Termination of Pregnancy

Consent according to Florida Statute 390.011

1. Exception: The physician must provide parental notice and obtain written consent from a parent or legal guardian for termination of a pregnancy of a minor unless a medical emergency exists or under the following circumstances:
    a. Minor is or has been married
    b. 16 years or older and emancipated by court order (Florida Statute 743.015)
    c. Minor has petitioned court and was granted a judicial waver for the parental notification and consent requirement
    d. Notice is waived in writing by the parent / legal guardian who is entitled to notice. The waiver must:
        1) Contains specific language of the waiver for parental notice and / or waiver for consent by parent / guardian and
        2) Is notarized and
        3) Dated not more than 30 days before termination of pregnancy

3. Parental / Legal Guardian Consent:

a. The physician must obtain written consent from parent or legal guardian before performing or inducing termination of pregnancy on the minor patient unless the parent has indicated otherwise (refer to H.1.d) or there is a medical emergency (refer to H.4. below)

b. The parent / legal guardian shall:
    1) Provide a copy of government issued proof of identification
    2) Certify in a signed, dated, notarized document with each page initialed that he or she consents to the termination of pregnancy of a minor

c. The parent / legal guardian shall complete the Parent / Legal Guardian Affidavit for Termination of Pregnancy for Minor Patient form.

d. The physician is to keep a copy of the parent / legal guardian government

issued proof of identification and certified statement in the minor's medical record for 5 years after the patient reaches the age of 18 years, but no less then 7 years.

4. Physician to admit the patient and provide informed consent. Physician to place orders fortermination of pregnancy and perform the termination and delivery. Note: According Florida Statute 390, only a medically licensed physician may perform the termination and deliver the fetus. A nurse midwife, APRN or PA can NOT perform the termination nor deliver the fetus.

2. All terminations of pregnancy shall be reviewed by the OB QI Committee at the next regularly scheduledmeeting following the termination.

3. The System Director of Women's Services or designee shall report in writing to the office of the Health First Corporate Chief Clinical Officer within 72 hours of the termination of pregnancy.

K. Reporting to Agency of HealthCare Administration (AHCA) Termination of Pregnancies:

The Risk Manager or designee shall submit a report ofterminations of pregnancies for each month to AHCA.

MONTHLY REPORTS

- Infection Prevention
- Quality
- Respiratory
- Nursing
- Pharmacy
- Risk Management

Holmes Regional Medical Center
OB-GYN Quality Dashboard
Published Month: April 2024

	Program Measures	Prior Year FY2023	Benchmark Goal	FY2024 YTD	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	Rolling 12 mth total
Efficiency	**Volumes**																	
	Total # Vaginal & C-section Deliveries	2944	-	**1454**	226	218	222	271	280	275	278	235	271	227	208	235		2946
	Total Vaginal Deliveries	1877	-	**923**	145	137	143	188	182	160	168	152	170	151	130	152		1878
	Total Cesarean Deliveries	1067	-	**531**	81	81	79	83	98	115	110	83	101	76	78	83		1068
	Secondary Cesarean Deliveries	455	-	**226**	36	33	44	37	38	45	48	37	41	36	33	31		459
	Primary Cesarean Deliveries	612	-	**305**	45	48	35	46	60	70	62	46	60	40	45	52		609
Process Measures	**Process Measures (Core Perinatal)**																	
	Core PC-1 - Elective Delivery	0%	0%	**0%**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%
	Core PC-2a - Cesarean Birth - Overall (NTSV)	31.2%	26.0%	**33.0%**	30.8%	27.3%	17.6%	20.6%	27.8%	32.4%	34.7%	38.7%	34.8%	30.2%	30.1%	29.1%		29.6%
	Core PC-5 - Exclusive Breast Milk Feeding	36.1%	51.2%	**40.4%**	35.9%	37.9%	33.9%	33.5%	38.7%	39.1%	36.7%	35.0%	38.7%	34.9%	42.8%	55.0%		38.4%
	Core PC-6.0 - Unexpected Complications in Term Newborn	3.2%	3.8%	**2.9%**	3.4%	3.6%	3.4%	1.4%	3.9%	3.9%	2.1%	3.2%	2.5%	3.2%	3.3%	3.1%		3.1%
Safety Related Measures	**Patient Safety Indicators**		***Benchmark Midas 50th***															
	PSI 17 (v2023-2) Birth Trauma/Injury to Neonate - *Per 1000 Live Births*	2.4	2.82	**2.06**	4.51	0.00	0.00	0.00	3.68	0.00	7.14	0.00	0.00	0.00	0.00	4.24		1.7
	PSI 18 (v2023-2) Obstetric Trauma, Vag Deliv w/ Instrument - *Per 1000 Deliveries w Instrument*	140.8	97.56	**100.00**	571.43	0.00	142.86	0.00	0.00	200.00	125.00	200.00	250.00	0.00	0.00	0.00		144.9
	PSI 19 (v2023-2) Obstetric Trauma, Vag Deliv w/o Instrument - *Per 1000 Deliveries w/o Instrument*	21.6	15.00	**16.95**	21.74	60.61	22.22	16.67	22.47	28.67	12.42	20.69	16.07	4.90	23.81	21.13		22.2
	Uterine Rupture During Labor, NPOA - (Count)	0	0.00	**0.00**	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		1
	Infection Related Harm																	
	Neonatal Intensive Care Hospital-Associated Infections	0.0	0.0	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
	Newborn Nursery Hospital-Acquired Infections	0.0	0.0	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
	Neonatal Group B Streptococcus Infection	0.0		**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
	Cesarean Section SSI	0.3%	0.6%	**0.4%**	1.2%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	1.3%	0.0%		0.0
	Vaginal Hysterectomy SSI (Gen'Nc Procedures)	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		0.0
	Abdominal Hysterectomy SSI	0.4%	0.0%	**0.8%**	0.0%	0.0%	0.0%	0.0%	2.8%	0.0%	3.1%	0.0%	0.0%	0.0%	1.9%	0.0%		0.0
Safety Related Measures	**Procedure Related Harm (Count of Events)**																	
	5 min Apgar ≤ 6	1		13	0	1	1	0	1	0	1	1	4	1	1	2		21
	RN Delivery	3		4	0	0	0	0	0	1	0	0	0	1	0	1		9
	Postpartum Transfusions			14	1								1					
	Post-Partum Hemorrhage Return Transfuse	1		1	0	0	0	0	1	0	1	0	0	0	0	0		2
	Unplanned Hysterectomy	1		0	0	0	0	0	0	0	0	0	0	0	0	0		1
	Perineal 4th Degree Laceration	4		2	2	1	0	0	0	1	1	0	1	0	0	0		6
	Neonatal Birth Injuries																	
	Brachial Plexus Injury	1		0	0	0	0	0	1	0	0	0	0	0	0	0		1
	Facial Nerve Injury	0		0	0	0	0	0	0	0	0	0	0	0	0	0		0
	Cerebral Injury	1		0	0	0	0	0	1	0	0	0	0	0	0	0		1

Outcome Measures

Program Measures	Prior Year FY2023	Benchmark Goal	FY2024 YTD	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total	Rolling 12 mth total
Mortality Measures		Goal															
Fetal Death > 20 weeks	12	0	4	0	0	1	4	0	0	1	1	1	0	0	1		12
Neonatal Mortality	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Maternal Mortality	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Transfers																	
Maternal Transfers to HRMC ICU	19	-	4	1	3	3	2	3	0	2	0	2	0	0	0		16
Maternal Acute Hospital Transfers	14	-	4	0	1	1	0	0	3	0	0	0	1	3	0		9
Readmission Measures		Goal															
Maternal Readmission <=7 Days post discharge	30	0	22	0	2	3	3	4	1	0	2	6	6	6	2		35
Maternal Readmission <=42 Days post discharge	46		30	1	4	4	5	6	5	0	5	6	6	7	6		55
Morbidity																	
Neonatal Pneumothorax (Non-Iatrogenic/Spontaneous)	3		9	1	1	0	0	3	2	1	2	2	1	1	2		16
Neonatal Pneumothorax (Iatrogenic)	0		0	0	0	0	0	0	0	0	0	0	0	0	0		0
Pre-Eclampsia Cases																	
Pre-Eclampsia Severe Complicating Birth	19		26	4	3	3	3	5	10	1	4	5	5	0	5		54

SSI PREVENTION

Tara et al.
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Antimicrobial Resistance and Infection Control
RESEARCH Open Access

Effectiveness of postoperative oral administration of cephalexin and metronidazole on surgical site infection among obese women undergoing cesarean section: a randomized, double-blind, placebo-controlled, parallel-group study—phase III

Fatemeh Tara[1], Sina Danesteh[2], Maral Rezaee[1], Kiarash Roustai Geraylow[2,3], AmirAli Moodi Ghalibaf[4] and Somayeh Moeindarbari[1*]

Abstract

Background: Cesarean section (CS) is the most frequently performed surgery in the United States. Compared to vaginal delivery, CS has a higher risk of maternal and neonatal mortality, morbidities, and complications, among which surgical site infection (SSI) is the most common. We aimed at evaluating the effectiveness of postoperative oral administration of cephalexin and metronidazole on SSI among obese women undergoing CS.

Methods: We conducted a randomized, double-blind clinical trial comparing the prophylactic effect of oral cephalexin and metronidazole vs cephalexin and placebo on SSI following CS among obese women who had received preoperative prophylactic cephalosporin antibiotics. The study was conducted at the Ommolbanin Hospital affiliated with Mashhad University of Medical Sciences from April 2019 to February 2020.

Result: [illegible]

Conclusion: [illegible] and wound infection symptoms in a 2-week follow-up

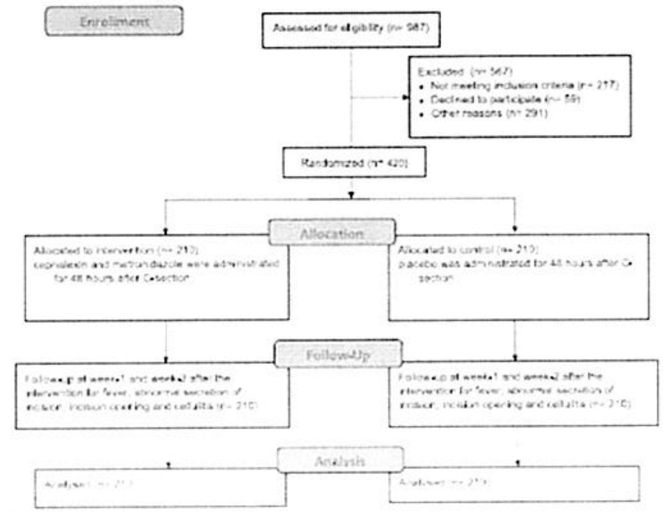

Fig. 1

Table 2

Variables	Week 1		Week 2	
	Intervention (n = 210)	Control (n = 210)	Intervention (n = 210)	Control (n = 210)
	N (%)	N (%)	N (%)	N (%)

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Hepatitis B and C in pregnancy: a review and recommendations for care

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Abstract

Our objective was to provide a comprehensive review of the current knowledge regarding pregnancy and hepatitis B virus (HBV) or hepatitis C virus (HCV) infection as well as recent efforts to reduce the rate of mother-to-child transmission (MTCT). Maternal infection with either HBV or HCV has been linked to adverse pregnancy and birth outcomes, including MTCT. MTCT for HBV has been reduced to approximately 5% overall in countries including the US that have instituted postpartum neonatal HBV vaccination and immunoprophylaxis with hepatitis B immune globulin. However, the rate of transmission of HBV to newborns is nearly 30% when maternal HBV levels are greater than 200 000 IU ml^{-1} (~6 log_{10} copies ml^{-1}). For these patients, new guidelines from the European Association for the Study of the Liver (EASL) and the Asian Pacific Association for the Study of the Liver (APASL) indicate that, in addition to neonatal vaccination and immunoprophylaxis, treating with antiviral agents such as tenofovir disoproxil fumarate or telbivudine during pregnancy beginning at 32 weeks of gestation is safe and effective in preventing MTCT. In contrast to HBV, no therapeutic agents are yet available or recommended to further decrease the risk of MTCT of HCV, which remains 5 to 10%. HCV MTCT can be minimized by avoiding fetal scalp electrodes and birth trauma whenever possible. Young women with HCV should be referred for treatment post delivery, and neonates should be closely followed to rule out infection. New, better-tolerated treatment regimens for HCV are now available, which should improve outcomes for all infected individuals.

