MEMORANDUM

To: Board of Directors

Cc: Bill Boyles, Esquire
Biju Mathews, M.D.

From: George Mikitarian
President/CEO

Subject: Board/Committee Meetings – April 4, 2022

Date: March 31, 2022

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

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

The Board of Directors will meet in executive session no earlier than 1:30 p.m. Following the Board of Directors Executive Session, the Board of Directors regularly scheduled meeting will be held immediately following, however no earlier than 2:00 p.m.

The Education and Planning Committee meetings have been canceled

QUALITY COMMITTEE
Elizabeth Galfo, M.D., Chairperson
Robert L. Jordan, Jr., C.M. (ex-officio)
Billy Specht
Billie Fitzgerald
Herman A. Cole, Jr.
Jerry Noffel
Stan Retz, CPA
Maureen Rupe
Ashok Shah, M.D.
Biju Mathews, M.D., President/Medical Staff
Greg Cuculino, M.D.
Kiran Modi, M.D., Designee
Francisco Garcia, M.D., Designee
Christopher Manion, M.D., Designee
George Mikitarian (non-voting)

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE
MONDAY, APRIL 4, 2022
12:00 P.M.
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Approval of Minutes

Motion to approve the minutes of the February 7, 2022 meeting.

II. Vision Statement

III. My Story

IV. Dashboard

V. Bedside Medication Barcoding

VI. Perinatal Immunization Quality Program

VII. Other

VIII. Executive Session (if necessary)

ADJOURNMENT

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

PERSONS WITH A DISABILITY WHO NEED A SPECIAL ACCOMMODATION TO PARTICIPATE IN THIS PROCEEDING SHOULD CONTACT THE ADMINISTRATIVE OFFICES AT 951 NORTH WASHINGTON AVENUE, TITUSVILLE, FLORIDA 32796, AT LEAST FORTY EIGHT (48) HOURS PRIOR TO THE MEETING. FOR INFORMATION CALL (321) 268-6110. THIS NOTICE WILL FURTHER SERVE TO INFORM THE PUBLIC THAT MEMBERS OF THE BOARD OF DIRECTORS OF NORTH BREVARD MEDICAL SUPPORT, INC. MAY BE IN ATTENDANCE AND MAY PARTICIPATE IN DISCUSSIONS OF MATTERS BEFORE THE NORTH BREVARD COUNTY HOSPITAL DISTRICT BOARD OF DIRECTORS EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE. TO THE EXTENT OF SUCH DISCUSSION, A JOINT PUBLIC MEETING OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT, BOARD OF DIRECTORS EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE AND NORTH BREVARD MEDICAL SUUPORT, INC. SHALL BE CONDUCTED.

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE

A regular meeting of the Quality Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on February 7, 2022 in Conference Room 2/3/4/5, First Floor. The following members were present.

Elizabeth Galfo, M.D., Chairperson
Maureen Rupe, Vice Chairperson
Robert L. Jordan, Jr., C.M.
Herman A. Cole, Jr.
Billie Fitzgerald
Jerry Noffel
Billy Specht
Stan Retz, CPA
Ashok Shah, M.D.
Christopher Manion, M.D.
Biju Mathews, M.D., President/Medical Staff (12:07 p.m.)
Gregory Cuculino M.D.
Kiran Modi, M.D.
George Mikitarian (non-voting)

Members absent:
Francisco Garcia, M.D. (excused)

CALL TO ORDER

Dr. Galfo called the meeting to order at 12:00 p.m.

ELECTION OF OFFICERS

Dr. Galfo opened the floor for nominations for Chairperson of the Quality Committee. Mr. Cole nominated Dr. Galfo; Mr. Retz seconded the nomination. Mr. Jordan moved to close nominations, seconded by Mr. Retz.

***ACTION TAKEN*: MOTION TO ELECT DR. ELIZABETH GALFO AS CHAIRPERSON OF THE QUALITY COMMITTEE.**

Dr. Galfo opened the floor for nominations for Vice Chairperson. Mr. Cole nominated Dr. Mathews; Mr. Jordan seconded the nomination and moved to close nominations.

***ACTION TAKEN*: MOTION TO ELECT DR. BIJU MATHEWS AS VICE-CHAIRPERSON OF THE QUALITY COMMITTEE.**

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Mr. Jordan, seconded by Mr. Cole and approved (12 ayes, 0 nays, 0 abstentions). Dr. Mathews was not present at the time the vote was taken.

ACTION TAKEN: **MOVED TO APPROVE THE DECEMBER 6, 2021 MEETING MINUTES, AS PRESENTED.**

VISION STATEMENT

Mr. Loftin summarized the committee's vision statement.

MY STORY

Mr. Loftin shared the story of Catherine, and the healing experience she received from her care team at Parrish Medical Center.

QUALITY DASHBOARD REVIEW

Mr. Loftin reviewed the November Quality Dashboard and discussed each indicator score as it relates to clinical quality and cost. Copies of the Power Point slides presented are appended to the file copy of these minutes.

POST-ACUTE COVID RECOVERY TRANSITION PROGRAM – IMPACT ON READMISSIONS

Mr. Loftin summarized the Post-Acute COVID Recovery Transition Program and the difference it has made and continues to make in the community.

OTHER

There was no other business brought before the committee.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 12:28 p.m.

Elizabeth Galfo, M.D.
Chairperson

PARRISH®
HEALTHCARE

Healing Families – Healing Communities®

parrishhealthcare.com

Board of Directors

Quality Committee Presentation

PARRISH HEALTHCARE

Healing Families – Healing Communities®

parrishhealthcare.com

Quality Agenda

April 2022

1. Approval of Minutes
2. Vision Statement
3. My Story
4. Dashboard
5. Bedside medication barcoding
6. Perinatal immunization quality program
7. Other
8. Executive Session

Quality Committee

Vision Statement

"Assure affordable access to safe, high quality patient care to the communities we serve."

My Story

Dashboard

Performance dashboard

Description	Jan	Nov-Jan	Actual YTD (CY)	Opportunity
Zero Harm	33	56	33	Jan 1 out of 3 = 33% Stroke Goal: 100% Actual 50% Sepsis Goal: 76% Actual 58% EED Goal 0% Actual 0%
HAI	3.32	3.38	3.32	
Readmission	9.88%	8.95%	9.88%	
Person Centered flow	617	423	617	
Person Experience	63.8%	63.5%	63.8%	

Better than expected

As expected

Needs Improvement

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parrishhealthcare.com

Bedside medication barcoding

PARRISH HEALTHCARE

Healing Families – Healing Communities®

parrishhealthcare.com

Bar code medication administration

Why is it important?

