Legal Counsel
Senior Vice President
Professional Services/In-house Counsel
Customer Relations
Coordinator
Director, QRM, Risk Manager
FTE
PMC's Safety
Officer (EOC)
QRM DEPARTMENT
QRM Medical Staff QI
Coordinator
FTE
Security
Supervisor
(has own
Secretarial
Support) FTE
Performance Improvement
& Patient Safety
Coordinator
FTE
Risk Management and Safety
Coordinator
FTE
Infection Control &
Safety Professional
FTE
Clinical Informatics
Coordinator
FTE
Secretary
FTE
Quality
Improvement
Coordinator
FTE
Infection Control &
Safety Coordinator
0.5 FTE
5/08
Direct or Line Authority Relationships
Indirect or Staff Relationships

ATTACHMENT "G"

SEND BOTH PAGES TO RISK MANAGEMENT WITHIN 72 HOURS

NORTH BREVARD HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
TITUSVILLE, FLORIDA 32796

Events involving serious patient injury must be reported to Risk Management immediately.

Use E149 for an Incident Report, E159 for Medication Events, or E148 for Adverse Drug Reactions

RISK MANAGEMENT BEHAVIORAL REPORT

For reporting actual and "near miss" events.

DATE OF REPORT / /	TIME OF REPORT (Use 24 hr clock)	DATE OF INCIDENT / /	TIME OF INCIDENT (Use 24 hr clock)	INCIDENT LOCATION/ ROOM #	STATUS ☐Physician ☐Employee ☐ Auxilian ☐Patient ☐Visitor

An incident is defined as any unexpected event or unintended act which caused, or may cause an adverse effect on patient care, the safety or well being of a patient, staff, or visitor, or loss/damage to property or resources.

PLEASE CHECK ALL APPROPRIATE ITEMS – PROVIDE DETAILS IN EXPLANATION / COMMENTS SECTION

TYPE OF BEHAVIOR / INCIDENT

☐ Under the Influence of Drugs or Alcohol	☐ Aggressive
☐ Verbally Abusive	☐ Public Humiliation
☐ Physically Abusive	☐ Unprofessional
☐ Rude- Nasty	☐ Disrespectful
☐ Non-Team Talk	☐ Disruptive

☐ **Supporting Documents**

NAME & TITLE OF PERSON(S) COMMITTING VARIANCE (Please Write Clearly)

REPORT COMPLETED BY: (name and title)	SUPERVISOR SIGNATURE (name and title)

PATIENT LABEL OR VISITOR INFORMATION

RISK MANAGEMENT USE ONLY

CRITERION NO.	INJURY: ☐ Yes ☐ No	INJURY CODE	REPORT STATUS: ☐ Code – 15 ☐ Annual ☐ SMDA ☐ S.E.
EVENT CODE	PROCEDURE CODE	SEVERITY CODE	
DISPOSITION: ☐ DNE ☐ Trend ☐Peer Review ☐ File ☐ Refer To:			

5/9/08

E147

ATTACHMENT "H"

PARRISH MEDICAL CENTER

Privileged and Confidential

INTERNAL PROCESS IMPROVEMENT COMMUNICATION

REPORT OF A VARIANCE OR CONCERN
D R A F T

REFER TO:
☐ Information Systems Department
☐ Admissions Department
☐ Nursing Department
☐ Diagnostic Imaging Department
☐ Clinical Laboratory
☐ Food and Nutrition Department
☐ Health Information (Medical Records)
☐ Housekeeping
☐ Ca ☐ Cardiopulmonary Department
☐ Emergency Department
☐ Medical Staff
☐ Other: _____
_____

DATE: _____REQUESTED BY: _____
(SIGNATURE / title)

PLEASE COMPLETE THIS SECTION IF RELATED TO PATIENT CARE.

PT. NAME:
_____

MR# _____ AGE: _____ ROOM # _____

DIAGNOSIS:_____

Description of action or inaction that caused a problem._____

_____

_____

Your Request / Concern:
_____

_____

_____

Follow-up/Action
Taken:_____

_____

_____

SIGNATURE: _____ DATE: _____

ATTACHMENT "I"

SAFE MEDICAL DEVICES ACT

When a device-related incident occurs, employees should:

- ✓ Save the device, packaging and all related parts, and note the device's clinical engineering number or serial number. Deliver to Risk Management. If equipment is too large to deliver to Risk Management, the staff member must contact Risk Management and Clinical Engineering.
- ✓ Place a "Defective . . . Do Not Use" tag on the device and remove it from use.
- ✓ Notify the patient's physician or refer the visitor to the Emergency Department or refer the employee to Employee Health.
- ✓ Notify the Clinical Engineering Department.
- ✓ Telephone Risk Management immediately (268-6236).
- ✓ Complete an incident report for Risk Management to receive within 72 hours following the occurrence.

The Risk Management office will file the report(s) with the manufacturer of the device and/or the FDA. Since these reports must be filed within ***ten working days*** of the date of the incident, ***prompt*** reporting to Risk Management is essential.

USE OF TEMPORARY EQUIPMENT NOT OWNED BY PMC

Any medical equipment not owned by PMC must be approved prior to use for diagnostic or therapeutic procedures. This is to ensure safe practices throughout PMC and to prevent unsafe conditions. This would include patient equipment (e.g. insulin pumps, morphine pumps), loaner equipment, or equipment used on a trial basis. Patient equipment must be checked by Clinical Engineering where appropriate as well as the healthcare staff who are caring for them in a PMC facility.

Requests for bringing in equipment from external agencies or facilities as loaners or on a trial basis must be made in writing using Form #P351 "Request for Use of Trial or Loaned Diagnostic/Therapeutic Equipment" and, must be done at least one week prior to intended use. Include the following information on Form #P351:

- ✓ Name of equipment and brand
- ✓ Date of desired used
- ✓ Reason for need/use
- ✓ Procedure to be used on

Form #P351 is given to/forwarded to the Department Director who will:

- ✓ Notify their respective Executive Management member or the Administrator on call
- ✓ Notify Materials Management and Clinical Engineering so that testing of the equipment can be scheduled accordingly
- ✓ Obtain vendor's or appropriate representative's (e.g. patients may sign form for their equipment) signature on the "Release of Responsibility" form, #P352
- ✓ Notify Risk Management

Materials Management will retain the original copy of both completed forms for two years. Loaned equipment should only be used for a period not to exceed 30 days while PMC equipment is in for servicing. Should the timeframe exceed 30 days, the Department Director must notify their respective Executive Management member with a written justification for approval.

Good Catch!

You're a PMC Patient Safety All-Star! Your "good catch" helps us to continuously improve and maintain a safe, healing environment for patients and staff alike!

SAFETY ALL-STAR

PARRISH MEDICAL CENTER

Employee Name: _____

Department: _____

Date: _____

Department Director: _____

QRM Director: _____

Good Catch Acknowledgement Card

(Baseball theme "Good Catch")

Goal

Promote non-punitive safety culture that rewards reporting "Good Catches" (medication and/or medical events) and to identify and fix system issues and trends related to patient safety.

Examples of "Good Catches" also known as "Near Miss" events

- Catching an error on an order before it reaches the patient
- Verifying an illegible order
- Catching a mislabeled specimen so that it can be corrected
- Correcting a calculation error for drug dosage before it reaches the patient
- Rectifying a transcription error
- Preventing a wrong site surgery or wrong procedure on a patient

Process

Each time an incident report is received by QRM, a "Good Catch" acknowledgement card with a "Star Buck" is sent to the employee's manager/director to present and recognize him/her.

