

From: [REDACTED]
To: [REDACTED]
Cc: [REDACTED]
Subject: [REDACTED] response
Date: Thursday, February 28, 2019 1:59:48 PM
Attachments: [REDACTED] cover letter.pdf
1. RCA CAP [REDACTED].doc
3. LO 209 Medical Examiner Policy CY19newDRAFT.doc
4. LO 117 Training Policy CY19_new DRAFT.doc
2. LO 801 OA Policy CY19newDRAFT.doc
5. ME Letters.pdf
6. March 2019 Clinical Quality meeting agenda.docx
7. Prelim Autopsy request.docx
8. LO 220 Post Procurement Follow Up and Reporting CY19FINAL.doc

Good afternoon [REDACTED]

This email and the attachments are in response to your inquiry letter we received today. This became an urgent matter beginning on February 15, 2019. Since then, we have been actively working through the items on the corrective action plan we developed following our root cause analysis (RCA). We are also in regular communication with the Mayo Clinic, and hope and pray their patient recovers.

Attached is our cover letter to you, our RCA and CAP, three amended LifeQuest policies, letters we sent to our Medical Examiners, an upcoming staff training agenda, a newly created form called a Preliminary Autopsy Request, and our standing (unchanged) Post Procurement Follow up and Reporting policy.

Please let us know if you need anything further, and as I outlined in our cover letter to you, we will forward any additional changes that we may make.

[REDACTED]
[REDACTED]
LifeQuest
[REDACTED]
[REDACTED]

Our vision: A transplant for every patient in need.



February 28, 2019

Mr. [REDACTED]
Safety Analyst
UNOS Member Quality

Dear [REDACTED]

This letter is in response to your recent inquiry regarding donor [REDACTED] from 2/18/18 with a cross-clamp time of 1344 EST. This donor was an accidental death and therefore had an autopsy by the local Medical Examiner. The autopsy report was provided to LifeQuest 4 months following the death of the donor and subsequent heart and liver transplantation.

At LifeQuest, when the medical director receives an autopsy report, he/she reviews it, and only contacts the director of clinical operations to report any findings that may indicate a communicable disease transmission. The director of clinical operations would then contact the patient safety contacts at each transplant center, the tissue and eye banks, and would follow the OPTN/UNOS DTAC protocol. If the medical director does not observe any questionable findings, then he/she dates and initials the report and gives it to the information associate or a secretary to upload into naviGator, the LifeQuest web-based donor database.

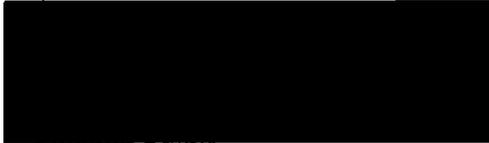
On Friday morning, February 15, 2019, LifeQuest received a call from a Mayo Clinic Jacksonville transplant coordinator who stated that during the liver transplant recipient's one-year follow-up appointment, an ultrasound revealed a large liver mass. Biopsy of the mass indicated it was a germ cell tumor, possibly embryonal. The Mayo coordinator asked if we would review our donor record to determine if this could have been donor derived. Upon review of the donor record, the medical examiner's autopsy report was reviewed and it clearly stated the donor had testicular cancer. The LifeQuest medical director overlooked this critical finding when he originally viewed the Medical Examiner's autopsy report on June 11, 2018. This is the reason why the autopsy findings were not communicated to Mayo nor UNOS/DTAC.

This became a priority issue for LifeQuest, as we take potential or actual disease transmission very seriously. The next business day, February 18, 2019, the medical director, the executive director, the entire management team and quality improvement committee performed a root cause analysis and developed a corrective action plan, which are enclosed for your review. The root cause analysis led to policy/practice changes (attached), the need for medical examiner education—which began with a letter to all of our medical examiners (attached), LifeQuest staff education regarding this event and the new policies (agenda attached), and the creation of a new form called Preliminary Autopsy Request form (attached). No changes were made to our Post-Procurement Follow Up and Reporting policy because had the potential disease transmission been discovered, it would have properly been reported. It is attached for reference.



Please let me know if you need anything further. If we learn anything else or if we change any additional practices, we will forward that information to you. Finally, if there is someone reviewing this who may have suggestions, we would like to hear them.

Sincerely,

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Executive Director
LifeQuest

cc:

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Root Cause Analysis & Action Plan – Donor Derived Cancer Transmission

Date of RCA: 2/18/19

Reference #: [REDACTED] Facility: UFH - LifeQuest Category: Major / Sentinel Event Team: [REDACTED]

Patient History & Initial Assessment

This patient was a 20 yo brain dead organ donor at TMH after sustaining head injuries and a cardiac arrest following [REDACTED] [REDACTED] disruptive behavior classified as excited delirium. Past medical / social history obtained by the father and included mental disorders that required at least one hospitalization in a psychiatric facility, medical marijuana use, short periods of jail time due to theft, DUI, and violation of probation.

Date/Time/ Reference	Details of the Event / Timeline
2.9.18 2345 EST	Patient admitted to TMH.
2.15.18 2000 EST	Referral of this patient made to LifeQuest (OPO).
2.16.18 1828 EST	Brain death declared.
2.16.18 1828 EST	Informed the family of patient’s registered decision to donate, for which they supported. The past medical and social history was obtained at this time from the father of the donor, who indicated no cancer history in the donor.
2.16.18 2040 EST	LifeQuest contacted the Medical Examiner (ME) who cleared the patient for organ donation, but did not permit tissue donation due to the multiple Taser markings the ME wanted to preserve.
2.16.18 2300 EST	A physical assessment was done by OPC #1.
2.17.18 0930 EST	A bronchoscopy was completed, unremarkable.
2.17.18 1130 EST	A physical assessment was done by OPC #2 with documentation of “redness/irritation noted between the legs/scrotal area with scrotum having notable swelling”.