- 7,000 deaths/international linked to med errors annually*
- Errors occur at all stages of the process, including
  - Ordering
  - Transcribing
  - Dispensing
  - Administration
- 30% of errors occur at the point of administration

*(IOM: https://ratings.leapfroggroup.org/sites/default/files/inline-files/2022%20BCMA%20Fact%20Sheet.pdf)

Bar code medication administration

The five rights

Right dose

Right medication

Right patient

Right route of administration

Right time of delivery

Bar code medication administration

Human factors leading to med errors

Fatigue/personal issues

Inability to focus on task

Distractions

Perceived/actual work overload

Rushing to complete task

Failure to follow established procedures

Work-arounds

Bar code medication administration

Leapfrog

Hospitals fully meeting the Leapfrog standard:

- 100% of required nursing units implemented
- 95% compliance with scanning of med and patient
- System includes decision support
- 6 of the 8 evidence based processes to prevent workarounds in place

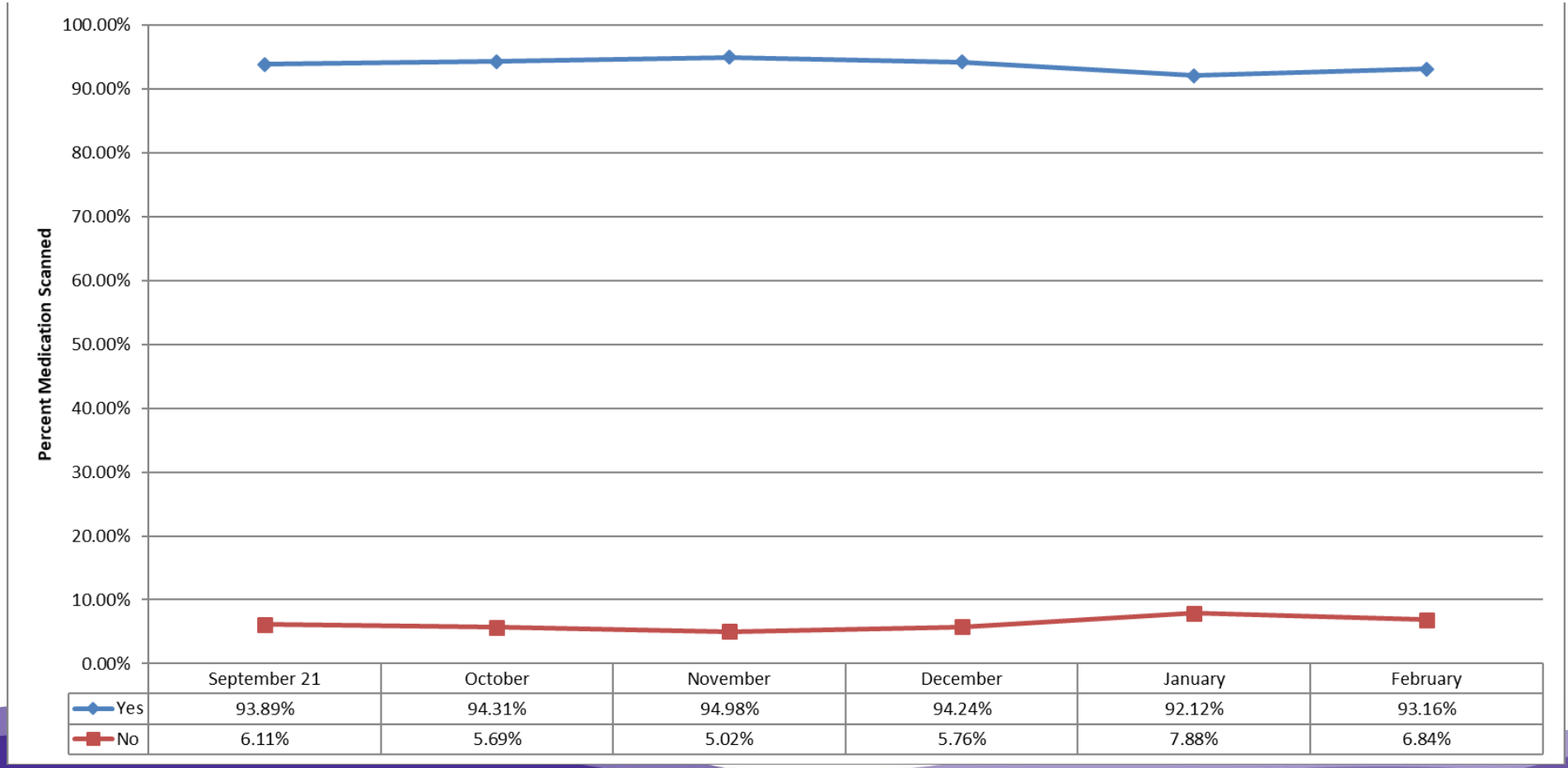
Bar code medication administration

Leapfrog – evidence based processes

Evidence based process	Parrish Performance
Formal committee to review data reports on BCMA system use	✓
Back-up systems for hardware failures	✓
Help desk that provides timely responses to urgent BCMA issues in real-time	✓
Conducts real-time observations of users at the unit level using the BCMA system	✓
Engages nursing leadership at the unit level on BCMA use	✓
Used the data obtained through items 1-5 to implement quality improvement **OR**	
Evaluated the results of the quality improvement projects (from 6) and demonstrated that these projects have resulted in higher adherence	✓
Communicated end users resolution of any system deficiencies and/or problems that may have contributed to the workarounds	✓

Bar code medication administration

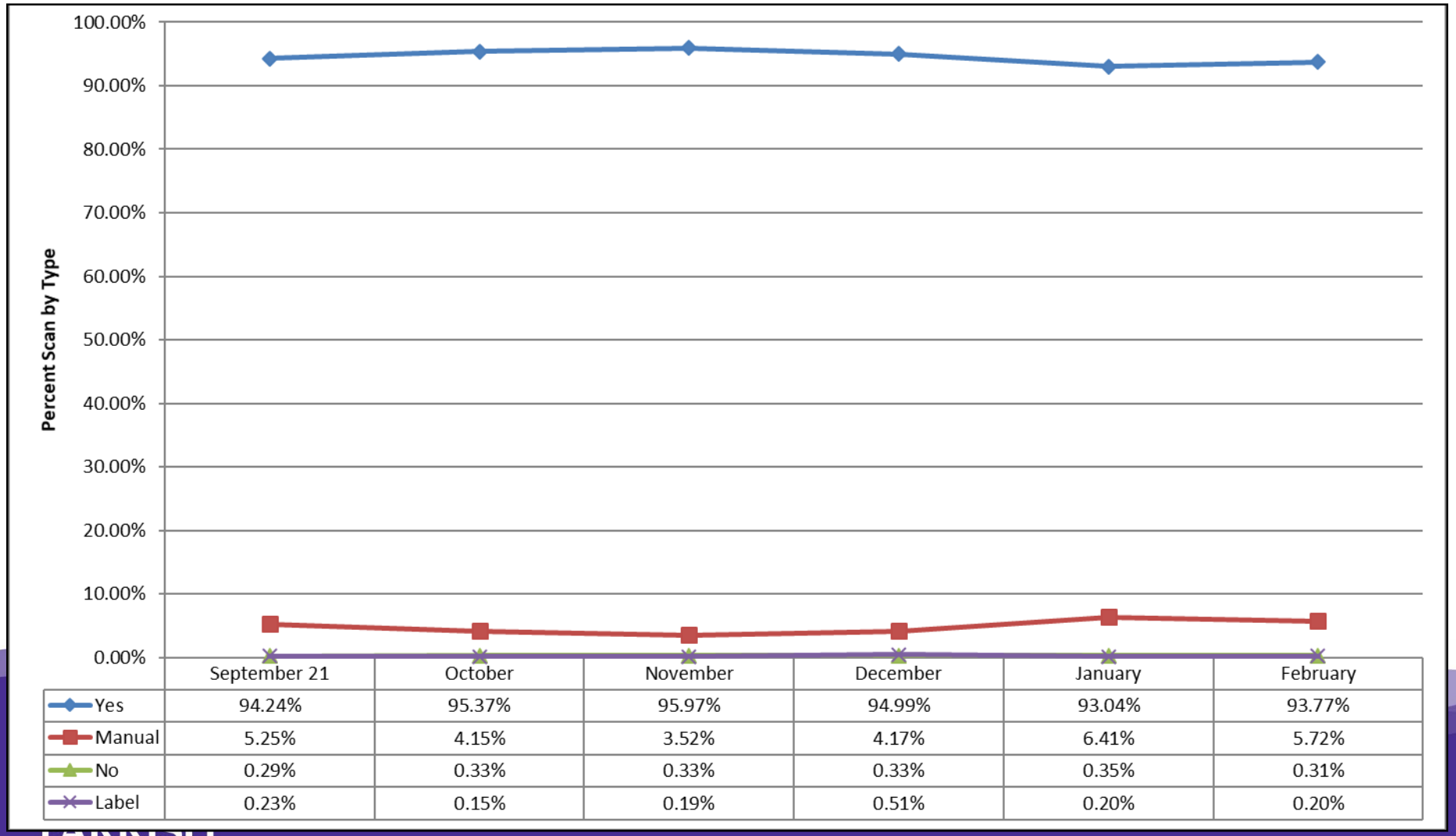
Parrish Performance – medication scans



	September 21	October	November	December	January	February
Yes	93.89%	94.31%	94.98%	94.24%	92.12%	93.16%
No	6.11%	5.69%	5.02%	5.76%	7.88%	6.84%