QRM Department will maintain a log of "Good Catch" nominees. On a quarterly basis, QRM Department will forward the list of nominees who received "Good Catch" recognition to Communications and Marketing Department to be honored in the PMC Newsletter. At the end of the year, QRM Department will review the log to determine an employee or employee(s) who submitted the most "Good Catches" so that they will receive recognition with awards at a PMC scheduled event.

ATTACHMENT "K"

CORRECTIVE ACTION PLAN FOR INAPPROPRIATE CHART COMMENTS

In addition to the Informal and Formal procedures provided in the Medical Staff General Rules and Regulations that apply to all forms of Disruptive Behavior, the following steps shall be taken regarding inappropriate chart comments:

CATEGORY A:

Minor or Infrequent Offenses: An educational memorandum shall be issued to remind a physician of the requirements of the Medical Staff General Rules and Regulations concerning dishonest, malicious, inappropriate or unsubstantiated chart comments in patient's charts and the increased potential for unwarranted litigation or misinterpretation resulting from such comments. The physician receiving such memo shall be offered the opportunity to review the basis for such comments with the appropriate members of Hospital Administration or the Medical Staff and be advised of any alternative lines of communication available.

CATEGORY B:

Repeated or Frequent Offenses: A warning letter shall be issued advising the physician that the appropriate Department Chief(s) and/or President of the Medical Staff will be notified and the formal procedure specified in the Medical Staff General Rules and Regulations initiated if necessary. At the request of Hospital Administration or the President of the Medical Staff, the Hospital Attorney will be directed to meet with the affected physician to review the applicable requirements and procedures concerning dishonest, malicious, inappropriate or unsubstantiated chart comments.

CATEGORY C:

Chronic Offenses or Egregious Isolated Offenses: The Medical Executive Committee and the Board of Directors will be notified in executive session and the appropriate procedures for disciplinary action initiated under the Medical Staff Bylaws.

ATTACHMENT "L"

North Brevard County Hospital District
operating as
PARRISH MEDICAL CENTER
Titusville, Florida 32796

CONSENT FOR MEDICAL OR RADIOLOGICAL INVASIVE DIAGNOSTIC PROCEDURES AND SURGICAL PROCEDURES

TO THE PATIENT: You have been given information about your condition and the recommended surgical, diagnostic, therapeutic, or interventional radiological procedures to be performed. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give, or withhold your consent to the proposed procedure(s).

1. **CONDITION:** Dr. _____ has explained to me the following conditions exist in my case:

   _____

   _____

2. **PROPOSED PROCEDURE(S):** I understand that the procedure(s) proposed for evaluating and treating my condition is (are):

   _____

   ☐ **Deep Sedation** ☐ **Moderate Sedation**

3. **RISKS/BENEFITS OF PROPOSED PROCEDURE(S):**

   Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve risks. These risks include allergic reactions, bleeding, blood clots, infections that may also include antibiotic resistant types of infections, adverse side effects of drugs, damage to adjacent structures or organs, and even loss of bodily function or life. As also, risks of transfusion reactions and the transmission of infectious disease, including Hepatitis and AIDS from the administration of blood and/or blood products. Additional possible complications specific to this procedure including, but not limited to this procedure are:

   _____

4. **COMPLICATIONS, UNFORESEEN CONDITIONS, RESULTS:**
   The practitioner(s) performing the procedure has explained to me in terms that I could understand, the most likely complications or problems that might occur during the study or procedure and during the healing period. I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that the doctor(s) may find something they did not expect. If this happens, they can use their judgement, and change the procedure. No one has given me a promise or guarantee of what the results of the procedure(s) will be.

5. **ACKNOWLEDGMENTS:**
   My physician has explained the potential risks, potential complications, and benefits of the procedure(s). We have discussed what could happen if nothing is done, and also alternative types of treatment for my condition. I understand what has been discussed with me, as well as the contents of this consent form and have been given the opportunity to ask questions and have received satisfactory answers.

6. **CONSENT TO PROCEDURE(S) AND TREATMENT:**
   Have read this form and talked with my physician(s)(s), my signature below acknowledges that:

   A. I voluntarily give my authorization and consent to the performance of the procedure(s) described above (including the administration of blood and disposal of what was removed) by my physician(s) and/or his/her delegated associates assisted by hospital personnel and other trained persons. If I receive a Food and Drug Administration designated implantable medical device, I consent to have my Social Security number used for tracking, which is required by Federal Statutes.

   B. **OBSERVERS**: I understand there may be qualified individuals who may observe my procedure per hospital policy. Manufacturer's Representative(s) to observe and offer technical advice; health care professional(s) or student(s), for educational purposes. All **observers** must adhere to strict confidentiality standards (per Policy #9500-148: **"Observers** in Procedure Rooms or Other Clinical Areas") **Note:** If you do not want **Observers**, please check the following box and initial: I ☐ **DO NOT Consent to Observers** _____

7. In preparation for your procedure, and the immediate post procedure period, your advance directive (such as "Do Not Resuscitate") may need to be modified. If you currently have such an advance directive, it should be discussed with the physician(s) prior to the procedure.

8. Your signature on this form indicates that: (1) you have read and understood the information provided in this for, (2) the operation or procedure and the anesthesia set forth above, and its risks, benefits, and alternatives have been adequately explained to you by your physician, (3) you have had a chance to ask your doctor(s) questions, (4) you have received all of the information you desire concerning the operation or procedure and the anesthesia, and (5) you authorize and consent to the performance of the operation or procedure and the anesthesia.

PATIENT LABEL

1. _____ Date/Time _____/_____
   PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT

2. _____ Date/Time _____/_____
   PHYSICIAN(S) / SURGEON

3. _____ Date/Time _____/_____
   WITNESS

ATTACHMENT "M" (Page 1 of 6)

Description	Special Consent Form
A. Any surgical procedure or invasive procedure performed in the hospital or associated facilities	Consent for Medical or Radiological Invasive Diagnostic Procedures and Surgical Procedures (E-10)
B. Other procedures – specified approved forms may be used in place of form E-10	Other approved consent forms
C. DIAGNOSTIC IMAGING: Any diagnostic or therapeutic procedure using invasive techniques, with or without contrast media, including, but not limited to:	
a. Arthrograms	Consent to Arthrogram (P-190)
b. Arteriograms	Consent to Angiogram (P-188)
c. Arteriogram with Carbon Dioxide	Arteriogram with Carbon Dioxide (P-395)
d. Myleograms	Consent to Myelogram (No Number)
e. Lymphangiograms	Consent for Moderate Sedation
f. Procedures involving placement of intravascular of intracavitary catheters	
g. Bronchogram	
h. Transhepati Cholangiography	
i. Biopsies	
j. Cisternogram (Nuclear Medicine)	
k. CT/Ultrasound Guided Biopsies, Thoracentesis, Paracentesis	
l. Ablation of Thyroid	
m. Sedation	
n. Stereotactic Breast Biopsy	
D. PATHOLOGY	
1. Needle Aspiration Biopsies	
2. Autopsy	
3. Substance Screen Re-Testing	
4. HIV Testing	HIV Consent (P-385)
E. ANESTHESIA	
1. General	Consent for Anesthesia (P-403)
2. Regional Blocks	
3. Field Blocks	
4. Conscious Sedation	
F. OBSTETRICS	
1. Vaginal or C-Section Delivery	
2. C-Section	
3. Tubal Ligations	
4. Anesthesia	Consent for Anesthesia (P-403)
5. Depo Provera Injections	Depo-Provera Consent Form
6. Administration of Blood and Blood Products	Consent to the Elective Administration of Blood or Blood Products (P-50)
7. HIV Testing	HIV Consent (P-385)
8. Emergency Transfer and Non-Emergency Patient Transfers	(8) Patient Transfer Checklist (P-422) (8) Emergency Patient Transfer Form (P-392) (8) Non-Emergency Transfer Form (P-390)
9. Mother/Baby Photography	Photograph Consent Form
10. Circumcisions (Nsy)	
11. Release of Infant to Family Members (Nsy)	Permission to D/C to Family Member Form
G. OTHER MEDICAL/SURGICAL PROCEDURES INCLUDING, BUT NOT LIMITED TO:	
1. Hemodialysis	
2. Lumbar Puncture	