2.17.18 1340 EST	A chest, abdomen and pelvis CT was performed. "The liver, spleen, kidneys, adrenals, pancreas and gallbladder were unremarkable. Small amount of ascites, no pelvic masses or lymphadenopathy".
2.18.18 0900 EST	A physical assessment was done by OPC #3 with a drawing that included scrotal swelling.
2.18.18 1230 EST	The donor was taken to the OR for liver and heart recovery for transplant, and small intestine recovery for research. Organ recovery was unremarkable, and cross-clamp was at 1344 EST. Abdominal surgeon attestation that there were no contraindications for donation, Mayo Clinic surgeon signature. Following organ recovery, the body was transported to the morgue to await pick up by the Leon County Medical Examiner's office.
2.19.18 0918 EST	The pathologist in the District Two Leon County Medical Examiner's office performed the autopsy on 2/19/18 at 0918 EST. According to the autopsy report, during the autopsy, "numerous hemorrhagic nodules were noted on the right testicle." Pathology later revealed right testicular embryonal carcinoma, and this was included in the final autopsy report. Also included, was a statement in all capital letters: "EVIDENCE OF MEDICAL INTERVENTION AND ORGAN PROCUREMENT". There were several other statements regarding organ recovery throughout the report.
March 2018	The LifeQuest Information Associate reached out to the ME office by e-fax to inform them we were still waiting on the final autopsy report. A quick response from the ME office indicated the final report was not available, as they were still waiting on toxicology results.
6.11.18	LifeQuest received the final autopsy report by U.S. Mail. The LifeQuest secretary wrote the UNOS ID on the report and gave it to the Medical Director for review.
6.11.18	The LifeQuest Medical Director reviewed the autopsy report, dated, initialed, and submitted it to the QA staff for scanning into the donor record. No information about the donor having testicular cancer was noted by the Medical Director.
2.15.19 0900	On the morning of February 15, <u>2019</u> , the Director of Clinical Operations received a call from a Mayo Clinic transplant coordinator, who stated that during the liver transplant recipient's one-year follow up appointment, an ultrasound revealed a large liver mass and was confirmed by MRI. Biopsy of the mass indicated that it was a germ cell tumor probably embryonal. It was asked by the Mayo coordinator if we would review our donor record to determine if this could have been donor derived.
2.15.19 0930	The Director of Clinical Operations quickly began reading through the donor record and eventually found the autopsy report from the ME office that revealed testicular embryonal carcinoma. She immediately notified the Associate Executive Director who then notified the Executive Director.

2.15.19 1000-1300	Between the hours of 1000-1300 Mayo (liver), Duke (heart) and DTAC were notified of the finding. During the call to Duke, the transplant coordinator stated that the heart patient died of multi-system organ failure in November of 2018, and never demonstrated any evidence of cancer. The Mayo liver surgeon indicated that treatment would begin for the recipient and that they reported this possible disease transmission to DTAC.
2.15.19 1605 EST	The Executive Director called the Medical Director to inform him.

Questions	Details of the Event
What are the current steps in the process, as designed?	<p>Current practice is:</p> <p>Medical Examiner may or may not send an autopsy report without prompting.</p> <p>No written requirement through policy for LifeQuest to contact the Medical Examiner’s office for a final autopsy report, though this has been the practice for the LifeQuest Information Associate.</p> <p>In the medical examiner section in naviGator, LifeQuest’s web-based database, it asks whether an autopsy was done. This has a yes or no box to check (it was checked yes for this case).</p> <p>The autopsy report is not part of formal chart closure, i.e., a donor record can close even if an autopsy is pending.</p> <p>When an autopsy report is sent to LifeQuest, the secretary or Information Associate receives the report and sends it to the Medical Director for review.</p> <p>The Medical Director reviews the autopsy report for anything that could lead to a disease transmission in a transplant recipient. If there is no evidence for possible disease transmission, the Medical Director initials, dates the front page of the report, and then gives it back to clerical staff for scanning into the donor record. If there is evidence for possible disease transmission, the Medical Director notifies the Director of Clinical Operations or his/her designee.</p> <p>The Director of Clinical Operations or his/her designee is responsible for notifying the AED, ED, patient safety contacts at all transplant centers, tissue, and eye banks affected, and filling out the requirements of the OPTN/UNOS DTAC.</p>
What other programs were possibly impacted as a result of this event?	<p>Mayo Clinic (Florida) Liver Transplant</p> <p>Duke Heart Transplant</p> <p>OPTN/UNOS DTAC</p>

SFC OPTN Hearing
Exhibit D.37

Questions	Analysis of the Event (cancer transmission) Why Did it Happen?	In Our Control Yes/No	Root Cause?	Contributing Cause? Can only be "yes" if not a root cause
What steps were involved that possibly contributed to the event?	Lack of communication from ME to OPO upon findings of testicular masses and identification of cancer	No	Yes	No
	ME report arrived 4 months after the donation and subsequent transplantation	No	Yes	No
	Lack of written protocol for reviewing/receiving of ME reports	Yes	No	possible
	Medical Director overlooked cancer in report	Yes	Yes	No
	Single person review of document	Yes	Yes	No
	Lack of tracking outstanding autopsy reports	Yes	No	Yes
	Initialing only first page of autopsy report by medical director	Yes	No	possible
	Lack of education for MEs to make aware that cancer can be transmitted from donor to recipient, and that the OPO should be notified	Yes	Yes	No
Human Factors: What human factors were relevant to the outcome?	Single review of autopsy report	Yes	Yes	No
	ME education	Yes	Yes	No
Policies & Protocols: What impact did the policies related to this event have on the outcome?	Lack of a specific process outlined in policy for autopsy receipt and review	Yes	No	Yes
	Lack of a protocol for educating Medical Examiners	Yes	No	Yes