HBV AND HCV IN PREGNANCY: SUMMARY AND RECOMMENDED GUIDELINES FOR TREATMENT

Antiviral therapy with TDF or telbivudine beginning at 32 weeks of gestation should be strongly considered for women with high HBV DNA levels (>200 000 IU ml^{-1} or 6 log_{10} copies ml^{-1}) to decrease the rate of MTCT of HBV infection (*Level A*) (Table 7). All infants born to HBsAg-positive mothers should receive HBIG and HBV vaccine as early as possible, no later than 12 h after birth (*Level A*). Newborns of mothers with unknown hepatitis B status should also receive immunoprophylaxis (*Level C*). The vaccine series should be completed according to recommended schedules.[107] Current guidelines do not recommend elective cesarean delivery for mothers with chronic HBV infection (*Level B*); however, a recent nonrandomized study showed elective cesarean section may decrease vertical transmission of HBV if the HBV DNA level is >20 million IU ml^{-1} (> 6 log_{10} copies ml^{-1}) at term.[65] Breast feeding does not increase MTCT of HBV and is not contraindicated (*Level B*), though breast feeding is not recommended during maternal antiviral therapy by drug manufacturers (*Level C*).

We recommend that all pregnant women with risk factors for hepatitis C or with abnormal ALT levels undergo screening for antibodies to HCV; if positive, PCR for quantitation of HCV RNA level should be performed (*Level B*). Women who are PCR-positive for HCV are at risk for MTCT of HCV, and infants born to these mothers should be screened for HCV infection (*Level B*). Women with HCV infection are at an increased risk for cholestasis of pregnancy (*Level B*). HCV-infected women on methadone have an increased risk for preterm birth, while their infants have a high incidence of neonatal withdrawal syndrome (*Level C*). Unlike HBV, patients are typically not treated for HCV during pregnancy. However, young women are ideal candidates for treatment of HCV infection in the postpartum period, with a greater than 90% chance of resolving the infection with less toxic and more efficacious new regimens (*Level A*).

ED Only: Rhogam Immune Globulin Task Administration

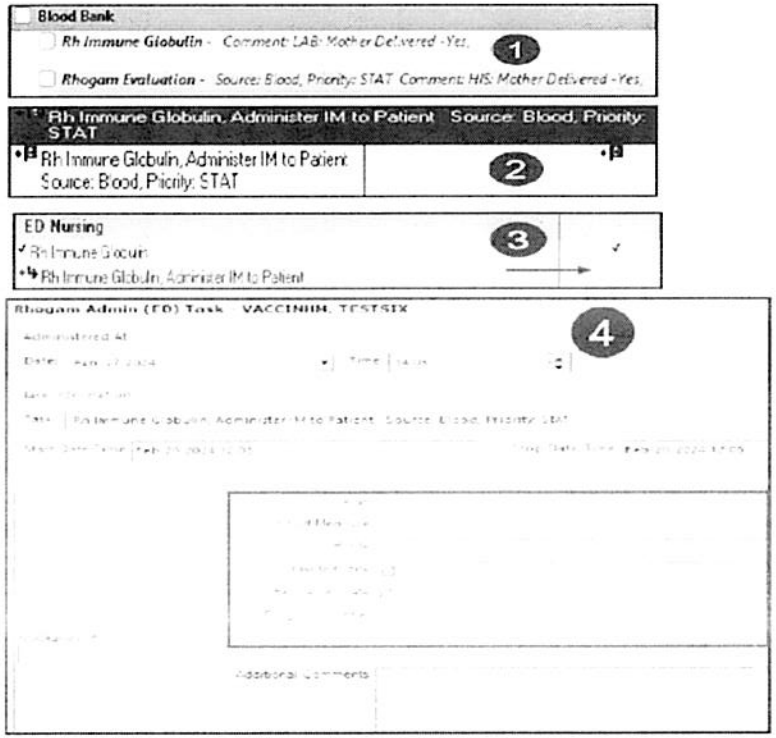
An alert has been added to the Worklist Manager to inform the ED Nurse to administer Rhogam Immune Globulin if the patient is found to be Rh-.

1. Rhogam Eval is ordered for the patient. The Blood Bank receives ***and*** results the specimen. **For the Rh- patients**, Blood Bank selects the Rhogam *"action"* in SoftBank.

2. SoftBank sends a message to SCM for the **Rh Immune Globulin, Administer IM to Patient** Order, which will appear under the Blood Bank section of the Orders tab as STAT order.

3. The task will appear on the *ED Nursing-Days* and *ED Nursing-Nights* on the Worklist Manager where it must be ***'Marked as Done...'*** Right click within the green trough to mark as complete.

4. When **Marking as Done**, a form will open for ED Nursing to document the injection.



Summary of Topics Discussed in Previous Meetings

- Management of Post Partum Hemorrhage:
  - Misoprostol Usage/addition to PPH Kits
- Spinal Headache Management
- Peri-operative Infection Prevention:
  - Addition of Azithromycin
  - Vaginal Prep Education
  - Monitoring Surgical Site Infections
- Florida Statute Changes:
  - Termination of Pregnancy- Legal Representation
- Screening for Premature Rupture of Membranes: research into use of additional test
- Consent Updates:
  - Use of Fetal Scalp Electrodes
  - Newborn consent to treat
- Escalation in Emergencies:
  - Use of RRT/ eICU/ SICU
  - Post Partum Hemorrhage Protocol
- NTSV C/Section Rate
- Patient Satisfaction Opportunities
- Blood Product Usage & Stewardship: Use of Mass Transfusion Protocol
- Readmission Opportunities: Preeclampsia
- Radiology Input on use of CT vs MRI in newly pregnant patients
- Circumcision Process Improvement
- Medication Shortages/ Alternatives
- Discharge Process Improvements:
  - Timely/ accurate completion of Discharge Orders/ Medication Reconciliation
  - Florida Perinatal Quality Collaborative (FPQC) Discharge Initiative
- Neonatal Interventions in First Hour of Life: "Golden Hour"
- Maternal Transfers to Higher Level of Care
- Post Partum Pain Management: Use of scheduled pain meds

Exhibit 3(i)

EMTALA & ED Registration Compliance Training Tip

HealthFirst

Revenue Operations Training Tips

EMTALA & ED Registration Compliance

All healthcare organizations that are participating in Medicare and have a dedicated emergency department (ED) are subject to *EMTALA (Emergency Medical Treatment and Active Labor Act)*.

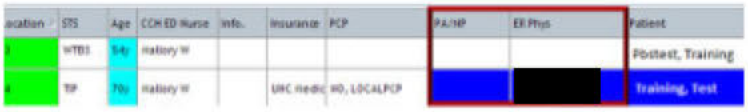
EMTALA ensures that hospitals provide emergency care to all individuals who may be in need of emergency treatment, regardless of their financial status.

EMTALA Frequently Asked Questions	
Can I ask for the patient's insurance card upon arrival?	**No.** This will be obtained during the bedside registration process through Phreesia or by a Patient Service Specialist.
Can I accept the patient's insurance card if they provide it at the triage desk?	**Yes.** We can accept the patient's insurance card **if and only if** they provide it to us. Under no circumstance should we ever ask the patient for the insurance card at the triage desk.
If the patient has their copay in hand upon arrival, can I take their payment while signing them in?	**No.** We cannot accept any form of payment until after the patient has been seen by the physician and a Medical Screening Exam (MSE) has been completed.
If a patient asks about their copay prior to being seen by the physician, can I tell them what it is?	**Yes.** We can provide copay information to a patient **if and only if** they voluntarily ask us and providing that information does not delay care. Under no other circumstance should we ever give out copay information prior to a patient being seen by a physician.

ED Registration Process for EMTALA Compliance

To ensure we are in compliance with *EMTALA* guidelines, Registration will follow the process detailed below to determine if they can proceed with the registration process.

- On the *SCM ED Manager* dashboard, locate the *PA/NP* and *ER Phys* columns.



- Choose next step:

If a physician...	Then...
IS assigned to the patient	Proceed with registration process.
IS NOT assigned to the patient	**Do not** proceed with registration process. A physician must be assigned in order to proceed with registration. ***Under no circumstance will we complete the registration process if a physician has not been assigned to the patient.***

Exhibit 4(a)

HealthFirst

Termination of Pregnancy.

Owner		Department	Procedure Number
System Director of Women and Children's Services		Maternal Newborn	CP 16.01.80 PRO
Approver	**Original Effective Date**	**Last Reviewed Date**	**Last Revised Date**
Clinical Best Practice Committee	08/20/2024		

Printed copies are for reference only. Please refer to the electronic copy for the latest version in the approved IDN Policy Management system.

Purpose.

The purpose of this document is to describe the indications for and process by which a pregnancy may be terminated based on the gestational age of the fetus and supporting criteria. This also outlines the case review and notification process. This document does not apply to spontaneous abortion, dilation, and curettage (D&C) or dilation and evacuation (D&E) for stillbirth, delivery for stillbirth, or when the termination of pregnancy is deemed by the physician to be inevitable.

Scope.

Cape Canaveral Hospital, Holmes Regional Medical Center, Viera Hospital (effective 8/2024), and Health First Medical Group in compliance with Florida Statute 390.0111: Termination of Pregnancies.

Definitions.

Born alive: The complete expulsion or extraction from the mother of a human infant, at any stage of development, who, after such expulsion or extraction, breathes or has a beating heart, or definite and voluntary movement of muscles, regardless of whether the umbilical cord has been cut and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, caesarean section, induced abortion, or other outside the womb and will result in death upon birth or imminently thereafter.

Fetus: Product of human conception in utero, prior to birth regardless of gestational age. A live birth (defined below) will need a birth certificate and when the newborn dies the obstetrician will sign the death certificate.

Gestation: Means the development of a human embryo or fetus as calculated from the first day of the pregnant woman's last menstrual period and/or as determined by ultrasound. (Florida Statute 390.011). Please refer to CP 16.01.71 CGU.

Live birth: The complete expulsion or extraction of a product of human conception from its mother, irrespective of the duration of pregnancy, which, after such expulsion, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, and definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. (Florida Statute 382.002)

Medical emergency: A condition that, based on a physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death, or for which a delay in the termination of her pregnancy will create serious risk of substantial and irreversible impairment of a major bodily function. (Florida Statute 390.0114)

Minor: Person under the age of 18 years. (Florida Statute 390.0114)

Newborn: An infant from birth to less than 28 days old.