Bar code medication administration

Parrish Performance – patient scans



	September 21	October	November	December	January	February
Yes	94.24%	95.37%	95.97%	94.99%	93.04%	93.77%
Manual	5.25%	4.15%	3.52%	4.17%	6.41%	5.72%
No	0.29%	0.33%	0.33%	0.33%	0.35%	0.31%
Label	0.23%	0.15%	0.19%	0.51%	0.20%	0.20%

Questions

Perinatal immunization quality program

PARRISH HEALTHCARE

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Perinatal Hepatitis B Monitoring

Why is it important

The CDC estimates that:

13% of babies born to Hepatitis B positive mothers will become infected with Hepatitis B

Perinatal Hepatitis B Monitoring

State audit overview

Purpose: Evaluate hepatitis B virus prevention activities

- Testing of pregnant women for the hepatitis B virus
- Administration of the hepatitis B vaccine to all infants

60 random paired mother-baby records from 12/1/2020-11/30/2021 were reviewed

Perinatal Hepatitis B Monitoring

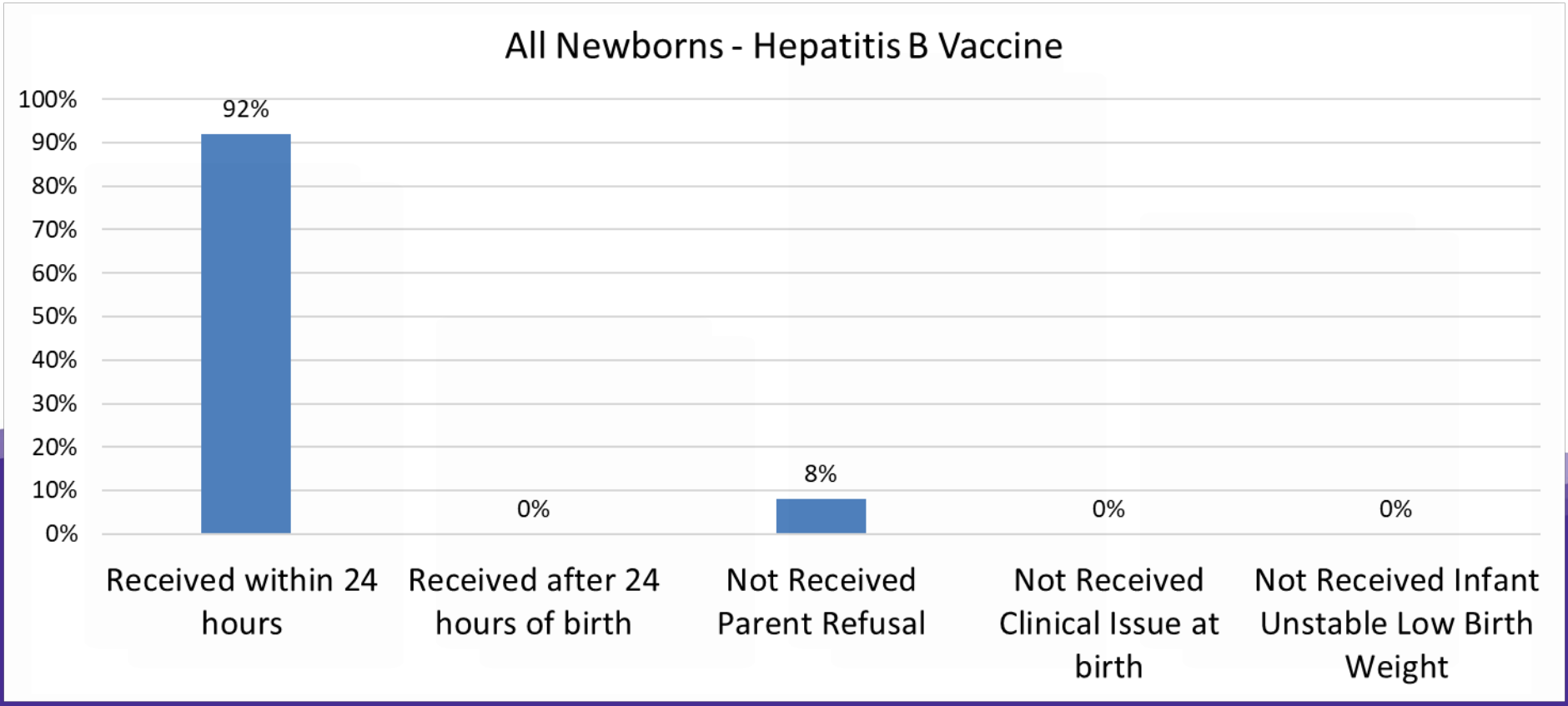
Program objectives

1. Screen pregnant women for the Hepatitis B Surface Antigen
2. Care for women with no prenatal care or no available Hepatitis B lab results
3. Medically manage newborns perinatally exposed to Hepatitis B
4. Standing orders to administer first dose of hepatitis B vaccine to all infants of HBsAg negative mothers at birth
5. Administer Tdap and flu vaccines to postpartum clients, hospital employees and volunteers

Perinatal Hepatitis B Monitoring

Results - Objective 4

ACIP recommendation to administer the first dose of the hepatitis B vaccine within 24 hours of birth to medically stable infants ≥2,000 grams born to HBsAg negative mothers



Perinatal Hepatitis B Monitoring

Recommendations

- Objective 1 - Update standing order to test women after the 27th week of pregnancy with no record of testing
- Objective 2 - Request all prenatal care providers include copies of all the original HBsAg laboratory reports in the records provided to the hospital
- Objective 3 – no recommendations
- Objective 4 – no recommendations

Perinatal Hepatitis B Monitoring

Recommendations

- Objective 5 –
  - If a woman did not receive Tdap during this pregnancy, she should receive it during the immediate postpartum period if she has not previously been vaccinated with Tdap.
  - Women who are pregnant, may be pregnant or are postpartum during the flu season should receive their flu vaccine.
  - Tdap vaccine should be offered to healthcare workers
  - Flu vaccine should be offered to health care workers

Questions?

FINANCE COMMITTEE
Herman A. Cole, Jr. Chairperson
Stan Retz, CPA, Vice Chairperson
Robert L. Jordan, Jr., C.M., (ex-officio)
Jerry Noffel
Billie Fitzgerald
Billy Specht
Maureen Rupe
Ashok Shah, M.D.
Elizabeth Galfo, M.D.
Christopher Manion, M.D.
Biju Mathews, M.D., President/Medical Staff
George Mikitarian, President/CEO (non-voting)

TENTATIVE AGENDA
FINANCE COMMITTEE MEETING - REGULAR
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, APRIL 4, 2022
FIRST FLOOR CONFERENCE ROOMS 2/3/4/5
(IMMEDIATELY FOLLOWING QUALITY COMMITTEE)

CALL TO ORDER

I. Public Comments

II. Review and approve minutes of (February 07, 2022)

Motion: To recommend approval of the February 07, 2022 minutes as presented.