SFC OPTN Hearing
Exhibit D.37

Questions	Analysis of the Event (cancer transmission) Why Did it Happen?	In Our Control Yes/No	Root Cause?	Contributing Cause?
Written documentation: To what degree was all necessary information available when needed? Accurate? Complete?	ME report sent to the OPO four months after the autopsy	No	Yes	No
	Medical Director practice of initialing only the first page of the autopsy report	Yes	No	Possible
	Method of receiving some autopsy reports in the mail	No	No	Possible
Oral Communication: To what degree was oral communication among participants inadequate?	Lack of communication from ME to OPO when testicular cancer was confirmed.	No	Yes	No
	Lack of communication from OPO to ME to obtain final report	Yes	No	Yes
Written/Oral Communication: What are the barriers to communication of potential risk factors?	Education of MEs	Yes	Yes	No
	Availability of autopsy reports to OPO	No	No	Yes
Staff Competency: What training systems are in place to assure adequate training/competency levels as related to this event?	ME competency with potential disease transmission and communication to the OPO	Yes	Yes	No
Staff Performance: To what degree is staff performance addressed?	Physical exam training begins during orientation and is ongoing as evidenced in our training records. LifeQuest physical exam training is comparable to OPOs and tissue banks throughout the industry.	Yes	No	No
	Medical Director is trained and qualified to review autopsy reports	Yes	No	No

CORRECTIVE ACTION PLAN (CAP)

	Risk Reduction Strategies	Date Implemented	Quality Monitoring	Responsible Personnel	Completed
Action Item #1	Two clinical reviews of autopsy report. The Medical and Executive Directors, or their designees if unavailable, will review every Medical Examiner autopsy initial and final reports (and private autopsy when available) within two business days from receipt of the report. Each page of the autopsy report will be dated and initialed by both parties.	2/15/19	The donor record QA committee will assure that both the Medical Director and the Executive Director (or their designees) have both dated and initialed each page of the initial and final autopsy report, that the report was scanned into the donor record, and that the newly formed check box was completed in naviGator.	[REDACTED]	✓
	Practice changes will be reflected in amendments to the Donor Record Quality Assurance Policy (LQ 801), the Medical Examiner policy (LQ 209), and a checkbox will be added to naviGator. All staff will be notified of the change and given ample opportunity to ask questions.	2/28/19			✓
Action Item #2:	Amend LifeQuest policy and procedure regarding receiving autopsy reports:	2.26.19	Donor record QA committee will track receipt, review and upload of final autopsy report from the Medical Examiner into the donor record.	[REDACTED]	✓
	Implement a backup system with secretary and information associate receiving autopsy reports and the process for handling them. Autopsy tracking system will be developed in naviGator. A new checkbox will be added into naviGator for private autopsies as well. When the report is received, the information associate or secretary will add the UNOS ID, date and initial, write the number of pages received, and scan into naviGator. Programming changes in naviGator will result in an instant and automatic email to the medical and executive directors that there is an autopsy report to review.	3.15.19			Pending
	Practice changes will be reflected in amendments to the Donor Record Quality Assurance Policy (LQ 801) and the Medical Examiner policy (LQ 209). All staff will be notified of the change and given ample opportunity to ask questions.	2.28.19			✓
Action Item #3	All Medical Examiners in the LifeQuest DSA will receive education from LifeQuest regarding possible disease transmission from donor to recipient, and the importance of communication to the OPO of early findings, and again on the final report. This education will	2/27/19	The CQI committee will be responsible for assuring documentation of newly required training by adding	[REDACTED]	✓

**SFC OPTN Hearing
Exhibit D.37**

	occur within days of this RCA, then annually or within one month of a newly appointed ME. Specific, focused contact with ME from District 2. This practice change will be reflected in the Training policy (LQ 117). All staff will be notified of the change and given ample opportunity to ask questions.	2/28/19 2/28/19	this to the CQI agenda once per year as an audit of training activities for Medical Examiners. Staff education and training records		✓ ✓
Action Item #4	Create a form that is faxed to the Medical Examiner's office within 1-3 business days that includes: 1. Upon initial autopsy, were there findings that could include possible disease transmission from organ donor to recipient: Y <input type="checkbox"/> N <input type="checkbox"/> 2. Please fax back to LifeQuest at  3. If the Yes box is checked, a representative from LifeQuest will contact your office within one business day of receipt. This practice change will be reflected in naviGator, the Donor Record Quality Assurance policy (LQ 801) and the Medical Examiner policy (LQ 209). All staff will be notified of the change and given ample opportunity to ask questions.	2/26/19 3/15/19 2/28/19	The donor record QA committee will assure the fax was submitted to the ME office as evidenced by the log-in history in naviGator. NaviGator will be programmed so that the form is sent automatically to the ME every week until it is received back. Training for this will be for all clinical staff and all new clinical staff from this date forward.		✓ Pending ✓
Action Item #5:	Contact the Chairperson of the state of Florida's Medical Examiner Commission and ask to get on the agenda for the next statewide meeting regarding potential disease transmission and the importance of communicating early and often with the OPO. Confirmation that LifeQuest will present at next MEC meeting. Contact other OPOs about Medical Examiner follow up with preliminary and/or final autopsy reporting to ascertain if there is something with their processes that could help improve ours.	First contact by 2.26.19 4/15/19 3/15/19	Medical Examiner Commission agenda Medical Examiner Commission agenda Report at the Director's meeting		✓ Pending Pending

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LIFEQUEST ORGAN RECOVERY SERVICES

POLICY NUMBER: 801
CATEGORY: QUALITY
REVIEW: FEBRUARY 2020

SUBJECT: Donor Record Quality Assurance Policy

PURPOSE: To provide guidelines regarding quality assurance as it pertains to donor record completion and to provide guidelines regarding the secure retention of all LifeQuest donor files.

POLICY STATEMENT: Clinical coordinator of record is responsible for completion of all required documentation as outlined on the Donor Record Quality Assurance Checklist (in naviGator). The Record Quality Assurance Committee will meet weekly to ensure compliance with this policy. Director of Clinical Operations and the Medical Director will sign off on all completed records after the Record QA Committee has determined that the record meets document requirements. All donor records—including consented-not-recovered (CNR) cases—will be maintained in a locked electronic format within naviGator. These files will be maintained for a minimum of 10 years.