3. Thoracentesis 4. Paracentesis 5. Chest Tube Insertion 6. Swan Ganz Catheter Insertion 7. Central Venous Pressure Line Insertion 8. Central Line Insertion 9. Temporary Pacemaker 10. Cardioversion 11. Tracheostomy 12. Bone Marrow Biopsies 13. Chemotherapy 14. Blood Transfusion 15. PICC Lines 16. Pericardiocentesis 17. Intra-Aortic Balloon Pump Insertion	Authorization for Treatment with Antineoplastic Agents (P-132) Consent to the Elective Administration of Blood or Blood Products (P-50)
H. CARDIOPULMONARY SERVICES 1. Cardiac Stress Test 2. Grated Sub-Maximal Exercise Stress Test 3. Stress Echo Procedure 4. Dobutamine Stress Test 5. Right and Left Cardiac Catheterization 6. Elective Cardioversion 7. Pericardiocentesis 8. Temporary Pacemaker 9. Intra-Aortic Balloon Pump 10. Transesophageal Echocardiogram 11. Bronchoscopy	Stress Test Authorization (P-04) Stress Test Authorization (P-04) Stress Test Authorization (E-127) Stress Test Authorization (P-04) Right and Left Cardiac Catheterization: - Individualized Consent Form: "Consent for Right &/or Left Cardiac Catheterization with Coronary & Left Ventricle Angiograms" Stress Test Authorization (P-04)
I. GI Laboratory 1. Colonoscopy (with or without biopsy) 2. Colon Dilatation 3. Endo Dilatation 4. Dilatation (w/o Endoscopy/Colonoscopy 5. Endo/Peg Replacement/Removal 6. Endo/Heat Probe 7. Enteroscopy (with or without biopsy) 8. Gowen Tube Placement	Consent for Colonoscopy Procedure (E-404)
I. GI Laboratory (Continued) 10. Endoscopy (with or without biopsy) 11. Gastroscopy (with or without biopsy) 12. Enteroscopy/Biopsy 13. ERCP Procedures 14. ERCP/Sphincterotomy 15. Flex Sigmoid Procedures (with or without biopsy) 16. Rigid Sigmoid	**Consent for Upper Endoscopy Procedure (P-433)** Consent for ERCP Procedure (E-322)
J. PHYSICAL THERAPY/REHAB 1. Cardiac Rehabilitation Program 2. Pulmonary Rehabilitation Program	Informed Consent (P-223) Informed Consent Form
K. PSYCHIATRY 1. Electroconvulsive Therapy	Consent for Electrotherapy (P-391)

OTHER CONSENTS / AUTHORIZATIONS

Description	Special Consent Form
1. Release of Medical Record Information (P-110)	Release of Medical Record Information (P-110)
2. Publication Authorization (P-35)	Publication Authorization (P-35)
3. Authorization to Photograph	Authorization to Photograph

REFUSAL FORMS

Description	Special Consent Form
1. Refusal of Treatment (E-270)	Refusal of Treatment (E-270)
2. Refusal of Blood Transfusion	Refusal of Blood Transfusion
3. Refusal of Life Prolonging Procedures *	Refusal of Life Prolonging Procedures (P-271)
4. Refusal of Life Prolonging Procedures for Hospice Patients	Refusal of Life Prolonging Procedures for Hospice Patients (P-47)

* See also Ethics Policy #9500-2035

MODERATE SEDATION ASSESSMENT/REASSESSMENT
For physicians performing both the procedure and sedation

DATE:_____ Physician Performing Procedure:_____

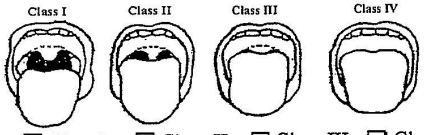
Pre-Procedure Assessment:

☐ NPO, H & P, Labs, EKG, x-rays reviewed as appropriate and on the chart
Patient interviewed and examination completed
☐ No interval changes since H & P

☐ Changes since H & P:_____

ASA Status: (Check One)

I. ☐ Normal, healthy
II. ☐ Mild/Moderate systemic disease, well controlled
III. ☐ A patient with a systemic disease that limits activity
IV. ☐ Severe disease, poorly controlled or threat to life
V. ☐ Moribund, not expected to survive



☐ Class I ☐ Class II ☐ Class III ☐ Class IV

Airway Assessment:
Neck mobility: ☐Normal ☐Other_____

Intubation difficulty per Mallampati Classification
Increased risk of airway obstructive: obstructive sleep apnea, obesity or abnormal airway anatomy: ☐ Yes ☐No

Sedation Assessment

☐Yes ☐No Previous anesthesia or sedation
☐Yes ☐No History of difficult intubation
☐Yes ☐No History of anesthesia/sedation complications

Planned Moderate Sedation:

☐ Fentanyl ☐Morphine ☐ Versed ☐ Other: (list)_____

Pre-Procedure Assessment Summary: The patient has been re-assessed and deemed acceptable for the planned procedure and moderate sedation.

PHYSICIAN'S SIGNATURE **DATE** **TIME**

_____ _____ _____

IMMEDIATE PRE-PROCEDURE RE-ASSESSMENT: There have been no changes since the previous assessment, and the patient is an appropriate candidate to undergo the planned procedure and moderate sedation.

☐ Final reassessment complete, vital signs stable

_____ _____ _____
PHYSICIAN'S SIGNATURE **DATE** **TIME**

POST MODERATE SEDATION ASSESSMENT:

Airway/Resp/CV/Vital Signs/Mental Status/Temp/N&V/Pain and Hydration Assessed:
☐STABLE/Adequately Controlled ☐ Altered-See Progress Notes
Sequela of Sedation: ☐ None noted ☐ Yes - See Progress Notes

Physician's Signature: _____ Date: _____ Time: _____

Patient Label

PARRISH MEDICAL CENTER

Revised/Reviewed: Dept of Anesthesia 9/05, 6/12
MEC Approval 5/03, 6/12

REV. 7/2012 FORM E712

North Brevard County Hospital District
Operating
Parrish Medical Center

PATIENT CONSENT FORM TO TEST FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODIES OR ANTIGENS

1. I, _____, have been advised by my physician(s) to have a blood test to detect the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS). I have been advised that the procedure involves the withdrawal by needle of a small amount of blood for laboratory testing (about 1 1/2 tablespoons) and may cause some slight discomfort at the site of entry of the needle, and that the procedure has minimal risks, such as bruising, soreness, and a slight risk of infection.