Parents: The legal guardians of the patient unless they have had their parental rights terminated.

- Mother means the woman who birthed the patient or the intended parent per CP 16.01.41 PRO.
- Other parent means either:
  - The husband OR spouse of the biological mother of the patient at the time of the patient's birth.
  - The intended parent per the gestation surrogacy policy CP 16.01.41 PRO.
  - The person named as the second parent on the patient's official birth certificate.

Standard medical measure: The medical care that a physician would provide based on the particular facts of the pregnancy, the information available to the physician, and the technology reasonably available in a hospital, as defined in Florida Statute 395.002, with an obstetrical department, to preserve the life and health of the fetus, with or without temporary artificial life-sustaining support, if the fetus were born at the same stage of fetal development. (Florida Statute 390.011)

Stillbirth: Birth of a fetus 20 weeks gestation or greater, born with no signs of life.
Viable or viability: the stage of fetal development when the life of a fetus is sustainable outside the womb through standard medical measures (Florida Statute 390.011).

Termination of Pregnancy Review Committee: is a subcommittee of the OB QI committee; consists of obstetricians, neonatologists, and perinatologists.

Procedure.

A. Termination of Pregnancy Qualifications / Criteria during:

1. Fertilization up to 6-weeks gestation:
   a. If the fetus has a condition incompatible with life outside of the womb.
   b. When continuation of the pregnancy may significantly threaten or impair the

health or life of the pregnant patient.

c. In the case of documented rape or incest.

2. 6-weeks and 0 day gestation and greater:
   a. If the fetus has not achieved viability and has a fatal fetal abnormality.
      - Fatal fetal abnormality is a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.
   b. When the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition.

B. 6 Weeks and 0 Day Gestation and Greater Requirements:

1. A termination of pregnancy 6-weeks and 0 day gestation and greater may occur only when one of the following requirements are met:
   a. A consultation between two providers – Maternal Fetal Medicine, Obstetrician, and/or Neonatologist will be held. Completion of the form, "Termination of Pregnancy Request and Review Form" FF#003296
   b. In the case of a medical emergency, one physician shall document in the medical record that, in reasonable medical judgment, there is medical necessity for a legitimate emergency medical procedure for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition and another physician is not available for consultation. Note: The physician(s) shall document in patient's medical record the rationale for the medical necessity / emergency termination of pregnancy.
   c. The fetus has not achieved viability and two physicians have documented in the medical record that in reasonable medical judgement, the fetus has a fatal fetal abnormality.
      i. **Viable or Viability** means the stage of fetal development when the life of a fetus is sustainable outside the womb through standard medical measures (Florida Statute 390.011).
      ii. **Fatal fetal abnormality** is a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.

C. Termination of Pregnancy During Fetus Viability:

1. If a termination of pregnancy is performed during viability for maternal life-saving measures, the person performing or inducing the termination of pregnancy shall use that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would exercise in order to preserve the life and health of any fetus intended to be born and not aborted.
2. If preserving the life and health of the fetus conflicts with preserving the life and health of the woman, the physician must consider preserving the woman's life and health the overriding and superior concern.

3. For matters of conscience with this procedure, associates may discuss alternative duty assignments with their manager or charge nurse.

D. Termination of Pregnancy Request, Review and Determination Process:

Prior to performing a termination of pregnancy, the Termination of Pregnancy Committee must review and approve the request, except in the case of a medical emergency (refer to B.1.b. above).

1. The requesting physician shall compile the appropriate documentation which would include, but are not limited to:
   a. History and Physical
   b. Prenatal records
   c. Ultrasound
   d. Chromosome studies if resulted.
   e. Complete Termination of Pregnancy Request and Review Form FF#003296
      Note: For fatal fetal abnormality 6 weeks and 0 day and greater gestation request: There must be documentation from two physicians indicating that the fetus has a fatal fetal abnormality.
2. Once the above documents are complete, the physician will present the case to at least two members of the Termination of Pregnancy Review Committee.
3. The Termination of Pregnancy committee members will review the request and either approve or deny.

E. The approval process is not required when the interruption of pregnancy is deemed inevitable and emergent (example, placental abruption or maternal hemorrhage).

1. The termination of pregnancy is to be retrospectively reviewed by the Termination of Pregnancy Committee within five to seven days of the event.
2. The physician shall document in the medical record the rationale and plan of care.

F. Informed Consent and Ultrasound to be performed at least 24 hours prior to termination of pregnancy, except in cases of medical emergency. After the termination of pregnancy has been approved by the Termination of Pregnancy Committee:

1. The following forms shall be completed and authenticated by the physician performing the procedure or the referring physician and signed by the patient at least 24 hours prior to the termination of pregnancy:
   a. Surgery / Procedure Consent form for Termination of Pregnancy.
      i. If the patient is a minor, refer to section F.
      ii. If the patient is an incompetent adult, then the consent must be obtained from court-appointed guardian who has been given permission by the court to consent to termination of pregnancy.
   b. Termination of Pregnancy Ultrasound Form, unless conditions below dictate otherwise applies. FF#003297
2. The physician who is to perform the termination of pregnancy or the referring physician shall provide informed consent to the patient at least 24 hours before the procedure, except in the case of a medical emergency, which shall include:
   a. The nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a knowing and willful decision of whether to terminate a pregnancy.

b. The probable gestational age of the fetus, verified by an ultrasound, at the time the termination is to be performed.

i. The ultrasound will be performed by the physician who is to perform the termination of pregnancy, referring physician or ARDMS (American Registry for Diagnostic Medical Sonography) credentialed /certified in OB/GYN ultrasound technologist / sonographer.

Note: If the gestational age is determined to be 24 weeks and 0 days or greater, the termination of pregnancy will not be performed except as stated in section B.1.a. and b. above.

ii. The physician shall offer the patient opportunity to view and hear an explanation of ultrasound images. This must be done prior to the patient giving informed consent to have the termination of pregnancy performed.

iii. The Termination of Pregnancy Ultrasound form must be completed except as noted in c. below. (FF#003297)

a) If the patient accepts, the patient is to view the ultrasound images and hear an explanation of them.
b) If the patient refuses to have an ultrasound (with or without viewing) at the time of termination of pregnancy, the termination of pregnancy will not be performed.
c) Unless the patient requests, the physician is not to offer the patient whose pregnancy is the result of rape, incest, domestic violence, or human trafficking as evidenced by a copy of a restraining order, police report, medical record or other documentation, an opportunity to view and hear an explanation of the ultrasound images. The patient is not required to sign the Termination of Pregnancy Ultrasound Form.
d) The patient is to be provided the Florida Department of Health (DOH) “Fetal Development and Alternatives to Terminating a Pregnancy” printed materials which she may choose to view available at Florida Department of Health floridahealth.gov).
1) English: vol 2 (floridahealth.gov)
2) Spanish: vol 2 (floridahealth.gov)
3) Haitian Creole: vol 2 (floridahealth.gov)

G. At Time of Admission:

1. Upon admission, a second Surgery Procedure consent form is to be completed after the physician or his associate who is to perform the termination provides informed consent. Exception: A second surgical consent is unnecessary if the physician who obtained the initial consent is also performing the termination of pregnancy.
2. Physician to admit and to provide informed consent.
3. Performance by a Physician required – No termination of pregnancy shall be performed at any time except by a physician.

H. Newborn Resuscitation Guidelines

1. Live births During or Immediately After Termination of Pregnancy Procedure:

a. If an infant is born alive during or immediately after an attempted termination of pregnancy, any health care practitioner present at the time will humanely exercise the same degree of professional skill, care, and diligence to preserve the life and health of the infant as a reasonably diligent and conscientious health care practitioner would render to an infant born alive at the same gestational age in the course of natural birth. The degree and type of care is based on the medical condition of the infant.
b. An infant born alive during or immediately after an attempted termination of pregnancy will be admitted to the hospital in the same way as other live births.
c. Any baby, at any gestation born alive, must have a birth certificate.

2. Resuscitation Guidelines:
   a. Newborn less than 24 weeks and 0 day gestation. For resuscitation based on gestation age, refer to the Resuscitation Guidelines for Fetus 22-24 Weeks Gestation #CP 16.01.71 CGU.
   b. Newborn 24 weeks and 0 day and greater gestation:
   The newborn shall be resuscitated.

3. Upon delivery:
   a. Assign APGAR score per CP 16.01.71 CGU.
   b. If APGAR score is greater than zero, check the infant's vital signs.
   c. Document APGAR scores and vital signs in the medical record.

4. For signs of life:
   a. For viable newborn, refer to Newborn Resuscitation CP 16.01.49 (PRO).
   b. When signs of life for nonviable newborn:
      i. Check infant's vital signs hourly till expiration.
      ii. The nurse is to assess and notify the physician when no signs of life.

I. Termination of Pregnancy on a MINOR patient: Written Notification and Consent according to Florida Statute 390.011.

1. Exception: The physician must provide parental notice and obtain written consent from a parent or legal guardian for termination of a pregnancy of a minor unless a medical emergency exists or under the following circumstances:
   a. Minor is or has been married.
   b. The minor has a dependent child.
   c. 16 years or older and emancipated by court order (Florida Statute 743.015)
   d. Minor has petitioned court and was granted a judicial waver for the parental notification and consent requirement.
   e. The minor is a victim of sexual abuse, incest, or human trafficking, as certified by a licensed professional.
   f. Notice is waived in writing by the parent / legal guardian who is entitled to notice. The waiver must:
      i. Contains specific language of the waiver for parental notice and / or waiver for consent by parent / guardian and
      ii. Is notarized and
      iii. Dated not more than 30 days before termination of pregnancy.

2. Parental / Legal Guardian Notification required:
    a. The physician performing or inducing the termination of pregnancy, or the referring physician must provide actual notice directly, in person or telephone, to the minor patient's parent / legal guardian at least 24 hours prior to the termination of pregnancy unless there is a medical emergency (refer to G.4.).
        i. The referring physician must provide to the physician performing the termination a written statement certifying the actual notice to parent / legal guardian has occurred.
        ii. The physician giving actual notice is to document in the minor patient's medical record the name of the parent / guardian, phone number and date and time when the notice was given in person or via telephone.
        iii. Actual notice given by telephone shall be confirmed in writing and signed by the physician providing actual notice. The confirmation shall be:
            a) Mailed to the parent / legal guardian last known address
            b) Sent certified first-class mail with return receipt requested with delivery
            c) Restricted to the parent / legal guardian.
    b. If the physician is unable to provide actual notice to the parent / legal guardian after a reasonable effort, then constructive notice which is notice given in writing and signed by the physician performing the termination of pregnancy or the referring physician. The notice to the parent/legal guardian shall be mailed at least 72-hours before the termination of pregnancy. The notice shall:
        i. Include the name and address of the facility where the physician is referring the patient to have the termination of pregnancy.
        ii. Be sent to the last known address of the parent / legal guardian of the minor.
        iii. Be sent certified with return receipt requested. The delivery shall be restricted to the parent / legal guardian.
    c. For actual notice by telephone or constructive notice, the physician shall complete the Termination of Pregnancy for Minor Patient Parent / Legal Guardian Notification form. The certified letter number shall be added to the form.