CONTENTS:

1. Completion of donor records
 - a. The primary clinical coordinator of record shall be responsible for completion of all documentation data entry within the time frame outlined. All corrections or additions to initial paper documentation must be made with a single line through the altered text, initialed and dated by the individual making the correction.
 - b. All initial paper documentation scanned and contained within the donor records shall be completed using ink.
 - c. All initial donor paperwork items must be completed (a strike-through line of “N/A” is an acceptable entry). Any additional information that is needed to be entered after the strike thru is made will require a note in NaviGator of justification. Any fields that are blank in naviGator after validation occurs are to be considered as intentionally left blank. Once the electronic record is validated, it is locked for changes requiring the donor record to be opened at the direction of the data quality analyst or LifeQuest administration.
 - d. All paper documentation will be included in the donor files as scanned electronic files in naviGator. This will include documents related to: declaration of death, consent/authorization, medical-social history, ABO, serologies, diagnostic testing, OR documentation and recipient information. When no longer needed all paper documents (after scanning into NaviGator) will be deposited into the secure documentation shred receptacle.
 - e. Only those LifeQuest employees with a need to know shall access the contents of the donor records for purpose of modification.
 - f. When access to a donor record is needed for modifications after the record has completed the QA process a staff member will need to get approval from the data quality analyst or a member of LifeQuest administration
 - g. With the exception of OPOs or transplant centers, when copies of a donor record are requested by non-LifeQuest entities, LifeQuest will always consult Legal Services before processing any request for copies of any donor record. Copies may be provided to donor/transplant entities involved with that donor.

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h. The Medical Director and the Executive Director (or his/her designees) are responsible for reviewing the initial and final autopsy reports from the Medical Examiner or in the rare instance of a private autopsy within two business days of receipt. This will be evidenced by the reviewers' initialing and dating of each page of the final autopsy report, and by documenting the review in naviGator. Any findings by the Medical Director or the Executive Director of potential communicable diseases will be reported to the Director of Clinical Operations, or his/her designee, in order to initiate the responsibilities of DTAC and contacting the transplant programs, tissue and eye banks.

2. Record Quality Assurance Committee

- a. The Record QA Committee shall be comprised of the director of clinical operations, data quality analyst, information associate, secretary, and a clinical coordinator who will attend as workload permits. Other staff may be directed to participate as well.
- b. The Record QA committee will meet once a week to review donor files and ensure compliance with document deadlines outlined in naviGator under record tracking.
- c. Coordinators must participate in the weekly meeting, either in person or via conference call to discuss and plan timely submission of documents and completion of electronic data entry.
- d. Records with outstanding documentation will remain within the committee's weekly review, with a target date of completion set.
- e. The assistant executive director, director of clinical operations or associate director of clinical operations will complete the DDR data upload and validation to UNET within the 28 day deadline imposed by UNOS.
- f. The clinical coordinator or a member of the QA committee will fax to the Medical Examiner's office within 1-3 business days, the Preliminary Autopsy Request form, found on naviGator.
- g. If the Medical Examiner's office returns the form with the checkbox marked yes, the medical director or his/her designee will contact the medical examiner's office within one business day of receipt of that information to obtain the potential communicable disease transmission information.
- h. The medical director will notify the AED, ED, and then the director of clinical operations at LifeQuest, of the potential disease transmission from organ donor to recipient(s) so that he/she or his/her designee can begin the DTAC process and notify all potentially affected transplant programs, including tissue and eye banks.
- e. i. The secretary and the information associate will be crossed-trained to receive initial and final autopsy reports from the Medical Examiner's offices. This back-up system will assure all autopsy reports are received and passed to the medical and executive directors in a timely manner.
- j. The Record QA committee will be responsible for assuring that both the medical director and executive directors (or his/her designees) have reviewed, dated, and initialed each page of the final autopsy report before it is scanned into naviGator. The autopsy tracking system within naviGator will be updated.

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Note: Most medical examiner reports received are final. Initial reports are very infrequent.

LIFEQUEST ORGAN RECOVERY SERVICES

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3. Final Approval
 - a. When a record is completed and approved by the members of the Record QA Committee, it will be directed to LifeQuest administration for final sign off.
 - b. Administration required for final sign-off includes the medical director and the director of clinical operations. The target goal for final approval is the chart is closed within 90 days of recovery.
 - c. If deficiencies are discovered, the electronic chart will remain open in the QA circulation for weekly review and correction of discrepancies.

LIFEQUEST ORGAN RECOVERY SERVICES

POLICY NUMBER: 209
CATEGORY: CLINICAL
REVIEW: FEBRUARY 2020

SUBJECT: Medical examiner cases

PURPOSE: To provide guidelines concerning organ donors under the jurisdiction of the medical examiner.

POLICY: It is the policy of LifeQuest to obtain permission from the medical examiner prior to the removal of organs and tissues, in compliance with Florida Statute. Furthermore, it is the policy of LifeQuest to develop a close working relationship based on mutual trust and collaboration to promote the release of medical examiner cases for donation. Florida Statutes can be found online.

CONTENTS:

1. **Obtaining Clearance for Donation from the Medical Examiner's Office:**

The clinical coordinator is responsible for requesting permission from the medical examiner for pre-autopsy removal of specific organs and tissues from a potential donor. Clearance for tissue donation will also be requested. The initial request is made to the medical examiner **in the county or district of jurisdiction, where the death occurred**. The clinical coordinator will provide the medical examiner's office with the following information:

- a. Name/age/sex/race/cause or circumstances of death
- b. Name and address of next-of-kin if requested
- c. Synopsis of injuries including CT scan reports, x-ray reports, other diagnostic imaging reports, reports of surgical procedures if requested
- d. Time of brain death declaration/intent for DCD recovery
- e. Location of incident and law enforcement agencies involved
- f. Any further information requested by the medical examiner's office

Note: The clinical coordinator will document in naviGator, the name of the person giving clearance for donation, the date and the time. Restrictions, if any, will be documented in the space marked "restrictions." If no restrictions are given, the clinical coordinator will document "no restrictions." The clinical coordinator is responsible for assuring that visiting surgeons comply explicitly with any limitations set forth by the medical examiner regarding this procedure.