III. Financial Review

IV. Capital Purchase – Pasteurizer

Motion: To recommend the Board of Directors approve the purchase of a pasteurizer at a total cost of $48,891.

V. Disposal

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

VI. Executive Session (if necessary)

ADJOURNMENT

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

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

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
FINANCE COMMITTEE

A regular meeting of the Finance Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on February 7, 2022 in Conference Room 2/3/4/5, First Floor. The following members, representing a quorum, were present:

Herman A. Cole, Jr., Chairperson
Stan Retz, Vice Chairperson
Robert Jordan, Jr., C.M.
Jerry Noffel
Billie Fitzgerald
Billy Specht
Maureen Rupe
Elizbeth Galfo, M.D.
Ashok Shah, M.D.
Christopher Manion, M.D.
Biju Mathews, M.D.
George Mikitarian (non-voting)

Member(s) Absent:
None

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

CALL TO ORDER

Mr. Cole called the meeting to order at 12:28 p.m.

ELECTION OF VICE CHAIRPERSON

Mr. Cole opened the floor for nominations for Vice Chairperson of the Finance Committee. Mr. Jordan nominated Dr. Shah; Dr. Galfo seconded the nomination. Mr. Jordan moved to close nominations , seconded by Mr. Retz.

***ACTION TAKEN*: MOTION TO ELECT ASHOK SHAH, M.D. AS VICE CHAIRPERSON OF THE FINANCE COMMITTEE.**

PUBLIC COMMENTS

There were no public comments.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Dr. Galfo seconded by Mr. Jordan and approved (10 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVED THAT THE FINANCE COMMITTEE OF THE BOARD OF DIRECTORS APPROVE THE DECEMBER 6, 2021 MEETING MINUTES, AS PRESENTED.**

LABORATORY EQUIPMENT REPLACEMENT SITE PREPARATION CONSTRUCTION PROJECT

Discussion ensued and the following motion was made by Mr. Jordan seconded by Mr. Retz and approved (10 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVED TO APPROVE THE PROJECT COST OF $188,043.00 WITH AN AMENDMENT OF THE FY 2022 CAPITAL BUDGET TO INCLUDE THE PROJECT.**

ARCHITECTURAL AND ENGINEERING DESIGN SERVICES

Discussion ensued and the following motion was made by Mr. Jordan seconded by Ms. Fitzgerald and approved (10 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVED TO APPROVE NEGOTIATIONS WITH FCA FOR ARCHITECTURAL AND ENGINEERING SERVICES AT A NOT TO EXCEED COST PER ENGAGEMENT OF $90,000.00. SHOULD NEGOTIATIONS FAIL WITH FCA, NEGOTIATIONS WILL BE APPROVED WITH THE NEXT FIRM BASED ON THE RFQ EVALUATION AND SCORING.**

FINANCIAL REVIEW

Mr. Bacon summarized the December 2021 financial statements and year to date financial performance of the Health System.

DISPOSAL OF SURPLUS PROPERTY

Discussion ensued and the following motion was made by Mr. Jordan, seconded by Mr. Retz and approved (10 ayes, 0 nays, 0 abstentions).

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

OTHER

There was no other business to come before the committee.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 12:38 p.m.

Stan Retz
Vice Chairperson

PARRISH MEDICAL CENTER
PARRISH HEALTHCARE

MEMORANDUM

TO: Finance Committee

FROM: Edwin Loftin, Senior Vice President Integrated and Acute Care / CNO

SUBJECT: FY 2022 Capital Purchase Request – Pasteurizer

DATE: April 4, 2022

The Parrish sleep center is required by The Joint Commission to utilize high level disinfection to clean PAP masks utilized in the sleep center **or** to have disposable, single use PAP masks.

The Parrish Sleep Center has historically chosen to utilize high level disinfection because it is much more cost effective for the organization. The Sleep Center pasteurizer is broken beyond repair and out of warranty. Purchasing a pasteurizer would save our organization $8,794 in the first year of replacement and save the organization $56,390 by year two vs the disposable, single use mask option.

We are asking for approval to utilize $48,891 of contingency capital funds for this request.

***Motion:* To recommend the Board of Directors approve the purchase of a pasteurizer at a total cost of $48,891.**

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

Request for Disposal of Obsolete or Surplus Property

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

Asset Description	Asset Control KN #	Purchase Date	Purchase Amount	CE #	Reason for Disposal	Net Book Value (Provided by Finance)	Dept. #
Steris Harmony LED light head / controller	KN029199	2/18/2009	$64,401.62	PMC01096 PMC02906 PMC02907	Unit is no longer in service. Cannot be repaired and replaced with lights from OR 6.	$8,994.62	1.351 OR/Spec

Requesting Department - 351 Department Director [signature] 1/26/22

Net Book Value (Finance) R. Gray 2/7/22 EMC Member [signature] 1.31.22

Sr. VP Finance/CFO① Vacant President/CEO

Board Approval: (Date) CFO Signature [signature] 3/29/22

Requestor Notified Finance

Asset Disposed of or Donated

Removed from Asset List (Finance)

Requested Public Entity for Donation

Entity Contact

Telephone

① [signature] 3/21/22

CREATED BY USER: FRANZAL

FROM FACILITY: SYSTEM
THRU FACILITY: SYSTEM

FROM ASSET NUMBER: KN029199
THRU ASSET NUMBER: KN029199

FROM ASSET CLASS: BEGINNING
THRU ASSET CLASS: END

FROM DEPARTMENT: BEGINNING
THRU DEPARTMENT: END

FROM STATUS DATE: BEGINNING
THRU STATUS DATE: END

FROM ACQUIRED DATE: BEGINNING
THRU ACQUIRED DATE: END

FROM RETIRE DATE: BEGINNING
THRU RETIRE DATE: END

FROM RETIRE TYPE: BEGINNING
THRU RETIRE TYPE: END

FROM RETIRE TYPE DATE:
THRU RETIRE TYPE DATE:

FACILITY: SYSTEM
DEPARTMENT: 1.351 1 0 R

NUMBER	DESCRIPTION	LIFE	STATUS	STS DATE	ACQ DATE	RET DATE	COST	BOOK
CLASS: MEQ-HOSP	MOVEABLE EQUIP - HOSPITAL							
KN029199	SURGICAL LIGHTS FOR OPERATING RM 1		ACTIVE	04/06/09	02/18/09		64401.62	8994.62
							64401.62	8994.62
						TOTAL FOR DEPARTMENT:	64401.62	8994.62

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

Request for Disposal of Obsolete or Surplus Property

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

Asset Description	Asset Control KN #	Purchase Date	Purchase Amount	CE #	Reason for Disposal	Net Book Value (Provided by Finance)	Dept. #
Fresenius C.A.T.S Cell washer	KN029947	4/30/2014	$6645.00	PMC01141	Unit is obsolete and no longer supported. Removed from service.	-0-	1.351 OR / Spec

Requesting Department - OR / Specials / Endo _____ Department Director Matthew F. Angles 2/4/22

Net Book Value (Finance) R. Torres 2/7/22 EMC Member _____ 2.4.22

Sr. VP Finance/CFO① Vacant President/CEO _____ 3/29/22

Board Approval: (Date) _____ CFO Signature _____

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

① Canceled 3/21/22

CREATED BY USER: FRANZAL

FROM FACILITY: SYSTEM
THRU FACILITY: SYSTEM

FROM ASSET NUMBER: KN029947
THRU ASSET NUMBER: KN029947

FROM ASSET CLASS: BEGINNING
THRU ASSET CLASS: END

FROM DEPARTMENT: BEGINNING
THRU DEPARTMENT: END

FROM STATUS DATE: BEGINNING
THRU STATUS DATE: END

FROM ACQUIRED DATE: BEGINNING
THRU ACQUIRED DATE: END

FROM RETIRE DATE: BEGINNING
THRU RETIRE DATE: END

FROM RETIRE TYPE: BEGINNING
THRU RETIRE TYPE: END

FROM RETIRE TYPE DATE:
THRU RETIRE TYPE DATE:

FACILITY: SYSTEM
DEPARTMENT: 1.351 I O R

NUMBER	DESCRIPTION	LIFE	STATUS	STS DATE	ACQ DATE	RET DATE	COST	BOOK
CLASS: MEQ-HOSP	MOVEABLE EQUIP - HOSPITAL							
KN029947	CELL SAVER AUTOTRANSFUSION SYTEM		ACTIVE	05/06/14	04/30/14		6645.00	0.00
							6645.00	0.00
						TOTAL FOR DEPARTMENT:	6645.00	0.00

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

Request for Disposal of Obsolete or Surplus Property

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

Asset Description	Asset Control KN #	Purchase Date	Purchase Amount	CE #	Reason for Disposal	Net Book Value (Provided by Finance)	Dept. #
OSI Orthopedic surgical table	KN028779	12/13/2006	72880.00	PMC02579	Unit is obsolete and removed from service. Table no longer supported.	—0—	1.351 OR/Spec

Requesting Department - 351-OR

Net Book Value (Finance) A. Finance 2/7/22

Sr. VP Finance/CFO ① Vacant

Board Approval: (Date) _____

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

Department Director Mathew F. Andrews

EMC Member [signature] 1.31.22

President/CEO _____

CFO Signature [signature] 3/29/22

① [signature] 3/21/22

Parrish Medical Center FA *Live*
CURRENT VALUES REPORT

CREATED BY USER: FRANZAL

FROM FACILITY: SYSTEM
THRU FACILITY: SYSTEM

FROM ASSET NUMBER: KN028779
THRU ASSET NUMBER: KN028779

FROM ASSET CLASS: BEGINNING
THRU ASSET CLASS: END

FROM DEPARTMENT: BEGINNING
THRU DEPARTMENT: END

FROM STATUS DATE: BEGINNING
THRU STATUS DATE: END

FROM ACQUIRED DATE: BEGINNING
THRU ACQUIRED DATE: END

FROM RETIRE DATE: BEGINNING
THRU RETIRE DATE: END

FROM RETIRE TYPE: BEGINNING
THRU RETIRE TYPE: END

FROM RETIRE TYPE DATE:
THRU RETIRE TYPE DATE:

FACILITY: SYSTEM
DEPARTMENT: 1.351 I O R

NUMBER	DESCRIPTION	LIFE	STATUS	STS DATE	ACQ DATE	RET DATE	COST	BOOK
CLASS: MEQ-HOSP	MOVEABLE EQUIP - HOSPITAL							
KN028779	JACKSON SPINAL TABLE SYSTEM (07-351-12)		ACTIVE	01/08/07	12/13/06		72880.00	0.00
							72880.00	0.00
						TOTAL FOR DEPARTMENT:	72880.00	0.00

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

Request for Disposal of Obsolete or Surplus Property

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

Asset Description	Asset Control KN #	Purchase Date	Purchase Amount	CE #	Reason for Disposal	Net Book Value (Provided by Finance)	Dept. #
Glide scope, emergency room	KN029712	2/8/2012	8700.00	PMC01405	Unit is not working and no longer supported.	-0-	1.381 ED

Requesting Department - Emergency Dept. 381 Department Director Marion F. Ayden

Net Book Value (Finance) A. Franey 3/21/22 EMC Member 3.18.22

Sr. VP Finance/CFO① Vacant President/CEO

Board Approval: (Date) CFO Signature 3/29/22

Requestor Notified Finance

Asset Disposed of or Donated

Removed from Asset List (Finance)

Requested Public Entity for Donation

Entity Contact

Telephone

① Denied 3/21/22

CREATED BY USER: FRANZAL

FROM FACILITY: SYSTEM
THRU FACILITY: SYSTEM

FROM ASSET NUMBER: KN029712
THRU ASSET NUMBER: KN029712

FROM ASSET CLASS: BEGINNING
THRU ASSET CLASS: END

FROM DEPARTMENT: BEGINNING
THRU DEPARTMENT: END

FROM STATUS DATE: BEGINNING
THRU STATUS DATE: END

FROM ACQUIRED DATE: BEGINNING
THRU ACQUIRED DATE: END

FROM RETIRE DATE: BEGINNING
THRU RETIRE DATE: END

FROM RETIRE TYPE: BEGINNING
THRU RETIRE TYPE: END

FROM RETIRE TYPE DATE:
THRU RETIRE TYPE DATE:

FACILITY: SYSTEM
DEPARTMENT: 1.381 1 ER DEPT

NUMBER	DESCRIPTION	LIFE	STATUS	STS DATE	ACQ DATE	RET DATE	COST	BOOK
CLASS: MEQ-HOSP	MOVEABLE EQUIP - HOSPITAL							
KN029712	PORTABLE STAND GLIDESCOPE COBALT		ACTIVE	03/06/12	02/08/12		8700.00	0.00
							8700.00	0.00
						TOTAL FOR DEPARTMENT:	8700.00	0.00

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

Request for Disposal of Obsolete or Surplus Property

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

Asset Description	Asset Control KN #	Purchase Date	Purchase Amount	CE #	Reason for Disposal	Net Book Value (Provided by Finance)	Dept. #
Patient stretcher, emergency room	KN023440	7/2/2002	3699.10	PMC01647	Unit is not working and no longer supported.	-0-	1.300 Beds
PSJ Stretcher	KN021897	7/5/2002	4854.40	PMC03080		-0-	427 -PSJ

Requesting Department - Beds / Pt floors _____ Department Director _____

Net Book Value (Finance) A. Franey 3/21/22 EMC Member _____ 3.18.22

Sr. VP Finance/CFO ① Vacant + President/CEO _____

Board Approval: (Date) _____ CFO Signature _____ 3/29/22

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

① 3/21/22

CREATED BY USER: FRANZAL

FROM FACILITY: SYSTEM
THRU FACILITY: SYSTEM

FROM ASSET NUMBER: KN023440
THRU ASSET NUMBER: KN023440

FROM ASSET CLASS: BEGINNING
THRU ASSET CLASS: END

FROM DEPARTMENT: BEGINNING
THRU DEPARTMENT: END

FROM STATUS DATE: BEGINNING
THRU STATUS DATE: END

FROM ACQUIRED DATE: BEGINNING
THRU ACQUIRED DATE: END

FROM RETIRE DATE: BEGINNING
THRU RETIRE DATE: END

FROM RETIRE TYPE: BEGINNING
THRU RETIRE TYPE: END

FROM RETIRE TYPE DATE:
THRU RETIRE TYPE DATE:

FACILITY: SYSTEM
DEPARTMENT: 1.381 1 ER DEPT

NUMBER	DESCRIPTION	LIFE	STATUS	STS DATE	ACQ DATE	RET DATE	COST	BOOK
CLASS: MEQ-HOSP	MOVEABLE EQUIP - HOSPITAL							
KN023440	STRETCHER - TRAUMA SERIES		ACTIVE	12/11/02	07/02/02		3699.10	0.00
							3699.10	0.00
						TOTAL FOR DEPARTMENT:	3699.10	0.00