3. Parental / Legal Guardian Consent:
    a. The physician must obtain written consent from parent or legal guardian before performing or inducing termination of pregnancy on the minor patient unless the parent has indicated otherwise (refer to H.1.d) or there is a medical emergency (refer to H.4. below).
    b. The parent / legal guardian shall:
        i. Provide a copy of government issued proof of identification
        ii. Certify in a signed, dated, notarized document with each page initialed that he or she consents to the termination of pregnancy of a minor.
    c. The parent / legal guardian shall complete the Parent / Legal Guardian Affidavit for Termination of Pregnancy for Minor Patient form.
    d. The physician is to keep a copy of the parent / legal guardian government issued proof of identification and certified statement in the minor's medical record for 5 years after the patient reaches the age of 18 years, but no less than 7 years.

e. The physician shall execute for inclusion in the medical record of the minor an affidavit indicating the information presented by the parent / legal guardian is sufficient evidence of identity.
f. The parent must sign and have notarized the Parent / Legal Guardian Consent Affidavit for "Termination of Pregnancy for Minor Patient" form (FF#003295) as well as the "Surgery/Procedure" consent form. These documents shall be scanned into the medical record.

4. Medical Emergency Process for Minor Patient:
   a. Parental Notification:
      If in the physician's good faith clinical judgment, a medical emergency exists and there is insufficient time for the attending physician to comply with the parental notification requirements the following shall occur:

      i. The physician shall make consent attempts, whenever possible, without endangering the minor, to contact the parent or legal guardian, and may proceed without the consent, but must document reasons for the medical necessity in the patient's medical records.
      ii. The physician shall provide notice directly, in person or by telephone, to the parent or legal guardian, including details of the medical emergency and any additional risks to the minor.
      iii. If the parent or legal guardian has not been notified within 24 hours after the termination of the pregnancy, the physician shall provide notice in writing, including details of the medical emergency and any additional risks to the minor, signed by the physician:
         a) To the last known address of the parent or legal guardian of the minor
         b) By first-class and certified mail, return receipt requested
         c) With delivery restricted to the parent or legal guardian.

   b. Parental Consent:
      If parental consent was unable to be obtained the following shall occur:
      i. The physician shall inform the parent / legal guardian, in person or by telephone, within 24 hours after the termination of the pregnancy of the minor, including details of the medical emergency that necessitated the termination of the pregnancy without the parent's or legal guardian's consent.
      ii. The physician shall also provide this information in writing to the parent or legal guardian:
         a) at the last known address
         b) by first-class mail, certified with return receipt requested
         c) with delivery restricted to the parent or legal guardian.
      iii. The physician is to complete Medical Emergency section of the "Termination of Pregnancy for Minor Patient Parent / Legal Guardian Notification Form" FF# 003295

J. Termination of Pregnancy Nursing Process:

Follow Termination of Pregnancy Procedure Perinatal Nursing Checklist FF# 003299.

K. Termination of Pregnancy Notification Process:

1. The Executive Director of Women's Services or designee shall report as soon as possible within 24 hours all termination of pregnancies to the involved campus:
   a. OB Nurse Manager/Director
   b. OB Medical Director
   c. Risk Management

2. All terminations of pregnancy shall be reviewed by the OB QI Committee at the next regularly scheduled meeting following the termination.

3. The Service-line Director of Women's Services or designee shall report in writing to the office of the Health First Corporate Chief Clinical Officer within 72 hours of the termination of pregnancy.

L. Reporting to Agency of HealthCare Administration (AHCA):

The Risk Manager or designee shall submit a report of terminations of pregnancies for each month to AHCA.

References.

Department of Health Printed Materials. Revision Date: 11/2016: Community Involvement | Florida Department of Health (floridahealth.gov)

1) English: vol 2 (floridahealth.gov), https://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/alternatives-english.pdf.
2) Spanish: vol 2 (floridahealth.gov) https://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/alternative%20brochure.span.2016.pdf
3) Haitian Creole: vol 2 (floridahealth.gov) https://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/alternative%20brochure.creo.2016.pdf

Florida Statutes. (2021). Title XXIX. Chapter 382.002 Vital Statistics Definitions. Statutes & Constitution: View Statutes: Online Sunshine (state.fl.us)

Florida Statutes. (2021). Title XXIX. Chapter 390: Termination of Pregnancies. §390.0111. Retrieved from: http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statue&URL=0300-399/0390/0390.html

Florida House Bill 5 – 2022 Legislation regarding Florida Statute 390.011 and 390.0112. Effective date 07/01/2022. Retrieved from: HB Florida Passed and signed into law - 15 weeks and greater gestation.pdf

Formerly known as. New

Secondary materials.

Termination of Pregnancy for Minor Patient Form FF#003295
Termination of Pregnancy Request and Review Form, FF#003296
Termination of Pregnancy Ultrasound Form, FF#003297
Termination of Pregnancy Procedure Perinatal Nursing Checklist FF# 003299

Effective: 08/20/24
Reviewed:
Revised:

Exhibit 5(a)

HealthFirst

Obstetrics Outpatient Medical Screening Exam (MSE), Testing, and Disposition.

Owner		Department	Procedure Number
System Director Women and Children		Maternal-Newborn	CP 16.01.37 PRO (DS)
Approver	**Original Effective Date**	**Last Reviewed Date**	**Last Revised Date**
Clinical Best Practice Committee	03/01/2007	08/22/2024	08/22/2024

Printed copies are for reference only. Please refer to the electronic copy for the latest version in the approved IDN Policy Management system.

Purpose.

To provide a consistent process for pregnant women who present for evaluation and disposition with pregnancy-related issues in compliance with federal Emergent Medical Treatment and Active Labor Act (EMTALA) requirements.

Scope.

Holmes Regional Medical Center and Viera Hospital

Definitions.

AWHONN: Association of Women's Health Obstetric and Neonatal Nurses.

Emergency Medical Condition (EMC): A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention can reasonably be expected to result in placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

Emergent Medical Treatment and Active Labor Act (EMTALA): A component of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Its purpose is to ensure that patients receive emergency or active labor care when they seek it.

Medical Screening Examination (MSE): The process required to reach with reasonable clinical confidence a determination whether an obstetric medical emergency does or does not exist. It may be performed by the physician or qualified medical professional (QMP).

Qualified Medical Professional (QMP): A professional that is qualified to perform the initial medical screening examination. While it is permissible for a hospital to designate a non-

physician practitioner as the QMP, the designated non-physician practitioner must be set forth in a document that is approved by the governing body of the hospital in the hospital by-laws or in the rules and regulations governing the medical staff following governing body approval. The QMP will have a completed competency.

Procedure.

To provide a medical screening examination to all patients presenting for unscheduled obstetrical evaluation, testing or services within the capabilities of labor and delivery and the ancillary services routinely available to labor and delivery. Patients 20 weeks gestation or greater, with obstetrical presentations/complaints will receive a medical screening examination consistent with this procedure. Only Registered Nurses (RNs) trained in AWHONN External Fetal Monitoring and who have a Qualified Medical Screening competency will perform the evaluations.

Patients less than 20 weeks gestation will be provided a medical screening examination in the Emergency Department (ED). Where emergent trauma and/or medical conditions that are present in the pregnant patient, the patient will be initially assessed in the Emergency Department. The location of further assessment and treatment will be at the medical discretion of the Emergency Department Physician.

Each obstetrical patient presenting to Labor and Delivery (L&D) will be assessed for signs and symptoms of labor or other obstetrical complaints through nursing assessment and review of the patient's prenatal record when available. The patient's signs and symptoms and the nurse's assessment will be reported to the Licensed Practitioner for disposition.

A. All pregnant patients presenting to Labor and Delivery will be logged in the Log Book.
B. Patients presenting to the ED <20 weeks gestation (less than 20 weeks gestation), with or without pregnancy related complaints, will be evaluated and treated in the ED.
    1. MSE will take place in the ED.
    2. Patients may be referred to OB/GYN services as indicated.
C. Patients presenting to the ED ≥ 20 weeks gestation (greater than or equal to 20 weeks gestation), with no peripartum symptoms or obstetrical complaints may be evaluated and treated in the ED for non-OB complaints.
    1. MSE will take place in the ED.
    2. FHR may be obtained via doppler and documented on admit and prior to discharge at the discretion of the provider.
    3. L&D staff may be contacted for review of FHR/monitoring as indicated.
    4. Patients may be referred to OB/GYN services as indicated.
D. Patients presenting to the ED ≥ 20 weeks gestation (greater than or equal to 20 weeks gestation), with stable OB-related or peripartum symptoms will be transported to L&D for evaluation and treatment (for facilities with OB services only).
    1. ED registrar will register and armband the patient for the L&D unit.
    2. ED will notify L&D charge nurse of incoming patient.
    3. The patient will be escorted to L&D.
    4. L&D will evaluate, conduct MSE, and provide monitoring, treatment and follow up as indicated.

E. Labor and Delivery associates will not discuss financial/insurance information with patients. For registration purposes, patient's name, date of birth, social security number, and Licensed Practitioner's name will be asked by the admitting registrar. In some instances, to comply with insurance requirements, additional information may be requested (i.e., admitting diagnosis).

F. Obtain consent for vaginal exam.

G. If over 28 weeks gestation provide Florida Birth-Related Neurological Injury Compensation Association (NICA) brochure.

H. An appropriate MSE will be provided to all patients presenting to Labor and Delivery. Place the patient on electronic fetal monitor and obtain maternal vital signs (blood pressure, pulse, respirations, and temperature) and fetal heart tones.

I. A 20-minute fetal monitor strip will be obtained on all patients. If unable due to the gestational age, presence of fetal heart tones will be verified. If fetal heart tones are not reassuring, contact Licensed Practitioner for further evaluation of fetal well being.

J. Perform and document maternal/fetal assessment and evaluation. This will include but is not limited to:
   - Fetal well being as appropriate for gestational age
   - Frequency, duration, and intensity of uterine contractions
   - Cervical dilatation and effacement unless vaginal exam contraindicated (i.e. vaginal bleeding with unknown placenta location)
   - Status of membranes
   - Pertinent patient history

K. Document notification of maternal/fetal assessments to Licensed Practitioner and his/her disposition.

L. Urine specimens will be done with Licensed Practitioner order.

M. Patients with complaint of leaking vaginal fluid will be evaluated for ruptured membranes.

N. All patients being assessed for labor will have a sterile vaginal or speculum exam to determine cervical dilation, effacement, and station if no vaginal bleeding is present.

O. The Licensed Practitioner will be notified of the patient's arrival, chief complaint, maternal, and fetal assessments. The patient's disposition (full admit, 23-hour observation, or discharge) should be determined within four hours.

P. Outpatients may only be discharged after a full report on maternal and fetal status is given to the Licensed Practitioner and a discharge order for disposition is obtained.

Q. Discharge instructions will be completed and reviewed with patient, follow up care will be clearly indicated on the form. Give patient a copy of the form once it has been signed.

R. In the presence of an OB Emergency Department, additional OB ED policies will apply.

S. Ensure that disposition is noted in Outpatient Logbook.

T. A medical record will be generated for every patient who is triaged by a Labor and Delivery RN. If the patient decides to leave without being seen:
   1. Notify Licensed Practitioner of patient leaving Against Medical Advice (AMA)
   2. Notify Risk Management
   3. Patient should sign AMA form
   4. Document in the medical record

Exceptions. None

References.

Centers for Medicare & Medicaid Services Certification and Compliance for the Emergency Treatment and Labor Act (EMTALA)

Online Sunshine, Florida Statute (2023) Chapter 766.302, paragraph (2). www.leg.state.fl.us.