2. **Required Blood and Body Fluid Samples:**

On all medical examiner's cases, the clinical coordinator will provide the medical examiner with (at minimum) **2 red top blood tubes, 2 gray top blood tubes, and 1 purple top blood tube**. At the request of the medical examiner's office, the clinical coordinator will provide one or all of the following samples:

- a. **Pre-transfusion blood sample**
- b. **urine sample**
- c. **bile sample**

All samples will be labeled with **donor name, date and time of sample drawn, draw location, UNOS ID, type of sample, and initials**. All specimens will be placed in a sealed bag for transport to the ME's office.

3. **Required Documentation:**

The clinical coordinator will provide the medical examiner's office with the following documentation:

- Copy of the LifeQuest donor information including consent and the medical/social history questionnaire.
- * Hospital record documentation including history and physical, progress notes, diagnostic imaging reports, consult reports, operative reports, consults from cardiology, pulmonary, cath lab for evaluation of heart and lungs for transplant, organ procurement specific operative notes and organ biopsy reports.

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- The clinical coordinator, information associate, or secretary will fax to the Medical Examiner's office within 1-3 business days, the Preliminary Autopsy Request form, found on naviGator. The system (naviGator) is programmed to resend the fax every week until a response is obtained from the Medical Examiner's office.
- If the medical examiner's office returns the form with the checkbox marked yes, the information associate or secretary will notify the medical director or his/her designee who will contact the medical examiner's office within one business day of receipt of that information to obtain the potential communicable disease transmission information.
- The medical director will notify the director of clinical operations at LifeQuest of the potential disease transmission from organ donor to recipient(s) so that he/she or his/her designee can begin the DTAC process and notify all potentially affected transplant programs, including tissue and eye banks.

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4. Photographs:

In all medical examiner cases, the clinical coordinator will provide the ME with photographs of the donor pre-procurement for the purpose of documenting physical condition of the body prior to surgery. The following views are required for all medical examiner's cases:

- a. close-up of the head from above
- b. 1/3 view of the head and thorax from above
- c. 1/3 view of the abdomen and pelvis from above
- d. 1/3 view of lower extremities from above
- e. full head to toe from lateral view
- f. close ups of all injury sites
- g. close-ups of all tattoos, scars other identifying features

Photographs for the medical examiner will have a card with the UNOS ID and date visible within the photo and all will be stored in electronic format. This information will be provided to the medical examiner's office. Copies of medical examiner pictures will NOT be maintained in LQ files or equipment.

5. Abnormal Findings:

The medical examiner needs to be informed of any abnormal findings discovered during the procurement surgery. The clinical coordinator will first contact the AOC to review abnormal findings and instruction regarding notification to ME will occur. These findings may be provided to the medical examiner by providing appropriate documentation or contacting the ME office during the procurement surgery.

- a. Abnormal findings will be documented on a hospital progress note or the organ procurement operative note.
- b. Document in detail the specifics of the abnormal finding i.e., organ damage, capsular tears, lacerations, hematomas and retroperitoneal injuries.
- c. Organ damage that does not preclude recovery is evaluated on a case-by-case basis. The administrator on-call MUST be consulted under this circumstance. This circumstance may require a call to the ME from the operating room to report the finding or taking a photograph of the organ and providing it to the ME via standard procedure.

6. Chain of Evidence Procedures:

All documentation and donor samples will be provided to the ME in a secure manner that maintains chain of evidence. All documentation, photographs and donor samples will be placed into the tamper-proof medical examiner's envelope. Once all information is enclosed, the envelope is sealed and cannot be re-opened. The

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label for the ME envelope is filled out and placed on the front side of the envelope. The completed medical examiner's packet must remain with the body or be hand carried to the ME's office by the clinical coordinator.

7. Medical Examiner Denial:

The clinical coordinator will contact the AOC if the medical examiner declines the case for organ donation. The AOC will consult with LifeQuest executive leadership to consider further action, including:

- a. Direct call from management to the medical examiner office
- b. Involvement of the Florida Medical Examiner Commission
- c. Direct call to the chief of the medical examiner of the involved district.

The medical examiner has final decision on clearance for donation. LifeQuest is obligated to report all denials to the Florida Medical Examiner Commission.

8. Medical Examiner Autopsy Reports

The information associate and/or the secretary at LifeQuest will receive all medical examiner's reports by email or US mail. These reports may be the initial or final reports. Once received, the information associate or secretary will add the UNOS ID, initial and date, mark the number of pages received, and upload into naviGator. This upload will generate an instant and automatic email to the medical and executive directors that there is an autopsy report to review.

The medical and executive directors, or his/her designees, will review all autopsy reports (initial and final) within two business days of receipt of the autopsy report to LifeQuest. Each page of autopsy report will be dated and initialed before given back to the information associate or the secretary for uploading into naviGator. If information in either the initial or final autopsy report suggests there is a potential for disease transmission from the donor to any recipient, the Medical Director and/or the Executive Director will notify the Director of Clinical Operations or his/her designee, to initiate the DTAC protocol and communication to the transplant programs, tissue and eye banks.

LIFEQUEST ORGAN RECOVERY SERVICES

POLICY NUMBER: 117
CATEGORY: ADMINISTRATIVE
REVIEW: FEBRUARY 2020

Subject: Employee Orientation and Training

Purpose: To establish guidelines for providing orientation and on-going training for LifeQuest employees, contracted staff, and Medical Examiners.

Policy Statement: It is the policy of LifeQuest to provide all new employees with a comprehensive orientation curriculum that covers job responsibilities, core behaviors, and information related to corporate compliance, QAPI, LifeQuest policies and procedures, HIPAA, HIV/AIDS, OSHA, blood borne pathogens, environment of care, infection control, risk management, patient safety and fire safety, occupational health, hazardous materials, code of conduct and goals.

LifeQuest also will provide ongoing training and UF Health Shands annual in-services for all employees.