CREATED BY USER: FRANZAL

FROM FACILITY: SYSTEM
THRU FACILITY: SYSTEM

FROM ASSET NUMBER: KN021897
THRU ASSET NUMBER: KN021897

FROM ASSET CLASS: BEGINNING
THRU ASSET CLASS: END

FROM DEPARTMENT: BEGINNING
THRU DEPARTMENT: END

FROM STATUS DATE: BEGINNING
THRU STATUS DATE: END

FROM ACQUIRED DATE: BEGINNING
THRU ACQUIRED DATE: END

FROM RETIRE DATE: BEGINNING
THRU RETIRE DATE: END

FROM RETIRE TYPE: BEGINNING
THRU RETIRE TYPE: END

FROM RETIRE TYPE DATE:
THRU RETIRE TYPE DATE:

FACILITY: SYSTEM
DEPARTMENT: 1.381 1 ER DEPT

NUMBER	DESCRIPTION	LIFE	STATUS	STS DATE	ACQ DATE	RET DATE	COST	BOOK
CLASS: MEQ-HOSP	MOVEABLE EQUIP - HOSPITAL							
KN021897	STRETCHER - EXTENDED STAY SYNERGY SERIES		ACTIVE	08/07/02	07/05/02		4854.40	0.00
							4854.40	0.00
						TOTAL FOR DEPARTMENT:	4854.40	0.00

Healing Families – Healing Communities®

parrishmed.com

Finance Committee

FYTD February 28, 2022 – Performance Dashboard

Indicator	FYTD 2022 Actual	FYTD 2022 Budget	FYTD 2021 Actual
IP Admissions	2,042	2,237	2,185
LOS	5.6	4.3	5.2
Surgical Procedures	2,038	2,354	1,985
ED Visits	11,776	13,310	12,660
OP Volumes	20,531	23,112	21,495
Hospital Margin %	2.95%	8.56%	11.59%
Investment Income $	-$1.5 Million	$1.9 Million	$7.7 Million
EBIDA Margin %	-5.64%	5.51%	16.61%
EBIDA Margin %- Excluding Invest Income	-3.19%	2.65%	6.22%

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

DRAFT AGENDA
EXECUTIVE COMMITTEE
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, APRIL 4, 2022
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5
IMMEDIATELY FOLLOWING FINANCE COMMITTEE

CALL TO ORDER

I. Approval of Minutes

Motion to approve the minutes of the February 7, 2022 regular meeting and the March 25, 2022 special meeting.

II. Reading of the Huddle

III. Physician Manpower Plan – Mr. Lifton

IV. Report from Titusville City Council Liaison – Scott Larese

V. Attorney Report – Mr. Boyles

VI. Other

VII. Executive Session (to approve minutes)

ADJOURNMENT

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

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

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EXECUTIVE COMMITTEE

A regular meeting of the Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on February 7, 2022 in Conference Room 2/3/4/5, First Floor. The following members were present:

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

Members Absent:
None

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

CALL TO ORDER

Mr. Retz called the meeting to order at 12:38 p.m.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Mr. Cole, seconded by Mr. Jordan and approved (4 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVED TO APPROVE THE DECEMBER 6, 2021 MEETING MINUTES OF THE EXECUTIVE COMMITTEE, AS PRESENTED.**

READING OF THE HUDDLE

Dr. Galfo read the Weekly Huddle.

ATTORNEY REPORT

Mr. Boyles summarized the recent activity surrounding the vaccine mandates, adding that there have been issues from some providers due to the Supreme Court decision to approve the healthcare mandate. Mr. Boyles noted he will bring any further developments back to the committee.
Mr. Boyles noted that the Gray Robinson firm was asked to look into amending the Bylaws to make the Credentials Committee a standing committee, adding he will continue to work with Executive Staff, Mr. Jordan and Mr. Noffel on the amendment.

OTHER

There was no other business to discuss.

ADJOURNMENT

There being no further business to discuss, the committee adjourned at 12:43 p.m.

Stan Retz, CPA
Chairman

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EXECUTIVE COMMITTEE

A special meeting of the Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on March 25, 2022 in the Executive Conference Room, Second Floor. The following members were present:

Stan Retz, CPA, Chairman
Robert L. Jordan, Jr., C.M., Vice Chairman
Herman A. Cole, Jr.
Elizabeth Galfo, M.D.
Maureen Rupe
George Mikitarian (non-voting) (via phone)

Members Absent:
None

CALL TO ORDER

Mr. Retz called the meeting to order at 8:41 a.m.

PEER REVIEW

At this time the committee entered executive session to discuss matters of peer review.
At 8:48 a.m., Executive Session ended and Executive Committee resumed.

ADJOURNMENT

There being no further business to discuss, the committee adjourned at 8:48 a.m.

Stan Retz, CPA
Chairman

Physician Manpower Plan

Findings and Conclusions

April 4, 2022

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ASSOCIATES, LLC

Physician Manpower Plan Overview

- Periodic update
  - Area demographics, other providers
  - Physician demand and supply; area and PMC
- Components
  - Quantitative
  - Qualitative; interviews
  - Synthesis; comparison, judgement
- Findings, conclusions, recommendations

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ASSOCIATES, LLC

Findings

1. Analysis indicates need in most specialties
   - ✓ Also found in 2019; previous Plan update
   - ✓ Common challenge for health care providers
2. PMC has lost physicians in core specialties, notably family medicine and cardiology
   - ✓ Retired, recruited by other health care systems, or left the area

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ASSOCIATES, LLC

Findings, continued

3. Less than one-third of family physicians in the area are on staff at PMC
   - ✓ Nurse practitioners playing increased role in primary care, e.g., urgent care centers
4. Key physicians will reach retirement age over the next five years
   - ✓ Clinical capability difficult to replace
   - ✓ Commitment to PMC impossible to replace

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ASSOCIATES, LLC

Findings, continued

5. Management has used innovative approaches to increase physician capacity, capabilities
   - ✓ Telemedicine
   - ✓ Radiology
   - ✓ Inpatient, subspecialty pediatrics
   - ✓ Space Coast Health Center (FQHC “look-alike”)
6. PMC at a disadvantage in recruitment
   - ✓ Systems; resources, options, opportunities
   - ✓ For-profits; flexibility in compensation

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ASSOCIATES, LLC

Conclusions

7. Expanding the primary care base the greatest need for PMC. A larger, stable primary care base is critical to the organization's ability to:
   - ✓ Serve current and growing population
   - ✓ Support needed specialists
   - ✓ Appropriately utilize PMC facilities, services

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ASSOCIATES, LLC

Conclusions, continued

8. Traditional approach – recruiting physicians individually and integrating them into the existing PMC/PMG structure – will limit PMC's ability to develop the necessary primary care base and add needed specialists
   - ✓ Consistent with management's assessment
   - ✓ In response, exploring options for fundamental change in physician recruitment, retention

LIFTON
ASSOCIATES, LLC

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ASSOCIATES, LLC

DRAFT AGENDA
BOARD OF DIRECTORS MEETING - REGULAR MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
APRIL 4, 2022
NO EARLIER THAN 2:00 P.M.,
FOLLOWING THE LAST COMMITTEE MEETING
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Pledge of Allegiance

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

III. Approval of Agenda

IV. Review and Approval of Minutes (February 7, 2022 Regular Meeting))

V. Recognitions(s)
A. New Providers (memo included)

VI. Open Forum for PMC Physicians

VII. Public Input and Comments***[1]

VIII. Unfinished Business***

IX. New Business***

A. **Environment of Care Annual Review –Mr. Loftin**

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

X. Medical Staff Report Recommendations/Announcements

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

XII. Consent Agenda***
A. Finance
1. Motion to recommend the Board of Directors approve the purchase of a pasteurizer at a total cost of $48,891.