Simpson, K. & Creehan, P. (2020). Perinatal Nursing, 5th ed. Association of Women's Health, Obstetrics, and Neonatal Nursing. Philadelphia: Lippincott, Williams, & Wilkins.

The Florida Birth-Related Neurological Injury Compensation Association. www.nica.com.

Formerly known as. CP 16.40

Secondary materials. None

Effective: 03/01/07
Reviewed: 03/01/11, 09/01/12, 12/01/12, 01/01/13, 01/01/14, 12/01/14, 12/01/15, 09/01/18, 10/01/21, 08/01/23, 08/07/24, 8/20/24, 8/22/24
Revised: 03/01/08, 03/01/09, 03/01/10, 09/01/11, 09/01/12, 12/01/12, 01/01/13, 12/01/14, 09/01/18, 10/01/21, 08/01/23, 08/07/24, 8/20/24, 8/22/24

Reviewed and Approved by Viera Hospital 09/01/10
Owner: Health First Clinical Best Practice Committee (Formerly HRMC L&D manual and CCH OB manual)

Exhibit 5(b)

HealthFirst

Nursing Consultation for Obstetric Patients.

Owner		Department	Procedure Number
System Director of Women's and Children's Services		Maternal - Newborn	CP 16.01.44 PRO (DS)
Approver	**Original Effective Date**	**Last Reviewed Date**	**Last Revised Date**
Clinical Best Practice Committee	07/01/2006	08/07/2024	08/07/2024

Printed copies are for reference only. Please refer to the electronic copy for the latest version in the approved IDN Policy Management system.

Purpose.

Support collaborative management and assessment of obstetric patients presenting to the main hospital Emergency Department (ED) for treatment or admitted to any inpatient unit.

Scope.

Cape Canaveral Hospital (CCH), Holmes Regional Medical Center (HRMC), Palm Bay Hospital (PBH), and Viera Hospital (VH).

Definitions. None

Procedure.

A. Urgent and non-urgent patients with a fetal gestation of twenty weeks with labor (suspected) or obstetrical complications are referred to Labor & Delivery (L&D) for evaluation. Refer to CP 16.01.37 PRO (“Outpatient Evaluation and Discharge”) for the evaluation and management of obstetric patients at hospitals with inpatient obstetrics. At hospitals without inpatient obstetrics the ED physician will assess the patient and may transfer if deemed necessary.

B. When a pregnant patient 20-week’s gestation or greater is being seen in the main ED, a Labor and Delivery nurse may be called to consult for fetal/obstetric nursing assessments as appropriate in hospitals with inpatient obstetrics.

C. Pregnant women 20-week’s gestation or greater requiring admission for pregnancy related condition should be admitted to the Labor and Delivery (L&D) Unit unless her condition requires care that cannot be provided in that setting (i.e., cardiac monitoring, mechanical ventilation, invasive hemodynamic monitoring). At hospitals without inpatient obstetrics, the patient will be transferred to an appropriate facility with obstetrical care.

D. When a pregnant patient 20-week's gestation or greater is admitted to an inpatient unit other than a L & D unit, a Labor and Delivery nurse may be called to perform fetal/obstetric assessments as indicated or ordered by physician at hospitals with inpatient obstetrics.

E. Labor and Delivery staff will be alerted, as appropriate, of pregnant patients 20-week's gestation or greater who are admitted to any inpatient unit at hospitals without inpatient obstetrics.

References.

American Academy of Pediatrics and American College of Obstetricians and Gynecologists. (2017). Guidelines for Perinatal Care. 8th Edition.

AWHONN and ENA. (2020). Consensus Statement. Emergency Care for Patients during Pregnancy and the Postpartum Period: Emergency Nurses Association and Association of Women's Health, Obstetric and Neonatal Nurses Consensus

Sweet, V., & Foley, A. (2020). Sheehy's emergency nursing: Principles and practice (Seventh). Elsevier.

Formerly known as. CP 16.25

Secondary materials. None

Effective: 07/01/06
Reviewed: 07/01/07, 09/01/09, 09/01/10, 09/01/12, 12/01/12, 12/01/13, 12/01/14, 05/01/16, 09/01/18, 12/01/21, 12/01/22, 08/07/24
Revised: 09/25/07, 09/01/08, 09/01/11, 09/01/12, 12/01/12, 07/12/13, 12/01/13, 05/01/16, 09/01/18, 12/01/21, 12/01/22, 08/07/24

Reviewed and Approved by Viera Hospital 12/01/10
Owner: Health First Clinical Best Practice Committee (Formerly HRMC/PBCH 2-04-09-02, CCH ED 170 and CCH OB manual)

Exhibit 5(c)

HealthFirst

Emergency Department Patient Care Policy

Owner	Department	Policy Number
Vice President of Nursing, Health First	Emergency Department Department Specific	CP 20.01 POL (DS)
Original Effective Date	**Last Reviewed Date**	**Last Revised Date**
09/01/2006	01/06/2023	01/06/2023

Printed copies are for reference only. Please refer to the electronic copy for the latest version in the approved IDN Policy Management system.

Policy statement.

To supply guidance for documentation of care provided to patients presenting to the Emergency Department.

Patient care may vary depending on clinical presentation, licensed independent practitioner orders, and procedures. Use of critical thinking, judgement, and clinical expertise may validate a deviation until further orders are received.

Scope.

Cape Canaveral Hospital, Holmes Regional Medical Center, Palm Bay Hospital, Viera Hospital.

Definitions.

Emergency Department (ED): Is an outpatient area of the hospital. Responsible for the provision of medical and surgical care to patients arriving at the hospital for immediate care.

Mini-reg: A modified registration process to place the patient in the medical record.

Provisions.

Health First is committed to maintain best practices in direct patient care which are found with greater specificity in the procedures. Applicable Procedures that supplement this Policy must also be adhered to.

A. A medical record will be initiated on all patients that present for treatment at the ED. The record will include information for patient identification, consent for treatment, and documentation of the care that was rendered.
B. A “mini-reg” will be completed on all patients cared for in the ED. Once the information crosses over to the emergency department, documentation will begin. For downtime procedures see the Downtime policy.

C. Every patient that presents to the Emergency Department must have a medical screening exam performed by an Emergency Department physician/Licensed Independent Practitioner (LIP). Refer to CP 16.01.44 PRO ("Nursing Consultation for Obstetric Patients") for the evaluation and management of obstetric patients.
D. If the patient has been discharged, and needs to be seen again, a new record will be generated.
E. If contact is made with patient by phone, an addendum (ED append note) will be added to the original medical record detailing the nature of the call.
F. The original medical record will reside with Health Information Management (HIM).

The following procedures should not be performed in the confines of the Emergency Department but referred to an environment which would provide the patient with privacy and asepsis and facilitate continuity of care with a specialist in that area of practice:

A. Routine enemas, removal of fecal impaction
B. Any procedure requiring general anesthesia
C. Dilation and Curettage
D. Chemotherapy
E. Routine tooth extractions
F. Recovery of outpatient surgical patients
G. Colonoscopy, Bronchoscopy or Endoscopy (unless emergent)
H. Open reductions of bone fractures
I. Routine Biopsies
J. Elective Blood Transfusions
K. Hemorrhoidectomies
L. Specialty line care
M. Elective Mid/PICC Lines

Exceptions. None

References.

Emergency Nursing Association. (2020). 2020 Sheehy's emergency nursing principles and practice (7th ed.). St. Louis: Mosby Elsevier.

EMTALA Answer Book. 2018 edition, Moy. Aspen Publishers

Formerly known as. CP 20.01 & CP 20.18

Secondary materials. None

Approved by: IDN Policy Review and Oversight Committee

Effective: 09/01/06
Reviewed: 09/01/07, 09/01/09, 09/01/11, 09/01/12, 09/01/13, 09/01/14, 09/01/15, 02/01/18, 06/08/20, 01/06/23
Revised: 09/01/08, 09/01/10, 06/08/20, 01/06/23

Owner: Health First Clinical Best Practice Committee (Formerly PBCH ED II-G and CCH ED 4 and HRMC ED Manual EM-4-06, PBCH ED Manual ED IV.B and CCH ED Manual E.D.-203)

Exhibit 5(d)

HealthFirst

Continuum of Care Policy

Owner	Department	Policy Number
Vice Presidents of Nursing, Health First	Continuum of Care	CP 7.01 POL
Original Effective Date	**Last Reviewed Date**	**Last Revised Date**
06/03/2019	07/14/2023	07/14/2023

Printed copies are for reference only. Please refer to the electronic copy for the latest version in the approved IDN Policy Management system.

Policy statement.

Health First is committed to maintaining best practices in direct patient care which are found with greater specificity in the procedures. Applicable Procedures that supplement this Policy must also be adhered to.

Scope.

Cape Canaveral Hospital, Holmes Regional Medical Center, Palm Bay Hospital, Viera Hospital and Hospice of Health First.

Definitions. None Listed

Provisions.

Patient care may vary depending on clinical presentation, licensed independent practitioner orders, and procedures. Use of critical thinking, judgement, and clinical expertise may validate a deviation until further orders are received.

Exceptions. None

References. None

Formerly known as. New

Secondary materials. None

Approved by: IDN Policy Review and Oversight Committee

Effective: 06/03/19
Reviewed: 07/14/23
Revised: 07/14/23
Owner: Health First Clinical Best Practice Committee

Exhibit 5(e)

Interfacility Transfer from a Health First Hospital to an Outside Facility

Owner (Name and Title):		Department:	Procedure Number:
[redacted] MSN, RN, Director of Patient Care Services		Continuum of Care	CP 7.01.06 PRO
Approver: Clinical Best Practice Committee	**Original Effective Date:** 07/01/2007	**Last Reviewed Date:** 10/01/2020	**Last Revised Date:** 10/01/2020

Printed copies are for reference only. Please refer to the electronic copy for the latest version in the approved IDN Policy Management system.

Purpose

To provide a safe and efficient transfer of patients who require medical services not available at a Health First hospital and to be in compliance with all State and Federal guidelines.

Scope

Cape Canaveral Hospital, Holmes Regional Medical Center, Palm Bay Hospital, Viera Hospital.

Definitions

Transport - involves the movement of a patient via ground ambulance and/or air ambulance to another facility for reasons of the availability of certain specialty services or preference of the patient or legally responsible person.

Baker Act: A means of providing an involuntary examination when there is reason to believe that the patient is mentally ill and because of his or her mental illness, the person has refused voluntary examination. The person is unable to determine for himself or herself whether examination is necessary and without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself and such refusal could pose a threat of harm to his or her well being. There is a substantial likelihood that without care or treatment, the person will cause serious bodily harm to himself, herself or others in the near future as evidenced by recent behavior.

Procedure

A. Prior to patient transfer it will be verified that the attending Physician/Emergency Department Physician/Licensed Independent Practitioner (LIP) has performed an initial evaluation, appropriate stabilization procedures and has certified in writing that the benefits of transfer outweigh the risks to the individual or to the unborn child and has completed the Physician Certification Statement.
B. The patient or legal representation will be advised of the risks of transfer based on the clinical situation. Patients refusing treatment or transfer must have a written release.