All current UF Health Shands policies can be found on the UF Health Shands portal/policies and procedures.
All LifeQuest training checklists referenced in this policy can be found on the V-drive/training

All LifeQuest Employees

1. As outlined in LifeQuest Safety Policy, upon hire, all LifeQuest employees shall receive education and training through UF Health Shands Hospital as part of their initial orientation, before reporting to LifeQuest for their initial assignment, and annually thereafter. Areas of training include environment of care, infection control, HIPAA, risk management and corporate compliance. The infection control section of the educational program has information on HIV/AIDS, OSHA Bloodborne Pathogens Standard and the Tuberculosis Control Plan (see UF Health Shands portal), corporate compliance as covered during initial orientation provided by UF Health Shands.
2. Documentation of completion of UF Health Shands' new employee orientation will be kept in the employee's personnel folder.
3. Training on LifeQuest's Electronic Information Management System (EIMS), naviGator is provided to LifeQuest employees and contract coordinators needing access to perform their job duties through face-to-face instruction as well as webinar training, as outlined in the LifeQuest EIMS policy.
4. All LifeQuest employees (non-internal transfers) will spend their first day at UF Health Shands at UF for new employee orientation and the remainder of the week at LifeQuest for continuation of their orientation under the direction of the immediate supervisor and executive assistant. In accordance with the staff orientation checklist, new employees will be oriented on:

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REVIEW: FEBRUARY 2020

- a. Mileage reimbursement, expenses and American Express protocols
 - b. PTO documentation
 - c. Procedure and policy manuals
 - d. Use of office equipment, such as cell phones, pagers and laptops
 - e. Computer access and email
 - f. QAPI
5. During the employee's first week at LifeQuest, he or she may also meet with:
- Executive director
 - Assistant executive director
 - Accounting personnel
 - Director of donor program development
 - Donor family services coordinator
 - Main office administrative staff
 - Medical director
 - Data analyst
 - Clinical operations leadership
6. Select LifeQuest employees will be given 30- and 90-day, post-hire interviews by a member of the management team if the supervisor identifies the need. These interviews will assess how the employees are assimilating to their new jobs and how the actual job duties compare to how they were presented to them during their pre-employment interviews.

Individualized Staff Training

1. Clinical Coordinators

- a. Clinical coordinators will be trained in all areas of their job function for a period lasting approximately six months, at which time they will have completed all of their core proficiencies or have their training period extended. Training will be under the supervision of the director of clinical operations. No clinical coordinator will be considered fully trained until all proficiencies have been verified as completed or met by the director of clinical operations.
- b. Documentation of satisfactory completion of job duties and proficiencies will be documented on the clinical coordinator training orientation skills check list, and kept in the employee's LifeQuest personnel file.
- c. Following orientation, the methodology for identifying additional training needs will be done through the six month review, annual reviews, routine competency testing, real time interaction with the administrators on call, internal and external peer input, and employee assessments during educational offerings.

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2. Contract Organ Procurement Coordinators

- a. Contract coordinators will be provided with or provide confirmation of, training that includes corporate compliance and blood borne pathogens.

3. Family Advocates (FA)

- a. FAs will be trained in all areas of their job function for a period lasting approximately six months, at which time they will have completed all of their core proficiencies or have their training period extended. Training will be under the supervision of the associate director of clinical operations/manager of family advocates. No FA will be considered fully trained until all proficiencies have been verified as completed or met by the associate director of clinical operations/manager of family advocates.
- b. Documentation of satisfactory completion of job duties and proficiencies will be documented on the FA checklist and kept in the employee's personnel file.
- c. Following orientation, the methodology for identifying additional training needs will be done through the six month review, annual reviews, routine competency testing, real time interaction with the administrators on call, internal and external peer input, and employee assessments during educational offerings.

4. Hospital Services Coordinators

- a. HSCs will be trained in all areas of their job function for a period lasting approximately six months, at which time they will have completed all of their core proficiencies or have their training period extended. Training will be under the supervision of the director of donor program development (DPD). No HSC will be considered fully trained until all proficiencies have been verified as completed or met by the director of DPD.
- b. Documentation of satisfactory completion of job duties and proficiencies will be documented on the HSC training checklist and kept in the employee's personnel file. In accordance with the training checklist, HSCs will be oriented on:
 - Introduction to the HS process, i.e., timely donor referrals and assessments,
 - Data collection procedures
 - Marketing skills
 - Death record and variance review
 - Professional education presentation skills
 - Electronic documentation of hospital binders
 - NaviGator training
- c. Following orientation, the methodology for identifying additional training needs will be done through the six month review, annual reviews, routine competency testing, internal peer feedback, external peer feedback, shadowing in the field, and deviation audits.

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5. Public Education Coordinators

- a. PECs will be trained in all areas of their job function for a period lasting approximately six months, at which time they will have completed all of their core proficiencies or have their training period extended. Training will be under the supervision of the director of donor program development (DPD). No PEC will be considered fully trained until all proficiencies have been verified as completed or met by the director DPD.
- b. Documentation of satisfactory completion of job duties and proficiencies will be documented on the PEC training checklist and kept in the employee's personnel file. In accordance with the training checklist, PEC will be oriented on:
 - Public speaking and presentation skills
 - Familiarity with donor family services
 - Familiarity with OPO operations
- c. Following orientation, the methodology for identifying additional training needs will be done through the six month review, annual reviews, internal and external peer input, and routine competency testing.

6. Donor Family Service Coordinators

- a. DFSCs will be trained in all areas of their job function for a period lasting approximately six months, at which time they will have completed all of their core proficiencies or have their training period extended. Training will be under the supervision of the director of DPD. No DFSC will be considered fully trained until all proficiencies have been verified as completed or met by the director of DPD.
- b. Documentation of satisfactory completion of job duties and proficiencies will be documented on the DFSC training checklist and kept in the employee's personnel file. In accordance with the training checklist, DFSCs will be oriented on:
 - Familiarity with OPO operations
 - Familiarity with donor database and donor chart protocols
 - Understanding of needs of donor families in time of grief
- c. Following orientation, the methodology for identifying additional training needs will be done through the six month review, annual reviews, internal and external peer input, and routine competency testing.