2. I have been provided with information about the test for the HIV virus, about the HIV virus, and about AIDS, and I have been given the opportunity to ask questions regarding this information and have my questions answered. I have been informed by my physician(s) that the test, in the opinion of the physician(s), is important both to my health care and to ensure that appropriate evaluation can be undertaken and adequate precautions taken to prevent transmission of the virus to others.

3. I have been informed by my physician(s) that if my test results are positive, it may be necessary to take infectious disease precautions about which my physician will provide me more detailed information. **Most test results are accurate (99.5%), but sometimes the results are wrong or uncertain. In some cases, the test result may indicate that the person is infected with HIV when the person is not (false positive < .5%). In other cases, the test may fail to detect that a person is infected with HIV when the person really is (false negative < .5%). Sometimes, the test cannot tell whether or not a person is infected at all (< .5%). If I have been recently infected with HIV, it may take sometime before the test will show the infection. For these reasons, I may have to repeat the test.**

4. My physician(s) have informed me that if I consent to have the test done, it is important, both for my health care and for the health of others who will be providing care to me, that the test results be placed in my health record, and that the health care record is the most accurate way for all health care providers involved in a patients' care to be fully informed of a patients' diagnosis and the treatment. Therefore, if I agree to have the test done, the results of the test will be recorded in my health record and persons involved in my health care will have access to that information.

5. I have been informed that the performance and results of the HIV antibody test are considered confidential. My physician(s) or HIV counselor has informed me that current State Legislation requires that HIV positive tests are reportable to the State Health Department. I have been informed by my physician(s) that the tests results are in my health record, but shall not be released without my permission, except to the individuals and organizations that have been given access by law to these records have informed me.

6. Benefits and Risks of the Test: The test results can help me make better decisions about my healthcare and my personal life. The test results can help me and my doctor make better decisions concerning medical treatment. If the results are positive, I know that I can infect others and I can act to prevent this. Potential risks of the test include psychological stress while awaiting the results and distress if the results are positive. Some persons have had trouble with relationships, jobs, housing, education, or insurance when their results have become known to other people.

7. I have been informed that anonymous tests can be obtained at the Brevard County Health Department, if I prefer.

_____ _____

PHYSICIAN/HIV COUNSELOR SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE

RELATIONSHIP TO PATIENT_____

_____ _____

DATE DATE

POST TEST COUNSELLING COMPLETED BY: _____ DATE: _____

PARRISH MEDICAL CENTER
Titusville, Florida 32796

WHITE-MEDICAL RECORDS

YELLOW-LAB COPY REV. 4/2009 FORM E-385

North Brevard County Hospital District
Operating
Parrish Medical Center

REFUSAL OF LIFE PROLONGING PROCEDURES

I, _____, have been informed by Dr. _____ that during the course of my hospitalization, or during the following planned procedure _____ _____, my medical condition may deteriorate in such a manner as to necessitate life prolonging procedures to be performed in order to save my life. I further have been given the opportunity to discuss the risks and benefits of such life prolonging procedures with the above named physician, and he/she has answered all my questions in regard to these issues. Based on my own personal beliefs, I hereby refuse to have the following life prolonging measures performed on me:

☐ ALL (Cardiopulmonary resuscitation, artificial ventilation, and artificial feeding & hydration)

☐ Only the following (specify): _____

_____

I have been informed and understand that I have the right to rescind or modify the instructions provided above and to further discuss the risks and benefits of such life prolonging procedures with the above named physician.

In the event I have provided these same instructions during a previous hospitalization by a physician for the same medical condition, then my physician shall not be required to execute this same form and I confirm that all my questions have been previously answered.

During a previous hospitalization, I had the risks and benefits explained to me by Dr. _____ I wish to continue my refusal of life prolonging procedures during this hospitalization.

Patient Date Physician
Date

Witness
Date

PATIENT LABEL	Rev. 8/2003 FORM E271

QUALIFICATIONS FOR SIGNING CONSENT FOR TREATMENT

ADULTS

Any adult patient who is conscious and mentally competent should be consulted and their consent obtained before commencing any medical treatment or testing. This should be evidenced by a witnessed, signed consent form.

A. LEGAL DEFINITION OF ADULTHOOD

1. Any person 18 years of age or older, who is assumed to be capable of making competent decisions in regard to his/her health care.

B. INCAPACITATED ADULTS

If the adult patient is incapable of making health care decisions, (the patient's judgment is so affected by a physical or mental condition that he lacks the ability to communicate a willful and knowing healthcare decision either physically or verbally) the following persons may consent in his behalf:

1. Legal Guardian
2. Designated Health Care Surrogate
3. Spouse
4. Adult Child (majority of children)
5. Next Closest Relative
6. Close Personal Friend

MINORS

A. LEGAL DEFINITION OF A MINOR.

1. A person under 18 years of age.

B. MINORS WHO MAY GIVE LEGAL CONSENT.

"The following persons under age 18 have the disability of nonage removed and may give consent":

1. Any person who is married, or has been married, or has a marriage dissolved, or subsequently becomes married, or is widowed.
(F.S. 743.01).

2. An unwed, pregnant minor may give consent for treatment related to her pregnancy.

3. A minor parent may give consent for treatment of his/her child.

4. A minor serving in the U.S. Armed Forces.

5. Emancipated minor - one who has broken all bonds to his parents, no longer lives at home, and collects and retains his own wages (requires confirmation by a court order).

6. A minor who is requesting an abortion does not require parental consent (but does require parental notification).

C. IF THE MINOR DOES NOT HAVE THE DISABILITY OF NONAGE REMOVED, CONSENT MUST BE OBTAINED FROM THE PARENTS (NATURAL OR ADOPTIVE).

1. If the parents are divorced, either may consent. However, if there is a conflict, the one having legal custody has final authority.

D. OTHERS THAT MAY CONSENT TO TREATMENT OF A MINOR.

Any of the following persons, who must be contacted in the priority listed, may consent to the treatment of a minor who is not committed to the Department of Children and Family Services or the Department of Juvenile Justice, if the person who has the power to consent under law (e.g. natural or adoptive parent, legal custodian, legal guardian) cannot be contacted.

1. Person with written Power of Attorney to provide medical consent.
2. A Healthcare Surrogate designated under Florida Statute 765.2035 after September
3. 30, 2015 by the natural guardian (generally parents), Legal Custodian or Legal
4. Guardian of the Person of the minor.
3. Step-parents
4. Grandparents
5. Adult brother or sister
6. Adult Aunt or Uncle

Source: Florida Status 743.0645

Brevard County Association of Chiefs of Police and Sheriffs Office
Imposition of disciplinary restrictions

Protocols for in-custody arrestees and jail inmates at the hospital

I. Notice to Hospitals and primary municipal police agency

1. The jail will send via facsimile, each day in the morning, a roster of inmates at the hospital to all the hospital's security departments and the municipal police agencies where the hospital is located including a list of inmates at the hospitals and category of inmate and any special notes or comments.
2. The Jail or municipal police agencies shall provide a 15-minute notice to the hospital's security department of any inmate(s) or in custody arrestee(s) being brought to the hospital or shall provide notice to the hospital security department upon arrival within 15-minutes.
3. Juvenile arrestee(s) and inmate(s) will follow the same format.