C. A written consent for transfer is obtained from the patient or legally responsible party. In the event the patient is unable to give consent and there is no known legally responsible party to sign the consent for transfer, then the transfer may continue if the patient's condition deems it necessary.
D. Transfers will be in compliance with applicable State and Federal regulations and meet the Guidelines of any patient Transfer Agreements. No adverse action or penalty will be taken against a physician or qualified medical person who refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital personnel because a report of a violation of a state or federal regulation is made.
E. Patients transferred to another facility must be accepted by an Attending Physician/LIP, or the Emergency Department physician of the receiving hospital.
F. Receiving facility must have the qualified personnel and appropriate equipment to care for the patient, confirm bed availability and agree to accept the patient prior to transfer.
G. The responsibility for the patient during transfer is determined in the following manner:
    - When the accepting facility uses their own transport system (ground or air), and their own personnel, the responsibility is assumed when they arrive and receive report on the patient.
    - When the transferring facility determines that ground transportation is appropriate, and/or uses their own personnel to accompany the patient, the responsibility during transport remains with the transferring facility until the patient's arrival at the accepting facility and a report is given to the nursing unit.
H. The licensed transporting service will conduct the transport in a permitted ambulance. If it is determined that the patient needs or is likely to need medical attention beyond the capability of the paramedic or EMT the transporting agencies medical director should be contacted for clearance before transfer. If the physician in charge of the transfer deems it necessary for a nurse or respiratory therapist to accompany the permitted ambulance they must hold a current certification in advance cardiac life support.
I. If a patient is no longer in need of the specialized care at the receiving facility, the patient may be transferred back to the originating Health First hospital, for continued medical care.
J. Medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place, or the geographically closest hospital is at its service capacity. However, when necessary, more distant facilities may be utilized per CFR 489.24(f) which states that "A participating hospital that has specialized capabilities or facilities may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual."
K. Clinical conditions that require an additional professional personnel (RN or RT) when using Coastal Ambulance of Brevard County.
    - Patients that cannot be managed with the transporting agencies ventilator system. (Need based on requirements of accepting physician/hospital/facility; requirements of ambulance crew's medical director; anticipated need for changing ventilator settings or hemodynamic drips; ambulance crew's discretion based on patient's acuity level.)
    - Patients requiring Intra Aortic Balloon Pump monitoring (If balloon pump should fail to function enroute to receiving facility staff will assist with all required BLS/ALS maneuvers; hospital provides balloon pump equipment/meds; ambulance crews operates stretcher, ambulance, and assists with patient care.)
    - Patients on titrated drips. – (Drips Pitocin, heparin, diprivan, integralin – required only if patient acuity dictates additional resources or at crew's discretion.)
    - Chest tube patients. Need based on requirements of accepting physician/hospital/facility; requirements of transport team's medical director; ambulance crew's discretion based on patient's acuity level.
    - Patients on insulin drips. (Blood sugar must be >200; if less than 200, transport teams medical director to be notified prior to transport or RN to accompany patient; ambulance protocols mandate blood sugar checks every hour during transport and/or if patient's condition changes.)

- Solu-medrol dictated by acuity level or at crew's discretion.
- Hemolytic transfusion. (Requires ALS level of care; Coastal does not require assistance from a RN during the transport of blood products; Coastal cannot hang or restart a new bag of blood products.) Coastal Transporter reserves the right to assess patient acuity and request RN to accompany patient during transport.
- If this is an internal transfer, RN must accompany patient during transport – please refer to policy CP 10.01.01 PRO Blood and Blood Products Issuing and Administering.
- Transport after Tissue Plasminogen Activator (t-PA). (RN and/or RT required ONLY if patient acuity level dictates additional resources or at crew's discretion.)
- Patients deemed NICU transfers (infants less than 28 days old or weigh less than 5 kg who are being transported to a neonatal intensive care unit; Specially trained transport teams to accompany the transport agency; hospital to provide NICU stretcher/isolette/meds, etc.; Ambulance crew is responsible to operate stretcher, ambulance, and assist with patient care.)

L. If personnel, (RT, RN) and/ or equipment are required for ground or air ambulance transport within the county, arrangements for the return of personnel and equipment will be made by the HF Transfer Access Center.

M. Personnel traveling outside of the county will be returned to hospital of origin via ground ambulance or First Flight.

N. Appropriate patients requiring transportation to the Circles of Care (CoC) facility adjacent to HRMC on East Sheridan Road may be transported directly there by Health First Associates from HRMC, PBH and CCH per a transportation exception which allows by-passing the traditional county agreement and transport provider. Transportation to all other CoC facilities will be provided by the approved transportation provider as designated by Brevard County.
    1. Patients escorted to CoC will be escorted/transported only by personnel 21 years of age or older.
    2. Patients being transferred to CoC who demonstrate any of the following behaviors will not be transported by Health First associates but will be transported using the approved transportation provider as designated by Brevard County:
        a. Aggressive or threatening behavior
        b. Self injurious behavior
        c. Psychomotor agitation i.e.: pacing, eyes darting, clenched fists, feet
        d. Severe thought disturbance
        e. Difficulty ambulating
        f. Threats or attempts to flee
    3. The following personnel may be used to transport patients to CoC
        a. Paramedics
        b. ED Techs
        c. Nurses
        d. Social Workers
        e. Security Officers (only in situations as required for safety concerns)
        f. Stellar NMS team
    4. When transported by Health First associates, the patient's belongings will accompany the patient but stay in the possession of Health First personnel until turned over to Circles of Care staff.
    5. Patients will be transported to Circles of Care one at a time and be accompanied by two Health First associates, one of which must be the same gender as the patient being transported.
    6. A copy of the patient's medical record including the original Baker Act (if applicable) in a sealed envelope addressed to CoC clearly labeled with the patient's name will accompany the patient.
    7. In the event a patient attempts to elope or flee during the transfer, the Health First associate will not attempt to physically intervene or restrain the patient but will call 911 and provide a physical description to the police, return the patient records to their point of origin, and notify CoC immediately.

Person responsible: Physician/LIP, RN

A. Determine that the patient requires a transfer to a specialized acute care facility.
B. Contact the Transfer Center to arrange for transfer and to facilitate MD to MD conference call. The Transfer Center will call nursing unit with accepting MD, Assigned Bed and Number to Call Report. Document this information in the patient's record.
C. When HF First Flight Dispatch is utilized, obtain and send to [redacted] or extension [redacted]
   - Face Sheet (patient's demographic information)
   - Physician Certification Statement
   - Out of County Letter (only if patient is going out of county)
   - Air Medical Necessity form. The First Flight Crew will pick this up on arrival
   - Patient Consent/Request/Refusal to Transfer
D. Copy all the necessary medical records. Complete all receiving facility forms, patient discharge forms and send to Subacute Nursing Facility/Rehab checklist, if indicated.
E. If any pertinent radiology images are needed to accompany patient, contact Health Information Management (HIM) in order for a CD to be burned in a timely manner. Some exceptions as follows:
   - All CCH transfers are handled by Radiology department
   - PBH and VH transfers after 5pm (weekdays) and after 4pm (weekends) are handled by Radiology department
   - HRMC transfers are handled by HIM 24/7
   - VH Transfers after 5 pm (weekdays) and after 4 pm (weekends) are handled by the House Supervisor/PFA.
F. Call the receiving facility within one hour of transport and provide a nursing report to the receiving personnel.
G. HF Transfer Access Center can assess appropriate mode of transportation, depending on the needs of the patient determined by the floor staff, and if any additional personnel are needed to accompany the patient. Case Management can be contacted to obtain authorization if necessary.
H. Obtain all written releases from the patient or legally responsible person.
I. When patient transport has arrived (ground or air), if personnel, (RT, RN) and/or equipment are needed for transport, notify the HF Flight Dispatch who will make arrangements for their return to the hospital of origin. Utilize the following options for return of personnel and equipment to hospital of origin:
   1. Out of county transport: Ground ambulance or First Flight
   2. In county transport:
      a. During Courier Service operational hours, notify Courier of need to transport personnel and equipment. Communicate location of personnel, and type of equipment to be retrieved so that appropriate vehicle will be used.
      b. When Courier Service is not available, contact Security and inquire if they are available to retrieve personnel and/or equipment.
      c. If Security is not available, contact Yellow Cab Taxi Service for transport. Yellow Cab Management Trust will bill the appropriate facility through the Case Management Department per standing agreement.
      d. If there is equipment that Yellow Cab declines or is unable to transport, make arrangements to transport the following day by another means. In such a case, document the name and title of person who the equipment is left with.
      e. If all the above options are unavailable, contact the ground ambulance company for transport of personnel and/or equipment. If transport needs coincide with their next call to the hospital of origin, they may return personnel and equipment at no charge. If not they will charge the hospital.

Documentation:

A. Complete all related forms and keep originals on record in the patient's chart.
B. Send copies of all pertinent hospital documentation records and forms with patient upon transfer. Exceptions: Send original forms of EMS Florida Do Not Resuscitate Order, DCF or Baker Act. Keep a copy in the patient's Medical Record.
C. Include the following data elements in the documentation in the patient's medical record:
    - Facility/physician accepting patient after transfer
    - Time/mode of transportation
    - Patient condition upon transfer
    - Family notification
    - Disposition of valuables
    - Accompanying personnel name/title if applicable
    - Hospital records/files sent if applicable
    - Handoff report to receiving facility including time of call and name of personnel receiving report
D. Documentation Forms:
    - Patient Consent/Request/Refusal to Transfer (FF000130)
    - Transfer Documentation Record (FF000746)
    - Physician Certification Statement (as appropriate) (FF000534)
    - Certificate of Medical Necessity First Flight Aeromedical Program
    - (as appropriate) (FF000183)
    - Out of County Form Letter (FF000506)
    - Hospital Discharge Request Form Medicaid Transportation (FF000472)
    - EMS Florida DNR Order Yellow Form (if patient DNR)
    - Authorization To Use Disclose Health Information (if indicated) (FF000369)
    - Transport request document FF000459 should be completed in medical record
E. Send a copy of the patient's record, including lab, pertinent radiological test results and/or images, EKG's, physician progress notes, signed consents and any other pertinent information with the patient at the time of transfer.
F. Provide the patient and/or legal representation with information regarding the reason for transfer and the risks associated with the transfer.
G. Health First Patient Logistics will notify the nursing unit if a particular transfer requires any additional paperwork for the transport.

References

Florida Laws: FL Statutes-Title XXIX Public Health Section 401.013 Legislative Intent

Moy, Mark, MD, MJ, IAAFP, FACEP. The EMTALA Answer Book, 2009 Edition.

Warren, Jonathan, MD, FCCM, FCCP. (2004). Guidelines for the inter- and intra-hospital transport of critically ill patients. Critical Care Medicine 32 (1), 256-62.

Formerly Known As: CP 7.06

Effective: 07/01/07
Reviewed: 06/01/12, 06/01/13, 10/01/14, 10/01/15, 04/01/2020, 06/03/20, 10/01/20
Revised: 07/01/08, 12/01/08, 12/01/09, 12/01/10, 03/15/11, 06/01/12, 10/01/15, 04/01/2020, 06/03/20, 10/01/20

Reviewed and Approved by Viera Hospital 09/01/10
Owner: Health First Clinical Best Practice Committee (Formerly: HRMC/PBCH Clinical Manual 2-06-01-07, 52-06-01-09, 2-06-01-11 and CCH NGP-21-42)

Exhibit 5(f)

HealthFirst

Health First Hospitals Patient Acceptance and Transfer Procedure

Owner		Department	Procedure Number
Vice President of Medical Affairs Medical Director, Transfer Center		Continuum of Care	CP 7.01.07 PRO
Approver	**Original Effective Date**	**Last Reviewed Date**	**Last Revised Date**
Clinical Best Practice Committee	07/01/2007	08/23/2023	08/23/2023

Printed copies are for reference only. Please refer to the electronic copy for the latest version in the approved IDN Policy Management system.