7. Accounting Staff

- a. Accounting staff will be trained in all areas of their job function for a period lasting approximately six months Training will be under the supervision of the executive director and other accounting staff.

LIFEQUEST ORGAN RECOVERY SERVICES

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- b. Documentation of satisfactory completion of job duties and proficiencies will be documented in the employee's personnel file.

8. Data Management Staff

- a. Data management staff will be trained in all areas of their job function for a period lasting approximately six months. Training will be under the supervision of the executive director and other data-related staff.
- b. Documentation of satisfactory completion of job duties and proficiencies will be documented in the employee's personnel file.

9. Clerical Staff

- a. Clerical staff will be trained in all areas of their job function for a period lasting approximately six months. Training will be under the direction of their immediate supervisor and other clerical staff.
- b. Documentation of satisfactory completion of job duties and proficiencies will be documented in the employee's personnel file.

Annual and Ongoing Training

1. All LifeQuest employees will complete the following mandatory inservices on an annual basis:
 - Fire safety
 - Infection control
 - HIPAA
 - Corporate compliance
 - Patient safety
 - Any other inservices as needed and requested by LifeQuest and/or UF Health Shands
2. The OPO executive director, medical director, senior management, procurement coordinators and advisory board members will review annually the LQ and UF Health Shands' policies on conflict of interest.
3. Clinical operations department employees will complete annual core competency requirements. Specific core competencies will be dictated by position. Some skills where annual core competency is demonstrated include but are not limited to:
 - Authorization
 - Obtaining medical-social history
 - Donor management
 - Packaging
 - DCD assessment
4. Ongoing training will be offered to all employees.

LIFEQUEST ORGAN RECOVERY SERVICES

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5. Ongoing training that offers continuing educational credits will be made available to all staff holding clinical licensure. Documentation of course completion will be kept in employee's personnel file. Supervisors will review individual training files annually when preparing for the employee's evaluation. LifeQuest will allow time off for employees to attend CEU classes.

6. All Medical Examiners in the LifeQuest DSA will receive education from LifeQuest regarding possible disease transmission from donor to recipient, and the importance of communication to the OPO of early findings. This education will occur annually, and will be documented in LifeQuest's training records. The continuous quality improvement committee will be responsible for assuring the documentation of this training.

Administrator-On-Call Training

1. Individuals identified as potential AOCs will be trained in those responsibilities by one or more of the following:
 - Medical director
 - Director of clinical operations
 - Associate director of clinical operations

2. Once an individual is proficient and can assume independent AOC responsibilities, a letter of competency will be documented by the Medical Director and placed in the employee's file.



February 27, 2019



Dear Dr. [Redacted]

We are writing about an important matter and asking for your immediate help. There have been organ donor cases across the U.S. that were also ME cases, and communicable disease transmissions occurred in the organ recipients that might have been able to be treated in a more timely manner had the OPO received the ME autopsy report sooner. In a most recent case, the ME found and confirmed testicular cancer, but the report did not arrive to the OPO for 5 months due to other tests that were unrelated to the testicular cancer but possibly related to the cause of death, that delayed the report. The recipient did end up with cancer in his new organ that doctors are sure originated from the donor. We understand that there are many factors that cause delays with the ME's ability to share the final autopsy reports.

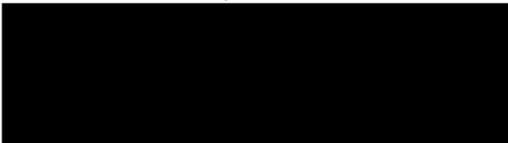
Therefore, LifeQuest has created an Initial Autopsy Findings form that we will be faxing Medical Examiner's offices throughout our service area within 1 to 3 business days of an organ donor case. We have made this such that it only requires a check to a yes or no box to a single question to you that asks: upon initial autopsy if there were things that could include possible disease transmission from an organ donor to a recipient. I have attached this form for you to review. Please contact us with any questions or concerns you may have this returning this form back to us.

Our Medical Examiners are widely known as supporters of organ donation and are recognized as a key contributor to life-saving transplants. We are asking if you could help us devise a communications pathway in the rare event you discover a relevant medical concern for those patients in the course of the autopsy phase of your efforts.

The recipients of donated organs are all treated with immunosuppressive drugs to prevent rejection so communicating any potential transmissible disease in a timely manner is essential. The sooner the transplant teams know what they may have to deal with, the better the clinical outcome will be for their patients. Medical Examiners play a key role in the process of transplantation and can play a vital role in the clinical success for the patients benefiting from their cooperation.



Medical Director, LifeQuest



Executive Director, LifeQuest



A Donate Life Organization





February 27, 2019

[REDACTED]
[REDACTED]
[REDACTED]
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Sincerely,

[REDACTED]
Medical Director, LifeQuest

[REDACTED]
Executive Director, LifeQuest





[Redacted]

February 27, 2019

[Redacted]

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[Redacted Signature]

Medical Director, LifeQuest

[Redacted Signature]

Executive Director, LifeQuest



A Donate Life Organization

[Redacted]



February 27, 2019

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[REDACTED]
Medical Director, LifeQuest

[REDACTED]
Executive Director, LifeQuest



A Private Life Organization



February 27, 2019

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A Donate Life Organization



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[Redacted Signature]

Executive Director, LifeQuest



A Donate Life Organization

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Sincerely,

[REDACTED]
Medical Director, LifeQuest

[REDACTED]
Executive Director, LifeQuest





To honor individuals' donor designations, to ensure a family's opportunity to donate and to maximize the Gift of Life through organ and tissue donation.