2. Motion: To recommend to the Board of Directors to declare the equipment listed in the requests for Disposal of Obsolete or Surplus Property Forms as surplus

and obsolete and dispose of same in accordance with FS274.05 and FS274.96.

_____

. ***1 Pursuant to PMC Policy 9500-154:

- non-agenda items – 3 minutes per citizen
- agenda items for board action -- 3 minutes per citizen, permitted prior to board discussion for regular agenda action items and prior to board action on consent agenda
- 10 minute total per citizen
- must be related to the responsibility and authority of the board or directly to an agenda item [see items marked ***]

XIII. Committee Reports

A. Quality Committee

B. Finance Committee

C. Executive Committee

D. Educational, Governmental and Community Relations Committee

E. Planning, Physical Facilities & Properties Committee

XIV. Process and Quality Report – Mr. Mikitarian

A. Other Related Management Issues/Information

B. Hospital Attorney - Mr. Boyles

XVI. Other

XVII. Closing Remarks – Chairman

XVIII. Executive Session (if necessary)

ADJOURNMENT

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ANY MEMBER OF THE PUBLIC THAT WILLFULLY INTERRUPTS OR DISTURBS A MEETING OF THE BOARD OF DIRECTORS IS SUBJECT TO REMOVAL FROM THE MEETING BY AN OFFICER AND SUCH OTHER ACTIONS AS MAY BE DEEMED APPROPRIATE AS PROVIDED IN SECTION 871.01 OF THE FLORIDA STATUTES.

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

A regular meeting of the Board of Directors of the North Brevard County Hospital District operating Parrish Medical Center was held at 2:00 p.m. on February 7, 2022 in Conference Room 2/3/4/5, First Floor. The following members were present:

Robert L. Jordan, Jr., C.M., Chairman
Stan Retz, Vice Chairman
Herman A. Cole, Jr.
Billy Specht
Elizabeth Galfo, M.D.
Billie Fitzgerald
Maureen Rupe
Ashok Shah, M.D.
Jerry Noffel

Member(s) Absent:

None

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

CALL TO ORDER

Mr. Jordan called the meeting to order at 2:00 p.m.

PLEDGE OF ALLEGIANCE

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

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

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

APPROVAL OF AGENDA

Mr. Jordan requested approval of the agenda in the packet as revised. Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Cole and approved (9 ayes, 0 nays, 0 abstentions).

***ACTION TAKEN*: MOVED TO APPROVE THE REVISED AGENDA AS PRESENTED.**

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Cole and approved (9 ayes, 0 nays, 0 abstentions).

***ACTION TAKEN:* MOVE TO APPROVE THE MINUTES OF THE DECEMBER 6, 2021 REGULAR MEETING OF THE BOARD OF DIRECTORS OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT DBA PARRISH MEDICAL CENTER, AS PRESENTED.**

RECOGNITIONS

Mr. Jordan presented a gift to Ms. Peggy Crooks in honor of her 20 years of service on the Board of Directors. Ms. Cooks shared that it was a wonderful experience with amazing fellow board members, staff and leadership.

Mr. Jordan presented a plaque to Dr. Patel for his service to the Board as 2021 Medical Staff President.

ELECTION OF MEMBER-AT-LARGE OF THE EXECUTIVE COMMITTEE

Mr. Jordan noted the Board must elect a Member-at-Large to serve on the Executive Committee. Mr. Cole nominated Ms. Rupe as Member-at-Large, and no other names were presented. Mr. Cole moved to close the nominations, seconded by Mr. Retz. Mr. Jordan announced the results, stating that Ms. Rupe was elected as Member-at Large of the Executive Committee, and this concluded the election.

OPEN FORUM FOR PMC PHYSICIANS

Dr. Mathew's introduced himself, adding it is a pleasure to be serving as Medical Staff President.

PUBLIC COMMENTS

There were no public comments.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Cole and approved (9 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: MOTION TO APPROVE THE PROCUREMENT POLICY, AS PRESENTED.

COMMITTEE REPORTS

Quality Committee

Dr. Galfo reported all items were covered during the meeting.

Finance Committee

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

Executive Committee

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

Educational, Governmental and Community Relations Committee

Ms. Fitzgerald reported all items were covered during the meeting.

Planning, Physical Facilities and Properties Committee

Mr. Jordan reported the Planning Physical Facilities and Properties Committee did not meet.

PROCESS AND QUALITY REPORT

No additional information was presented.

Hospital Attorney

Legal counsel had no report.

OTHER

There was no other business.

CLOSING REMARKS

There were no closing remarks.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 2:09 p.m.

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING PARRISH MEDICAL CENTER
MEDICAL EXECUTIVE COMMITTEE MEETING – REGULAR SESSION MINUTES
February 15, 2022

Present: B. Mathews, MD, G. Mikitarian, J. Rojas, MD, A. Ochoa, MD, M. Navas, MD, K. Patel, MD, P. Carmona, MD, I. Rashid, MD, MD, R. Rivera-Morales, MD, C. Fernandez, MD, G. Cuculino, MD, C. Manion, MD, V. Williams, MD

Absent: C. McAlpine, R. Patel, MD, H. Cole , D. Barimo, MD

The meeting of the Medical Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was called to order on February 15, 2022 at 5:30 pm in the Women's Conference Center. A quorum was determined to be present.

CALL TO ORDER.

Dr. Biju Mathews, President, called the meeting to order at 5:34pm.

I. REVIEW AND APPROVAL OF MINUTES

The following motion was made by Dr. Rojas, seconded by Dr. Ochoa, and unanimously approved.

ACTION TAKEN: Motion to approve the previous Regular Session minutes (January 18, 2022) as written and distributed.

II. OLD BUSINESS: None

III. FOLLOW UP MEC BUSINESS: None

IV. NEW BUSINESS:

A. Policies for Review: 10899464
Policy for Monitoring and Management of Patients Receiving Sedation for Short-Term Therapeutic, Diagnostic, or Invasive Procedures (attached)

Discussion ensued regarding first, reappointment requirements. Where is the information generated, recorded, distributed and second, reversals? ***Motion to table the policy until further review was made by Dr. Ochoa and seconded by Dr. Patel. The motion was unanimously approved.***

Policies for Retirement: 10520500 Oncology Navigation Guidelines (attached)

Replaced by 9500-2001 Patient Navigation Process/Oncology Navigator Practice Guidelines

Motion to approve the retirement of policy was made by Dr. Cuculino and seconded by Dr. Rojas. The motion was unanimously approved.

V. REPORT FROM ADMINISTRATION - None.

II. Report from the Board - **None**. **Minutes attached**

a. Quality Committee – Board of Directors, December 6, 2021
b. Regular Session – Board of Directors, December 6, 2021

III. Committee Reports - **No action. Noted for the minutes**.

A. Credentialing & Medical Ethics (Regular Session, February 14, 2022) **(*attached*.)**

VI. CONSENT AGENDA – STANDING ORDERS

Neonatal Opioid **Withdrawal (E3518)** - Replaced prior version of Order Set. Neonatal Opioid Withdrawal MED **(E3633)** - New Order Set.
Neonatal Opioid Withdrawal Syndrom Protocol **(E3634ab**) - New Order Set.

Motion by Dr. Rojas to approved the Neonatal order sets above as written, seconded by Dr. Cuculino and unanimously approved.

Infusion Center PRN **MEDS (E3648**) - New Order Set.

Motion made by Dr. Manion to approve the new order set as written, seconded by Dr. Carmona and unanimously approved.

ED Code Stemi Protocol **(E3344)** - Triennial review, no changes.

Motion made to approve as written by Dr. Rojas, seconded by Dr. Manion and unanimously approved.

ED Vaginal Bleeding **(E3351ab)** - Review for deactivation. Per Dr. Cuculino this is no longer in use.