Purpose.

To provide for the safe and efficient acceptance of all patients who require medical or surgical care not available at the transferring facility. The goal of the Health First Transfer Access Center (TAC) is that a single phone call, from a requesting facility, is all that is needed.

Scope.

Cape Canaveral Hospital, Holmes Regional Medical Center, Palm Bay Hospital, Viera Hospital.

Definitions.

Capacity: Receiving facility has appropriate space (open bed) to accommodate the patient's arrival.

Capability: Receiving facility has qualified and available personnel, equipment, and services.

Procedure.

A. Patients may be transferred to Health First hospitals for reasons of availability of specialty care, insurance coverage issues, or at request of patient or legally responsible person.
B. All transfers will be in compliance with the procedures below and all applicable State and Federal regulations.
C. All transfer requests to a Health First hospital will be received and coordinated by the Health First Transfer Access Center (TAC) at 1-800-541-1928 or (321) 434-5626
D. All transfers shall be subject to the following requirements:
    - The receiving facility must have both Capacity and Capability to care for the patient.
    - All patients should be appropriately stabilized by the referring facility.
    - Transfers for specialty needs must be to a higher level of care.
    - An appropriate admitting physician at the receiving facility must accept the patient.

- Transfers of all Emergency Department patients must be in compliance with Emergency Medical Treatment and Labor Act (EMTALA) and the State of Florida Access to Care (395.1041).
- TAC: Transfers of inpatients from sending facilities will be screened for insurance benefits for Health First..on non-EMTALA transfers.
- Inpatient transfers for reasons of specialty physician services - every attempt should be made to contact the intended specialist.

E. Emergency Department (E.D.) to E.D. transfers are only appropriate for patients not requiring admission, such as when a specialist needs to physically treat a patient in the E.D. The requirements in (D) still apply.
F. Patients meeting Trauma Transport Guidelines shall be managed according to the Interfacility Trauma Criteria/Interfacility Transfers to the Trauma Service Guidelines((TR 01.05.03 PRO).
G. Patients meeting time sensitive emergent transfer criteria shall be managed according to the appropriate notification algorithm (ex: STEMI, Stroke, Clot, PE, Trauma, and Code Rupture).
H. All transfers shall comply with the requirements of any patient transfer agreements currently in effect.

TAC - Evaluation

A. Receive incoming calls and obtain Basic Information on each patient.
B. Determine the necessity of admission and problem type.
C. Notify the requesting facility promptly if unable to accept transfer due to unavailable resources.
D. Determine appropriate receiving facility
E. Contact appropriate on-call physician to arrange physician-to-physician discussion of case.
F. Facilitate determination of appropriateness of transfer and mode of transport among physicians.
G. Obtain a disposition of acceptance (or denial) from the appropriate on-call physician.

TAC - Patient Acceptance

After confirming acceptance of patient by the appropriate on-call physician, Health First TACstaff complete the following:

A. Verify interventions for patient with sending facility Registered Nurse and request any appropriate demographic information, physician orders, air medical necessary or ground paperwork.
B. Request a bed assignment from Centralized Patient Logistics.
C. Transport Inpatients directly to the receiving nursing unit, operating room, Cath lab, or other specialty care area. E.D. to Inpatient transfers go to the appropriate unit (as above). Patients who only need specialty services that may be provided in the E.D. (i.e., ophthalmology or GI procedures) may be transferred directly to E.D. The accepting physician may be the E.D. physician only in these cases.
D. If a patient is being transferred within the Health First system, radiological and special procedure reports should be obtained through the PACS system. Digital images are preferred from any referring institution, as per transfer agreements. If the system is down, please send original digital images. Transfer Center will request a copy of the complete medical record from the Transferring facility.

Patient Denials

A. When the appropriate on-call physician has declined the patient, the Health First

Transfer/Access Center specialist shall review the case for appropriateness and consensus of the referring physician and (requested) and receiving physician. A clear consensus for an appropriate denial of acceptance shall be documented (electronically).

B. Immediately refer any cases of questionable non-compliance or disagreement among the parties regarding EMTALA, Florida Access to Care, or these policies as follows:
   1. For trauma referrals to Holmes Regional Medical Center (HRMC), the Trauma Program Medical Director.
   2. For Hospitalist referrals to HRMC or Cape Canaveral Hospital (CCH), the Hospitalist Program Director.
   3. For other referrals, the inability to contact the above, or any question of refusal of an appropriate incoming transfer, the following order shall be used:
      a. Appropriate Department or Section Chairman
      b. Physician Advisors
      c. Vice President, Medical Affairs

Quality Control

Any receiving physicians may refer any transfer felt to be unnecessary to the Quality Improvement (QI) process at the referring facility.

Exceptions. None

References. None

Formerly known as. CP 7.07

Secondary materials. None

Effective: 07/01/07
Reviewed: 10/07/12, 10/01/13, 10/01/14, 10/01/15, 08/01/17, 04/01/20, 08/23/23
Revised: 10/01/08, 10/01/09, 10/01/10, 03/15/11, 05/01/1, 03/01/12, 10/07/12, 10/01/13, 10/01/15, 04/01/20, 08/23/23

Owner: Health First Clinical Best Practice Committee (10/01/12 Combined with HRMC/PBCH Clinical Manual 2-06-01-08, 2-06-01-07, 2-06-01-09, 3-06-01-11)

Exhibit 6(a)

HealthFirst

Care of the Emergency Department Patient

Owner		Department	Procedure Number
System Director of Emergency Services		Emergency Department Department Specific	CP 20.01.16 PRO (DS)
Approver	**Original Effective Date**	**Last Reviewed Date**	**Last Revised Date**
Clinical Best Practice Committee	07/01/2006	11/20/2023	10/24/2022

Printed copies are for reference only. Please refer to the electronic copy for the latest version in the approved IDN Policy Management system.

Purpose.

To define and outline the process for preparing the patient presenting to the Emergency department, for treatment and diagnostic testing, and the reassessment of the patient through disposition.

Scope.

Cape Canaveral Hospital, Holmes Regional Medical Center, Palm Bay Hospital, Viera Hospital.

Definitions.

Assessment: is an objective evaluation of the patient's signs and symptoms and chief complaint.

Reassessment: is the process of reevaluating the patient.

Procedure.

A. Patients presenting to the Emergency Department will be assessed by a Registered Nurse and triaged to initiate medical screening and treatment.
B. Patients will be placed in the treatment area and prepared for treatment and diagnostic evaluation.
C. A reassessment will be performed and documented as the patients' medical condition warrants.
D. A reassessment will be performed and documented after a therapeutic intervention.
E. Verify patient identification utilizing two patient identifiers.
F. Obtain and document vital signs to include pain assessment and weight upon arrival and repeated as condition warrants.
G. Repeat and document vital signs on all patients being admitted or transferred.

H. Assess patients receiving parenteral medication for evidence of adverse reactions and medication effect.
I. Document all assessments and reassessments in the medical record.
J. Report abnormal findings in any area of assessment.

Exceptions. None

References.

Emergency Nursing Association. (2020). 2020 Sheehy's emergency nursing principles and practice (7th ed.). St. Louis: Mosby Elsevier.

Formerly known as. CP 20.17

Secondary materials. None

Effective: 07/01/06
Reviewed: 07/01/07, 07/01/11, 07/01/12, 07/01/13, 07/01/14, 07/01/15, 07/01/16, 06/01/19, 06/01/21, 10/24/22, 11/20/23
Revised: 07/01/08, 07/01/09, 07/01/10, 07/01/12, 07/01/16, 06/01/19, 10/24/22

Reviewed and Approved by Viera Hospital 12/01/10
Owner: Health First Clinical Best Practice Committee (Formally HRMC ED: EM 2.10.1, EM-5-02, PBCH ED: ED IV.F. and ED II.U and CCH E.D. 263)

Exhibit 6(b)

HealthFirst

Emergency Department Patient Care Policy

Owner	Department	Policy Number
Vice President of Nursing, Health First	Emergency Department Department Specific	CP 20.01 POL (DS)
Original Effective Date	**Last Reviewed Date**	**Last Revised Date**
09/01/2006	01/06/2023	01/06/2023

Printed copies are for reference only. Please refer to the electronic copy for the latest version in the approved IDN Policy Management system.

Policy statement.

To supply guidance for documentation of care provided to patients presenting to the Emergency Department.

Patient care may vary depending on clinical presentation, licensed independent practitioner orders, and procedures. Use of critical thinking, judgement, and clinical expertise may validate a deviation until further orders are received.

Scope.

Cape Canaveral Hospital, Holmes Regional Medical Center, Palm Bay Hospital, Viera Hospital.

Definitions.

Emergency Department (ED): Is an outpatient area of the hospital. Responsible for the provision of medical and surgical care to patients arriving at the hospital for immediate care.

Mini-reg: A modified registration process to place the patient in the medical record.

Provisions.

Health First is committed to maintain best practices in direct patient care which are found with greater specificity in the procedures. Applicable Procedures that supplement this Policy must also be adhered to.

A. A medical record will be initiated on all patients that present for treatment at the ED. The record will include information for patient identification, consent for treatment, and documentation of the care that was rendered.
B. A “mini-reg” will be completed on all patients cared for in the ED. Once the information crosses over to the emergency department, documentation will begin. For downtime procedures see the Downtime policy.

C. Every patient that presents to the Emergency Department must have a medical screening exam performed by an Emergency Department physician/Licensed Independent Practitioner (LIP). Refer to CP 16.01.44 PRO ("Nursing Consultation for Obstetric Patients") for the evaluation and management of obstetric patients.
D. If the patient has been discharged, and needs to be seen again, a new record will be generated.
E. If contact is made with patient by phone, an addendum (ED append note) will be added to the original medical record detailing the nature of the call.
F. The original medical record will reside with Health Information Management (HIM).

The following procedures should not be performed in the confines of the Emergency Department but referred to an environment which would provide the patient with privacy and asepsis and facilitate continuity of care with a specialist in that area of practice:

A. Routine enemas, removal of fecal impaction
B. Any procedure requiring general anesthesia
C. Dilation and Curettage
D. Chemotherapy
E. Routine tooth extractions
F. Recovery of outpatient surgical patients
G. Colonoscopy, Bronchoscopy or Endoscopy (unless emergent)
H. Open reductions of bone fractures
I. Routine Biopsies
J. Elective Blood Transfusions
K. Hemorrhoidectomies
L. Specialty line care
M. Elective Mid/PICC Lines

Exceptions. None

References.

Emergency Nursing Association. (2020). 2020 Sheehy's emergency nursing principles and practice (7th ed.). St. Louis: Mosby Elsevier.

EMTALA Answer Book. 2018 edition, Moy. Aspen Publishers

Formerly known as. CP 20.01 & CP 20.18

Secondary materials. None

Approved by: IDN Policy Review and Oversight Committee

Effective: 09/01/06
Reviewed: 09/01/07, 09/01/09, 09/01/11, 09/01/12, 09/01/13, 09/01/14, 09/01/15, 02/01/18, 06/08/20, 01/06/23
Revised: 09/01/08, 09/01/10, 06/08/20, 01/06/23

Owner: Health First Clinical Best Practice Committee (Formerly PBCH ED II-G and CCH ED 4 and HRMC ED Manual EM-4-06, PBCH ED Manual ED IV.B and CCH ED Manual E.D.-203)

Exhibit 7(a)

HealthFirst

System Wide Patient Safety Event Reporting System

Owner		Department	Procedure Number
[redacted], Chief Clinical Officer, Chief Nursing Officer		Clinical Risk Management	RM 01.01.01 PRO
Approver	**Original Effective Date**	**Last Reviewed Date**	**Last Revised Date**
IDN Policy Committee	February 1986	October 2023	October 2023

Printed copies are for reference only. Please refer to the electronic copy for the latest version in the approved IDN Policy Management system.