MEETING NAME	DATE/TIME
Clinical Quality meeting	March 7th

SHARED DESKTOP LINK: [REDACTED] with the password [REDACTED]

ATTENDEES:

AGENDA	
Opening Remarks	
<p>QUALITY: Authorization case review</p> <p>Donate Life month activities: KG to review Documentation for current inmate: KG to review</p>	[REDACTED]
<p>AFBP150: <i>brief review but don't go into a lot of details now. Review following policy changes.</i></p> <p>LQ 801: <i>Review Initial Autopsy Findings form and when to send it. Two person autopsy review. Need to make sure that if a case isn't a ME case we are still asking the family if they are having a private autopsy and document that in NG.</i></p> <p>LQ 117: <i>updating physical exam training and will be rolling that out to all the offices very soon. ME education- LC and HM are setting dates with ME offices to educate</i></p> <p>LQ 209: <i>Initial Autopsy Findings form (goes with 801)</i></p>	[REDACTED]
<p>PROCUREMENT: Vessel ties- <i>using long ties on major vessels and reminding surgeons: go over funeral home issue</i></p> <p>UA requirements: <i>remind people to do it at OR set and UPLOAD</i></p> <p>Sputum gram stain: <i>NEED to get one at the donor hospital PRIOR to making lung offer. Remind everyone this is minimum information for a lung offer and it has to be upload prior to hitting send on the offer!</i></p>	[REDACTED]

<p>PD corrections: <i>if a correction is sent from PD and it has a document that needs to be corrected send that to Sheri and she will put the correction thru to me.</i></p> <p>Label PDSA: <i>Chris will present his practice and we will get these labels out to all offices</i></p>	
<p><u>EMR updates:</u> Access issues</p>	
<p><u>Upcoming training/events:</u> -OR skills training - education- mandatory -Monthly education series Clinical Education Feb- cancelled for OR training March 21-  May 16th- LifeNet Health- tissue donation</p>	
<p><u>Staffing Updates</u></p>	
<p><u>Question and Answer Session</u></p>	All
<p>Adjournment</p>	

[today's date]

Dear [*Medical Examiner name*],

We are requesting preliminary information on [*donor full name*], Date of Birth [*DOB*], Date of Death [*DOD*], who was authorized to be an organ donor. Your office indicated to our organ procurement coordinator that an autopsy would be performed.

Upon initial autopsy, were there findings that could include possible disease transmission from organ donor to recipient?

Please check one: Yes **No**

Please fax this page back to LifeQuest at [REDACTED] as soon as possible.

If the Yes box is checked, a representative from LifeQuest will contact your office within one business day of receipt.

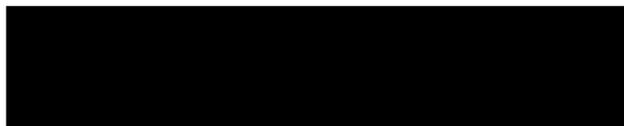
We appreciate your assistance,

LifeQuest

Ref:[*unos id*]



A Donate Life Organization



LIFEQUEST ORGAN RECOVERY SERVICES

POLICY NUMBER: 220
CATEGORY: CLINICAL
REVIEW: FEBRUARY 2020

SUBJECT: Post-Procurement Follow Up and Reporting

POLICY: The organ donor look-back policy and procedure contains information about cultures drawn during the organ donor process, the reporting of culture results to transplant centers, and potential disease transmission malignancy reporting.

PURPOSE: To provide guidelines regarding the responsibilities of the clinical coordinator and LifeQuest administration concerning post-procurement follow up and reporting.

CONTENTS:

Donor Culture Reporting

1. **Blood Cultures** will be sent pre-recovery on ALL organ donors by the clinical coordinator while the donor is still in the ICU.
2. **Urine Culture** will be sent pre-recovery on ALL donors with renal function by the clinical coordinator while the donor is still in the ICU, regardless of renal placement.
3. **Sputum Cultures** will be sent on ALL donors where lungs are evaluated and specimens obtained.
4. **Preservation solutions:** Cultures of preservation solutions that are in contact with an organ(s) at the end of the surgical recovery should only be done if there is a question of a break in sterile technique during the procedure.

Culture reports will be obtained as soon as possible post organ recovery. All results should be final at this time. The hospital or laboratory will be asked to fax all final culture results to LifeQuest's main office. The culture results will be collected by administrative personnel and reviewed by the director of clinical operations or designee. The results will be uploaded to naviGator. The coordinator of record, or designee if original coordinator of record is unavailable, will be informed that the culture results are available.

The clinical coordinator will report the results as follows:

- All negative results will be uploaded to DonorNET.
- All positive results will be called or faxed/emailed to the appropriate transplant centers' patient safety contact as soon as possible but within 24 hours of receipt of results. The results will also be uploaded to DonorNet.
- All results will be faxed or emailed to the appropriate tissue/eye banks if the donor was also a tissue or eye donor.

The documentation of culture reporting will be completed in naviGator. If unable to obtain a written report, an explanation will be documented in naviGator by the clinical coordinator or QA staff and a follow up letter from LifeQuest's medical director will be sent reiterating the importance of obtaining donor culture information for the safety of transplant recipients.

Potential Disease Transmission – Infection or Malignancy

1. Upon receipt of information from any agency (e.g., transplant center(s), tissue/eye banks, medical examiners, hospitals) that there is suspicion of potential donor-derived disease transmission(s), LifeQuest will take the following steps:
 - a. The person who received the information will obtain contact information from the transplant center.

LIFEQUEST ORGAN RECOVERY SERVICES

**POLICY NUMBER: 220
CATEGORY: CLINICAL
REVIEW: FEBRUARY 2020**

- b. The director of clinical operations or associate director of clinical operations will be notified immediately. If they are not available, the assistant executive director or executive director will be notified.
- c. LifeQuest administration will communicate the reported findings to all transplant centers who received organs from the donor within 24 hours.
- d. LifeQuest will report a potential disease transmission to the UNOS Disease Transmission Advisory Committee within 24 hours.
- e. LifeQuest will fill out the OPTN potential disease transmission initial report form and submit to UNOS.
- f. LifeQuest will cooperate with requests and comply with timelines from involved agencies including DTAC, CDC or other agency as applicable to the specific case.