II. Duties of Hospital (Inpatient Setting)

1. The hospital's Security Department shall conduct an orientation to any law enforcement guarding an in-custody arrestee or jail inmate.
2. The hospital will provide a safe "finger" meal to the in custody arrestee or jail inmate (e.g., sandwich, milk carton consistent with the medical condition(s) present).
3. The hospital shall provide a meal to the law enforcement officer or corrections officer and invoice the agency accordingly.
4. The hospital shall provide a private room (when available) for the in-custody arrestee or jail inmate.
5. The phone shall be available in the room and is to be used only by the law enforcement or corrections officer in attendance.
6. There will be no visitation allowed for any in-custody arrestee or jail inmate.
    a. Exceptions to be approved by the Commander of the Jail or municipal police agency (or designee) and the Chief of Hospital Security for consultation with a lawyer or end of life situation and other approved situations.
    b. Exception for juveniles; parent(s) or guardian(s) are permitted to visit.
7. The hospital's Security Department will provide a bathroom break for the law enforcement or the corrections officer guarding the patient and observe the patient during this brief time period.
8. The hospital's shift lead security representative shall travel to the in-custody arrestee(s) or inmate's room on each shift and introduce him or herself.
9. The hospital Security Department shall provide a department radio to provide priority communication capability.
10. Follow up appointments and discharge instructions will be provided to the law enforcement officer or corrections officer guarding the patient only.
11. The patient's medical needs (including toileting) shall be the responsibility of the clinical employees of the hospital.

III. Law Enforcement or Corrections Responsibility at the Hospital

1. Sign the acknowledgment form when the orientation is conducted.
2. The law enforcement or corrections officer shall sit in the patient's room to maintain "line of sight" observation of the patient.
    a. Exception to this rule is when the patient is in airborne isolation and the law enforcement officer or corrections officer shall place themselves where they can observe the patient.
3. There shall be no smoking by the in-custody arrestee or inmate or the law enforcement officer or corrections officer while at the hospital.
4. Showers shall be conducted at shift change while there are two corrections officers present (long term care).
5. The law enforcement or corrections officer will provide a detailed report of any untoward event and cooperate with hospital officials conducting the investigation.

Hospital Payment

1. Payment for the hospital bill for service by law enforcement shall be governed by financial responsibility for medical expenses (901.35 FS).
2. Payment for inmates shall be coordinated through the Jail's third party medical administrator.
3. Payment for juvenile inmates is the responsibility of the parent(s) or guardian(s).

IV. Escape

1. The hospital shall notify the local municipal police agency by dialing 911.
2. The hospital shall conduct an interior search of the facility to discern if the in custody arrestee or inmate is still within the premises.
3. The hospital shall complete a lock down of the facility.
4. The hospital shall open its Command Center to coordinate the activities of the hospital and coordinate with law enforcement or corrections officials.
5. The hospital will notify any contiguous hospital based childcare facility, as appropriate.
6. The hospital shall coordinate its press releases with the law enforcement or corrections press information officer (PIO).
7. The law enforcement officer or corrections officer shall pursue and apprehend the in custody arrestee or inmate with due diligence.
8. The municipal police agency or jail shall coordinate their activities with the hospital's command center.
9. The hospital shall share any relevant recordings from the closed circuit television system.

V. Emergency Department or Outpatient Visits

1. The Jail or municipal police agencies shall provide a 15-minute notice to the hospital's security department of any inmate(s) or in custody arrestee(s) being brought to the hospital or shall provide notice to the hospital security department upon arrival within 15-minutes.
2. The use of cell phones is permitted within the hospital however, if there is medical equipment in use – the officer must stand three (3) feet away from the equipment.
3. If the law enforcement or corrections agency is unable to reach the officer via radio or cell phone, please contact the hospital's security department assist in communicating with the officer.
4. The hospital will make every effort to "fast-track" law enforcement or corrections escorted patients in the Emergency Department.
5. The hospital's clinical staff and/or security officers will direct where the officer can stand so as to maintain a "line of sight" view of the patient but also in a location where patient care may be conducted.
6. A hospital based radio with the security frequency will be offered to the law enforcement or corrections officer if appropriate (based upon joint discussion and perceived need).
7. The hospital will provide the names of employees involved in the care and treatment of the patient consistent with any request for law enforcement. The Security Department will assist in obtaining this information as needed.
8. The law enforcement or corrections officer will sign the acknowledgement form when the orientation is completed.
9. In the surgery or procedure areas, the hospital staff will assist the officer in acquisition of forensic evidence, etc.

EMERGENCY TRANSFERS

A. Transfer of non-stabilized patients

If the patient cannot be medically stabilized, or is an obstetrical patient in active labor, then they may be transferred only if a physician documents in writing that the medical benefits to the patient that can be expected from transfer to another facility outweigh the risks of the transfer, or transfer is requested in accordance with Section B.

Situations may arise in which PMC does not have service capability (e.g. trauma patients, severe burns, high-risk pregnancies, cardiopulmonary bypass patients, high risk neonates, substance abuse, and mental health). In such situations, PMC will affect an appropriate transfer to the geographically closest hospital with the service capability, unless a prior arrangement is in place or the geographically closest hospital is at service capacity.

B. Patient requested transfers

A patient may be transferred at their own request, or by their designated proxy/healthcare surrogate, as long as they understand the relative risks and benefits of the transfer that are documented on a consent form that is signed by the patient or their proxy/healthcare surrogate, and have been informed of PMC's obligations under EMTALA and Florida law.

C. Receiving facility acceptance

The receiving facility shall agree to accept the patient for treatment before any patient is transferred. An exception to this is when the transfer cannot be delayed due to life threatening condition, the patient may be transferred under Florida Access to Care Law ("911" transfer). A receiving hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of a patient who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. A receiving hospital must accept a medically necessary transfer of a patient from PMC, unless the receiving hospital is at service capacity.

D. Required documentation

The "Emergency Transfer Form" must be completed. The transferring physician must document the name of the physician, or other person, who has accepted the transfer of the patient; the name of the receiving facility, the name of the accepting party or their position, the information given to the receiving facility and any other information that was provided must be documented in the medical record; the risks and benefits of the transfer must be documented; the patient's or their proxy/healthcare surrogate's consent must be documented when possible; the reasons for the transfer or not to transfer should be fully documented and discussed with the patient or their healthcare surrogate, and, if the patient requested the transfer, this must also be documented.

The medical record must be completed, and a copy is to be sent with the patient. It must include all the transfer documentation, pertinent treatments, medications administered, and working diagnosis, all diagnostic tests with results along with the required transfer forms, and the name and address of any on- call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g. test results not yet available or historical records not readily available from PMC's files) must be sent as soon as practicable after transfer.

If the patient is transferred prior to results being obtained, a notation must be made about this in the transfer documentation.

E. Emergency transfers with prior consent

A telephone order for immediate transfer post-procedure may be accepted if the patient has signed a procedural consent form that includes consent for emergency transfer (e.g. Informed Consent for t-PA Administration).

If a physician has previously discussed a transfer and obtained written consent from their Patient this may also be accepted.

If the patient's condition significantly deteriorates while awaiting transfer, the attending physician must make a reasonable attempt to re-assess the patient and review the risks and benefits of transfer with the patient or their proxy/healthcare surrogate.