Purpose.

It is the absolute moral, ethical and professional responsibility and accountability of every associate to ensure that any safety event, in which they were involved or of which they have knowledge, must be reported. The Health First event reporting system is a patient safety activity and is an integral part of our overall patient safety evaluation system, conducted in an effort to improve patient safety, health care quality, and health care outcomes of our patients. Health First is a member of the Clarity Patient Safety Organization (PSO) and The Patient Safety Organization of Florida. The event reporting process is conducted within the Health First Patient Safety Evaluation System (PSES) for the purpose of reporting to the PSO patient safety events. The Safety Zone Portal (SZP) is the online reporting system that is used by Health First. The "Submit Event" screen shall be used for associates to complete the initial event report. The "Submit Event" screen contains all the required data points to comply with Statutory (s.395.0197) reporting requirements, and therefore is not considered (PSWP) Patient Safety Work Product. All other tabs within the SZP form contain the aggregation, deliberation, and analysis of data, and are therefore considered (PSWP) Patient Safety Work Product, unless otherwise designated by the Risk Management PSES representative. Event Reporting is in no way viewed as punitive and should be regarded by all health care providers as a constructive means to address opportunities for improvement.

Scope.

All Health First Integrated Delivery Network (IDN) Entities

Definitions.

Event: An unplanned occurrence during the care/treatment of a patient which directly impacted the patient, having reached the patient, or had the potential to do so or did not reach the patient (also referred to as a “near miss”).

Clarity Safety Zone Portal (SZP): online event reporting system that is used by Health First. Event reports are used as a mechanism to collect data to be analyzed for the purpose of improving patient, visitor, and employee safety and well as the quality of clinical care delivered.

Electronic forms:

Hospital Patient Events: This form is for the specific purpose of collecting reports on events that relate directly to patient care and safety for patients who are receiving care in one of the IDN hospitals. The event type categories are: Safety Event, Patient Concern/Grievance, Care Provider Behavior, and Ethics consult. *Please refer to RM 01.01.01 PRO Attachment A for list.*

Information Privacy HIPAA: This form is used by the Information Privacy department for the Health First IDN, to capture events or potential events, document investigations and follow-up as defined by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and applicable State Laws.

Ambulatory Safety Module: This form is for the specific purpose of collecting reports on events that relate directly to patient care and safety delivered outside of the hospital including Health First Medical Group, Hospice of Health First, William Childs Hospice House, Health First Home Care, Health First Aging Institute, Health First Medical Equipment, Health First Private Duty, Melbourne GI Center, Surgery Center at Babcock, Health First Family Pharmacy, and Center for Child Development . *Please refer to RM 01.01.01 PRO Attachment B for list.*

HFHP Event/Grievance Tracker: This form is used by Health First Health Plans to capture regulatory events and document their investigation results. This form is used by Health First Health Plans to capture grievances received from their members, document their investigation results, and member follow-up.

Potential Drug Diversion Reporting: This form is used to collect reports of potential drug diversion across the Health First IDN.

Proactive Diversion Report: This form is used by the Pharmacy teams, within the Hospital IDN, to track potential diversions based upon data from the electronic medication dispensing equipment. The review and tracking are done with the collaboration of nursing.

ProHealth Events: This form is used to report safety events or concerns by members of Health First ProHealth and fitness.

Volunteer Events: This form is used to report safety events that involved our volunteers, that may or may not have resulted in an injury.

Florida Statutory Adverse Event Reporting

Adverse Incident: Health First and the State of Florida defines "adverse incident" as an incident over which health care personnel could exercise control and which is associated in whole or in part with medical intervention rather than the condition for which such intervention occurred, and which results in one of the following injuries:

a) Death;

b) Brain or spinal damage;

c) Permanent disfigurement;

d) Fracture or dislocation of bones or joints;

e) A resulting limitation of neurological, physical or sensory function which continues after discharge from the facility;

f) 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 his or her informed consent;

g) Any condition that required the transfer of the patient, within or outside 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;

h) Was the performance of a surgical procedure on the wrong patient;

i) Wrong surgical procedure;

j) A wrong-site surgical procedure;

k) A surgical procedure otherwise unrelated to the patient's diagnosis or medical condition;

l) Required the 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;

m) A procedure to remove unplanned foreign objects remaining from a surgical procedure.

Code 15 Reporting: Any of the following adverse incidents, whether occurring in the licensed facility **or *arising from care prior to admission to the licensed facility***, shall be reported by the facility to the agency within 15 calendar days after its occurrence:

a) Death of a patient

b) Brain or spinal damage to a patient

c) The performance of a surgical procedure on the wrong patient

d) The performance of a wrong-site surgical procedure

e) The performance of a wrong surgical procedure

f) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition

g) The 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

h) The performance of a procedure to removed unplanned foreign objects remaining from a surgical procedure

Procedure.

A. The associate who discovers the safety event or has the most knowledge of the event will initiate the online SZP entry.
   1. During the submission, the SZP event is to be completed in its entirety.
   2. The SZP is self-explanatory. Questions regarding completion should be directed to the associate's supervisor or Risk Management.
   3. Make a clear, concise statement of all relevant facts. Do not make assumptions, do not express opinions and do not write what someone else tells you to write.
   4. If the original report indicated no harm but subsequent examination reveals an injury was sustained due to the event, immediately notify Risk Management.
   5. Managers will receive notice of events via email in their purview. Every report requires managerial review and follow-up if necessary.

B. Every "adverse incident" as defined above shall be immediately communicated to the Risk Manager regardless of the day of the week or time of day. A Safety Zone Portal report shall be completed as soon as reasonably possible. Florida Law also places an affirmative duty (a legal obligation) on all health care providers and all agents and associates of our health care facilities to report an adverse incident as defined above by the Agency for Healthcare Administration (AHCA).

1. If an event meets the definition of an "adverse incident," the Risk Manager will determine whether circumstances exist to report to the Agency for Health Care Administration (AHCA) as a Code 15. In addition, should the Risk Manager determine that the "adverse incident" represents a potential for litigation, outside council may be engaged immediately to assist with the investigation in an effort to evaluate and prepare in anticipation of litigation.

2. Every "allegation of sexual misconduct" shall be immediately communicated to the Risk Manager regardless of the day of the week or time of day for further investigation. The Risk Manager of record will report to the Department of Health every allegation of sexual misconduct (as defined in chapter 456 and the

respective practice act) by a licensed health care practitioner that involves a patient.

3. Elopement of a patient, who is under the protection of a Baker Act/Suicide Precaution, Marchman Act or with a diagnosis of Alzheimer's or dementia or has been deemed to lack capacity to make medical decisions, shall be immediately communicated to the Risk Manager regardless of the day of the week or time of the day. Elopement is defined as the patient who has left the hospital (or is unable to be located in the facility) without going through the discharge process or leaving AMA.

Exceptions.

None

References.

395.0197 Florida Statute (2023)

EX 2.13 Missing Patient/Patient Elopement

CP 5.04 Suicide Precautions/Baker Act Patients

Formerly known as.

RM 01.01 POL

Secondary materials.

None

Developed: 02/86

Reviewed: 06/98, 07/01, 06/02, 05/04, 07/05, 07/06, 01/07, 04/07, 08/07, 09/09, 07/10, 10/10, 02/11, 04/11, 10/11, 06/12, 02/14, 02/16, 10/23

Revised: 03/97, 06/98, 07/04, 07/05, 01/07, 04/07, 08/07, 09/09, 07/10, 10/10, 02/11, 04/11, 10/11, 06/12, 02/14, 02/16, 10/23

Reviewed & Approved for Viera Hospital: 01/11

Attachment A:

Event Type	Event Sub Type
Safety Event	Abuse Allegation
	Action by Patient, Family, or Significant Other
	Action taken / Order written without physician input
	Allegation of Sexual Misconduct
	AMA
	Appropriateness of the management of patient care
	Blood Product Event
	Central Line Associate Bloodstream Infection
	Clostridium difficile gastroenteritis
	Condition necessitating use of reversal agent
	Consent
	Correct patient, wrong account number
	Critical Value
	Delay in Patient Care
	Device or Medical / Surgical Supply
	Dislodgement of tubes, lines, or catheters
	Drug Inventory Discrepancy
	Drug/Medication Reaction (ADR)
	Dx/Test Interpretation Discrepancy
	Elopement
	Extubation requiring re-intubation
	Fall
	Hand Hygiene Event
	Handoff Communication
	Illegible documentation requiring clarification
	Improper Specimen Collection
	Indwelling urinary catheter
	Intravenous or Arterial access events
	Isolation Event
	Lost/Missing Patient Chart
	Lost/Missing Specimen
	Medication (Incorrect Action)
	Medication Reconciliation
	Misidentification
	Non physician procedure event
	Order canceled without notifying respective department
	Order changed after submission to Pharmacy
	Perinatal
	Pressure Injury (HAPI)
	Prohibited Abbreviation
	Restraint death
	Restraint Order Not Authenticated
	Skin Integrity Event (Not a Pressure Ulcer)

	Specimen Mislabeling
	Surgery/Anesthesia/Radiology (Procedures in the OR, Cath Lab, Endoscopy, IR L&D, etc.)
	Telemetry event
	Transfer - Higher Level of Care
	Transport Event
	Venous Thromboembolism (VTE not present on admission)
	Ventilator Associated Pneumonia
Patient Concern	Behavior
	Civil Rights (ADA/504/1557)
	Communication
	Delay
	Dietary
	Discharge Process
	Environmental
	Financial / Billing
	Integrity Referral
	Lost / Stolen / Damaged Item
	Quality of Care Provided
Care Provider Behavior	Physician/PA/ARNP
	Non-Physician/LIP
Ethics Consult	Advanced Directives
	Conflict
	End of Life
	Surrogate

Attachment B:

Event Type	Event Sub Type
Center for Child Development	Report on child who caused event
	Report on child who was affected by event
Dismissal	Practice Initiated Dismissal
	Patient Initiated Dismissal
Integrity Referral	Allegation/Concern
	Audit Review
	Inquiry request
	On-site Vendor promotional training
	Physician non-monetary compensation
	Vendor issue/compliance
Near Event (Miss) - A safety event that could have but did not reach the patient	
Patient Concern	Behavior
	Civil Rights (ADA/504/1557)
	Communication
	Delay
	Financial/Billing
	Injury Post Lab Draw
	Lost/Stolen/Damaged Items
	Other
	Quality of Care
Safety Event	Allegation of Abuse
	Allegation of Sexual Misconduct
	AMA - Against Medical Advice
	Behavior Issue
	Consent
	Delay in Care
	Equipment/Medical/Surgical
	Fall - Patient
	Fall - Visitor
	Lab Specimen
	Left Without Treatment
	Medical Event
	Medication
	Security Event
	Surgical - Procedural
	Transfer to a Higher Level of Care
	Wrong Patient (Misidentification event)