If the physician determines that the transfer cannot be delayed for an in-person re-assessment, Transfer Form (attached) may be completed and faxed to the receiving facility within 24 hours. Contact should be made with the receiving facility following faxing to ensure they received the faxed document(s).

NON-EMERGENCY TRANSFERS

A. Patients requiring specialty care that is outside PMC's service capability

1. Bypass (CABG) patients

2. Extensive burn patients

3. Neonates and children less than 12 years of age that require intensive care units

4. Other medical/surgical conditions requiring specialized care outside PMC's services

4. Psychiatric illness and/or substance abuse

5. Trauma patients

A. Required Forms:

Required transfer forms are to be completed to accompany the patient.

DISCHARGES TO CONTINUED SKILL CARE FACILITIES

A. Transfers to Extended Care Facilities (ECF)

B. Transfers to Rehabilitation Hospitals

C. Transfers to VA Hospitals

Nursing will notify/alert Case Management who will coordinate all transfers.

TRANSFER VEHICLE & STAFF

All patients shall be transferred in a vehicle with necessary and medically appropriate life support equipment that is staffed by appropriately trained personnel.

It may be necessary for additional specialized personnel from the transferring or receiving hospital to accompany the patient.

The transferring physician is responsible for ensuring that transporting personnel and equipment is adequate to meet the anticipated needs of the patient.

Upon patient request, patients discharged and transferred to another facility may be permitted to travel by private vehicle so long as patient is medically stable.

TRANSFERS TO & RETURN TRANSFERS FROM OTHER HEALTHCARE FACILITIES

A. Transfer agreements with referring facilities

1. PMC is required to accept return transfers within its service capability and capacity, regardless of having a transfer agreement, per Florida law.]

2. The attending physician who initiated the transfer will accept the patient at the time of the return transfer, within PMC's service capability.

   - If the attending physician is unavailable on the day the return transfer is made, the covering physician may accept the transfer for admission to the appropriate physician. All communications should be peer to peer and documented accordingly.

3. If the patient was a direct Emergency Department transfer, the physician on the Emergency Department's call list for the particular service/specialty needs of the patient will accept the patient.

4. A physician from the transferring facility must speak directly with the accepting PMC physician regarding the patient transfer.

   - The 'on call' PMC physician will determine the appropriate specialty to manage the patient.

   - Any disagreements regarding the appropriate accepting physician will be resolved by the President of the Medical Staff.

B. Other transfers

Other area hospitals may transfer emergency or non-emergency patients to PMC if there is capacity that the transferring facilities are unable to provide at the time (e.g. their ICU is full, they cannot provide for dialysis, they are unable to provide for ENT needs).

PHYSICIAN

Emergency Medical Condition (EMC) Identified: (Mark appropriate box; have physician certify if I.c or I.d selected and then go to Section II.)

I. **MEDICAL CONDITION: Diagnosis:** _____

a. ☐ **No Emergency Medical Condition Identified:** This patient has been examined and an EMC has not been identified.

Screening Physician Signature: _____ Date: ____/____/____ Time: _____ AM / PM

b. ☐ **Unstable Patient, Request for Transfer:** The patient has been examined and an EMC has been identified and the patient is not stable. The hospital has the capability and capacity to provide the care needed but the patient has specifically requested to be transferred to another facility after being informed of the hospital's legal responsibilities and the risk of transfer, and notified that the hospital can and is willing to provide the care needed to stabilize and treat the EMC.

c. ☐ **Patient Stabilized:** The patient has been examined and any medical condition stabilized such that, within reasonable medical probability, no material deterioration of this patient's condition is likely to result from transfer of the patient from the hospital.

d. ☐ **Patient Unstable:** The patient has been examined, an EMC has been identified and patient is not stable, but the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital outweigh the increased risks to the patient's medical condition from effecting the transfer.

I.c and I.d Physician Certification: *I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital outweigh the increased risk to this patient's medical condition from effecting this transfer.*

Physician Signature: _____ Date: ____/____/____ Time: _____ AM / PM

Signature applies to any checked boxes

II. REASON FOR TRANSFER ☐ **Medically Indicated** ☐ Patient Requested (see patient request documentation: Section VII)

☐ Nearest facility at service capacity (i.e. temporarily unable to provide service due to maximum use of service at time of request.

☐ On-call physician refused or failed to respond within a reasonable period of time.

On-Call Physician Name: _____ Address _____

III. **RISKS AND BENEFITS FOR TRANSFER:** [Note: This is not a substitute for appropriate documentation in patient's chart.]

Medical Benefits:	**Medical Risks**
☐ Obtain level of care/ service unavailable at this facility.	☐ Deterioration of condition in route
Service: _____	☐ Worsening of condition or death if you stay here.
☐ Medical Benefits outweigh the risks.	☐ Risk of traffic delay/accident resulting in condition deterioration or death.
☐ Other _____	☐ Other _____

IV. **MODE/SUPPORT DURING TRANSFER AS DETERMINED BY PHYSICIAN**

Mode of transportation for transfer ☐ BLS ☐ ALS ☐ Helicopter ☐ Neonatal Unit ☐ Other _____

Agency: _____

Name/Title of accompanying hospital employee if required _____

Support/Treatment during transfer ☐ Cardiac Monitor ☐ Oxygen: _____ ☐ IV Pump ☐ Pulse Oximeter

☐ IV Fluid: _____ Rate: _____ ☐ Restraints - Type: _____ ☐ Other: _____ ☐ None

V. **RECEIVING FACILITY AND INDIVIDUAL:** The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility: _____

Patient Label

Parrish Medical Center
Transfer Form

Reviewed: 7/23/13, 9/17/13, 11/13

PHYSICIAN

Person accepting Transfer: _____ Date: ____/____/____ Time:_____ AM / PM

Receiving MD_____ Date: ____/____/____ Time:_____ AM / PM

Questions regarding Medication Reconciliation Information may be directed to _____or Transferring Physician. Transferring Physician Signature if different from Certifying Physician: _____

Date: ___/___/___ Time:_____ AM / PM

If no physician immediately available, transfer authorized by Qualified Medical Person per Dr. _____

QMP Signature _____ Date: ____/____/____ Time:_____ AM / PM

Authorizing Physician Signature _____ Date: ____/____/____ Time:_____ AM / PM

NURSING

VI. **ACCOMPANYING DOCUMENTATION** sent via: ☐ Patient/Responsible Party ☐ Fax ☐ Transporter

Documentation includes ☐ Copy of Medical Record ☐ Lab/ EKG/ X-Ray ☐ Copy of Transfer Form

☐ Medication Reconciliation Information ☐ Advanced Directive ☐ Other _____

Report given to: (Person/title): _____

Nurse Signature: _____Transferring Unit:_____

Time of Transfer: Time:_____ AM / PM Date: ____/____/____

Vital Signs Just Prior to Transfer:

Time: _____ Temp: _____ Pulse _____ R _____ BP _____ Pulse OX: _____

PATIENT

VII. **PATIENT CONSENT TO MEDICALLY INDICATED TRANSFER or PATIENT REQUEST FOR TRANSFER:**

☐ I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits of this transfer.

☐ I hereby **REQUEST TRANSFER** to _____ I understand and have considered the hospital's legal responsibilities (including, but not limited to, the hospital's EMTALA responsibilities) that have been explained to me, the medical risks and benefits of transfer and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician or anyone associated with the hospital. I agree to accept the risks associated with my decision.

The reason I request transfer is: _____

Signature of: ☐ Patient ☐ Responsible Person_____

Relationship to patient_____

Physician Signature _____ Date: ____/____/____ Time:_____ AM / PM

Witness_____ Title _____

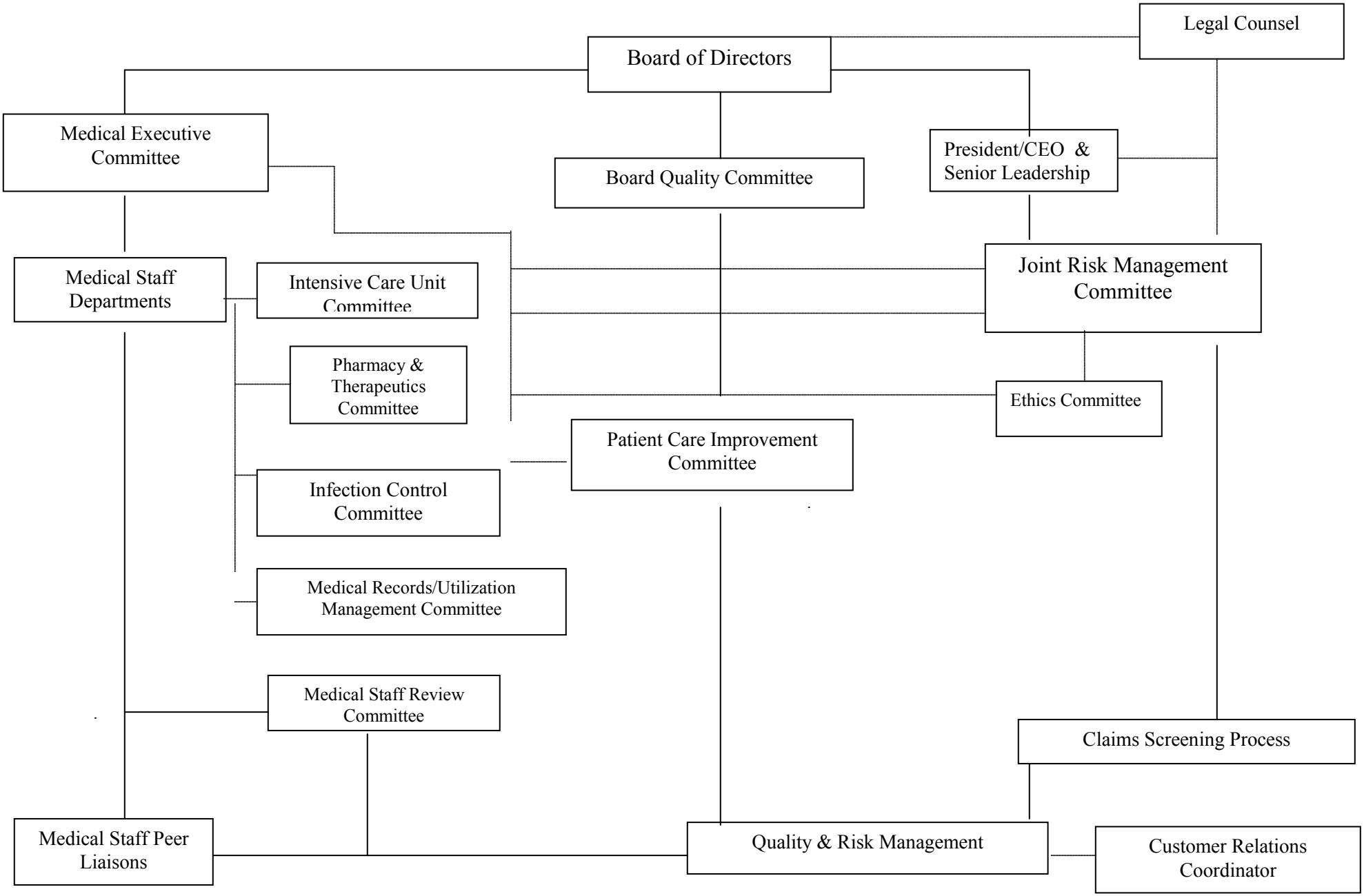
Date: ____/____/____ Time:_____ AM / PM

Patient Label

Parrish Medical Center
Transfer Form

Reviewed: 7/23/13, 9/17/13, 11/13

PMC ORGANIZATIONAL RELATIONSHIP CHART
RELATIONSHIPS CHART

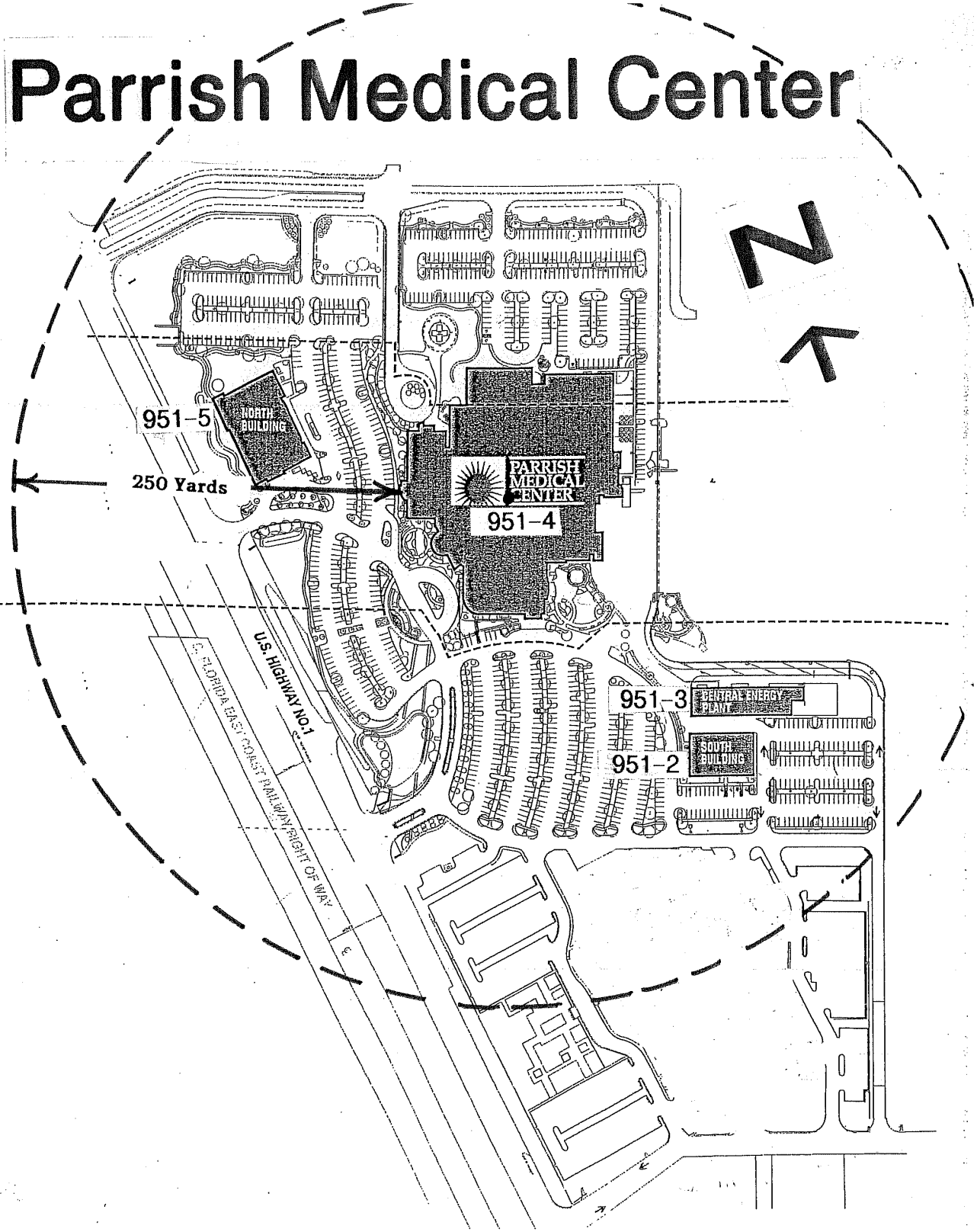


Direct or Line Authority Relationships

Indirect Relationships

11/2011

ATTACHMENT "Q"



10-13-06

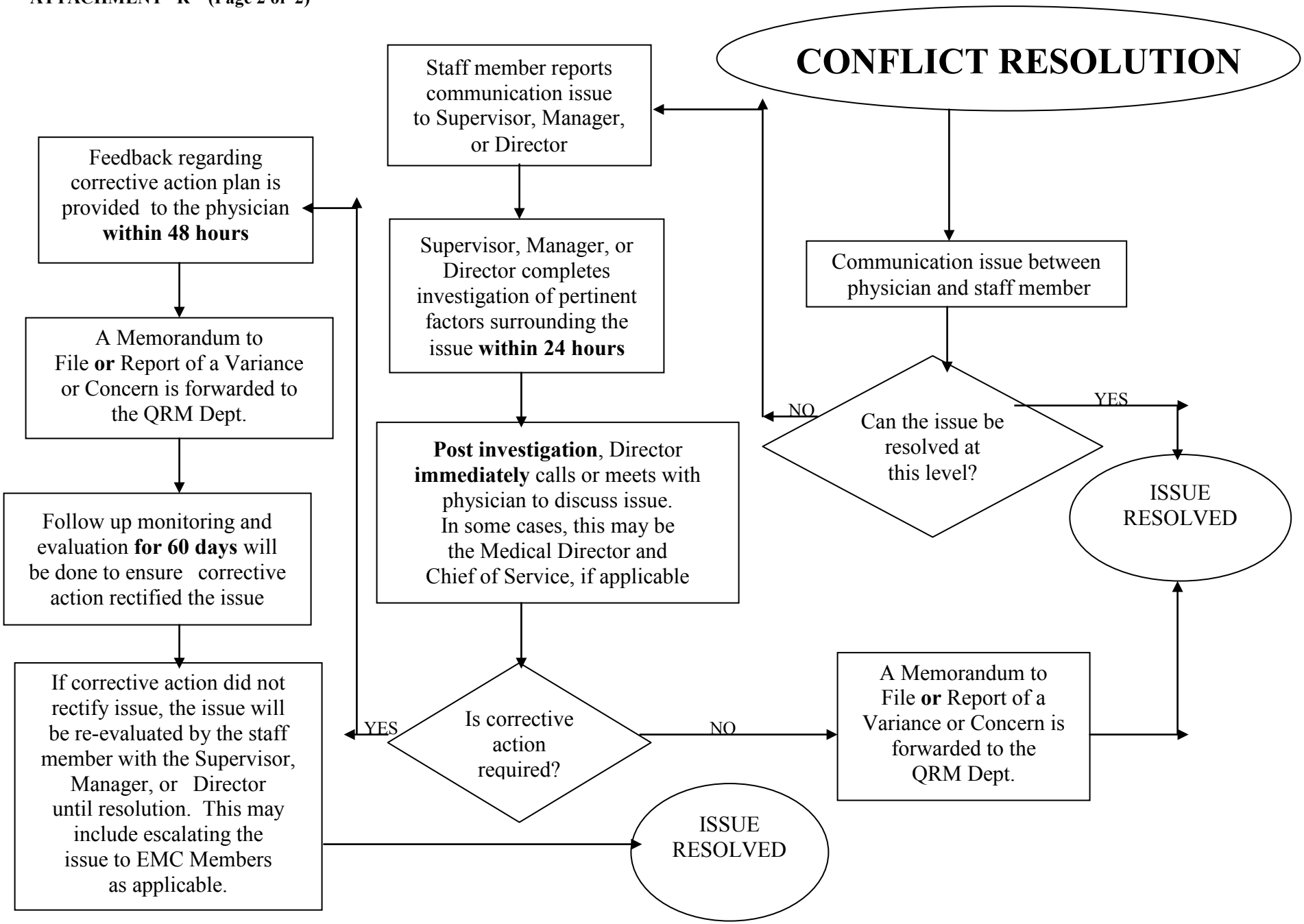
REC

CHAIN OF COMMAND PROCESS FOR CONFLICT RESOLUTION

1. The hospital employee has the duty to discuss the inconsistency or practice question with the patient's physician and the employee's supervisor.

2. Should further assistance be necessary to address the situation, the following steps are followed until resolution occurs:

    1. Issue identified and addressed at level of occurrence. Issue is considered to be resolved.
    2. Issue identified but is unable to be resolved at level of occurrence. Chain of command is initiated. Staff member(s) contact(s) their immediate Supervisor(s). Immediate Supervisors investigate/resolve issue. If unable to resolve, they communicate to Manager or Director. For physicians, contact would be with the Chief of the Service, followed by the President of the Medical Staff.
    3. Manager or Director investigates further and resolves the issue. Investigation should take place within 24 hours.
    4. Meetings should be set up immediately post investigation as applicable.
    5. If further corrective action(s) is necessary, feedback is expected to be given within 48 hours.
    6. A Memorandum to File or Report of a Variance or Concern is forwarded to the QRM Department.
    7. Follow up monitoring and evaluation will be performed for 60 days to ensure corrective actions correct the issue(s).
    8. If corrective action(s) did not resolve the issue, the issue will be re-evaluated by the staff member, Supervisor, Manager or Director until it is resolved. This may once again require escalating the issue to EMC members as applicable.


CONFLICT RESOLUTION
Staff member reports communication issue to Supervisor, Manager, or Director
Communication issue between physician and staff member
Can the issue be resolved at this level?
NO
YES
ISSUE RESOLVED
Supervisor, Manager, or Director completes investigation of pertinent factors surrounding the issue **within 24 hours**
Post investigation, Director **immediately** calls or meets with physician to discuss issue. In some cases, this may be the Medical Director and Chief of Service, if applicable
Is corrective action required?
YES
NO
A Memorandum to File **or** Report of a Variance or Concern is forwarded to the QRM Dept.
ISSUE RESOLVED
Feedback regarding corrective action plan is provided to the physician **within 48 hours**
A Memorandum to File **or** Report of a Variance or Concern is forwarded to the QRM Dept.
Follow up monitoring and evaluation **for 60 days** will be done to ensure corrective action rectified the issue
If corrective action did not rectify issue, the issue will be re-evaluated by the staff member with the Supervisor, Manager, or Director until resolution. This may include escalating the issue to EMC Members as applicable.