Motion made by Dr. Rojas, seconded by Dr. Cuculino to retire/deactivate the order set, was unanimously approved.

VII. Open Forum:

Dr. Navas reviewed the Baby Friendly certification scheduled for February 17th and 18th. The Baby Friendly Hospital Initiative is a global program to encourage the broad-scale implementation of breastfeeding, and provides special recognition to the hospitals that successfully implement the guidelines. Dr. Navas stressed that the core of the program has already been in practice at Parrish and falls under "best practices" however the "stamp" of Baby Friendly certification would provide Parrish with another marketing tool as a birthing center of excellence. ***Attached: ACOG Committee Opinion submitted for the minutes in tandem with Baby Friendly review.***

Dr. Carmona reported that the first stages of implementation of new processing equipment is underway. In addition, he reported on the shortage of phlebotomists.

Dr. Mathews introduced the possibility of Medical Student internships in a joint program with Burrell College of Osteopathic Medicine, New Mexico. Mr. Mikitarian noted that he would be interested in discussing the opportunity further. Burrell currently has a relationship with Steward but seeks other sites due to student volume.

XI. Adjournment: There being no further business the meeting adjourned at 5:55.

_____	_____
Biju Mathews M.D.	Christopher Manion, M.D.
Medical Staff President	Secretary/Treasurer

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MEDICAL CENTER

PARRISH HEALTHCARE

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Welcome New Providers

Rocco J. Santarelli, DO – Critical Care

Medical School:

Doctor of Osteopathic Medicine– New England College of Osteopathic Medicine

Fellowship:

Pulmonary/Critical Care– Cooper Hospital/University Medical Center

Welcome New Providers

Yamen Smadi, MD – Pediatrics

Medical School:

Doctor of Medicine – University of Damascus School of Medicine

Residency:

Pediatrics – St. John Hospital & Medical Center

Pediatric Gastroenterology, Hepatology & Nutrition – Arnold Palmer Medical Center

Endosonography – Center Hospitalier de l'Univerite de Montreal

North Brevard County Hospital District
Environment of Care (EOC) Committee Report:
Annual Report for Calendar Year 2021
Executive Summary

Safety and Security

2021 Goal(s):

A. Ninety percent (90%) of all bags, purses, suitcases, duffels, etc. entering through the Main and ER entrances will have thorough bag checks done prior to entry into the building. This is accomplished through review of cameras at each location for a minimum of 4 bags/persons by each officer. NOT MET

B. Loading dock rounds will be completed every two (2) hours at a minimum of 90% (11 every 24 hours). NOTMET

C. Ninety percent (90%) of active care partners will receive education on de-escalation techniques by December 31, 2021. **NOT MET**

The ongoing pandemic and staffing challenges led to the inability to meet the stated goals. Installation of additional cameras throughout the facility will assist in meeting goals A and B for 2022. Goal C was met by 100% of security staff being educated and trained on de-escalation techniques.

2022 Goal(s):

A. Ninety percent Ninety percent (90%) of all bags, purses, suitcases, duffels, etc. entering through the Main and ER entrances will have thorough bag checks done prior to entry into the building. This is accomplished through review of cameras at each location for a minimum of 4 bags/persons by each officer per month.

B. Loading dock rounds will be completed every two (2) hours at a minimum of 90% (11 every 24 hours)

C. Ninety percent (90%) of active care partners will receive education on de-escalation techniques by December 31, 2022

Hazardous Materials

2021 Goal(s)

A. 75% of care partners questioned during environmental rounds will be able to speak correctly concerning actions to take when a Code Orange (hazardous spill/event) occurs. **Not Met**

This was met at 61%. The goal will be repeated with a threshold above what was met.

B. Reduce the number of hazardous waste disposal deficiencies by 10 percent from 2020 as reported through the monthly audit of same. **Not Met**

This goal was not met, and unfortunately, the number of deficiencies increased by 22%. We believe this to be related to the increase in PPE use in 2021 as well as the staffing issues associated with the COVID-19 pandemic.

2022 Goal(s):

A. 67% of care partners questioned during environmental rounds will be able to speak correctly concerning actions to take when a Code Orange (hazardous spill/event) occurs. This is an annual percentage rate.
B. Reduce the number of hazardous waste disposal deficiencies as reported through the monthly audit of same by 10 percent as measured in 2020.

Emergency Management

2021 Goal(s)

In spite of the ongoing Code Green, PHC will conduct several tests of the Comprehensive Emergency Management Plan:

1. Internal Event: Code Black at the hospital MET
2. Internal Event: Code Black at the Port St. John Building **Not Met**
3. Internal Event: Code Black at the Titus Landing Building **Not Met**
4. Internal Event: Code Pink MET
5. External Event: Code Green – Covid-19 continues currently at a level 3 MET
6. Any other test that may appear on the Hazard Vulnerability Analysis which will be completed not later than May 31, 2021 **None Identified**
7. Participation in any Brevard County Emergency Management Drill, if available. **None Held**

   Drills not conducted were due to time factors and staffing to do an off-site event. These will be done as part of the 2022 goals.

2022 Goal(s):

A. Perform one Code Black drill at each of the off-site medical office facilities in 2022
B. Have the Comprehensive Emergency Plan prepared for review and deliver to the Brevard County Emergency Management office not later than July 31, 2022

Life Safety

2021 Goal(s)

A. Portable fire extinguisher inventory with all proper documentation will be completed by April 30, 2021. MET
B. Compliance with the hospital's fire response plan will be 100% as measured after online training and evaluated by onsite questions/education to three (3) care partners during each EOC rounds. UNMET

While the fire response plan was updated, the education to go to staff was not completed in 2021. Staff could not speak to the revised plan. This goal is being repeated with a shorter completion time.

2022 Goal(s):

A. 100% of active Care Partners will complete education on the revised fire procedures not later than July 15, 2022.
B. 60% (annual aggregate) of care partners questioned concerning the revised fire procedures will be able to speak correctly to same.

Utilities Management

2021 Goals

A. Improvement of room pressure compliance in all designated high risk areas and in licensed off-site locations to 90% MET

B. A adopt a standardized flushing program to include chlorine content and water temperature monitoring not later than April 30, 2021 MET After April 30

2022 Goal(s):

A. The hospital will reduce downtime due to waste water system failures by 10% from last year's data. The results will be monitored and documented through our CMMS system monthly through 12-31-2022.

B. The hospital will reduce downtime due to elevator failures by 10% from last year's data. The results will be monitored and documented through 12-31-2022.

Medical Equipment

2021 Goal(s)

A. Determine the cause of medical equipment repair. If due to user error, trend for one rolling quarter. If repeated as to a person or a particular device, training will be requested – then track for repeat errors . MET

B. Determine the cause of medical equipment repair. If due to damage or abuse, determine the cause of such damage or abuse and trend for the year by damage. MET

2022 Goal(s):

A. Review 100% of all battery failures to determine:
   a. The battery's function is to power a medical device
   b. Length of time battery has been in use
   c. Compare manufacturer/supplier length of battery life
   d. Assess for consistency of battery life and a consolidation of supplier/brand of batteries for medical equipment

Worker Safety

2021 Goal(s)

A. One Hundred percent (100%) of employees with musculoskeletal injuries during 2021 will be referred to Rehab ("back school") for education and training in proper movement and lifting skills. MET
B. Reduce the number of injuries to care partners by ten percent (10%). MET

2022 Goal(s)

A. Continue to assure that all musculoskeletal injuries are referred to Rehab for training in proper movement and lifting (100%).

B. 100% of employees with a job code of transporter will be trained in the use of patient handling equipment, turning and repositioning so that they can assist with our more challenging or disabled patients. The goal is to assure that members of a "transition team" are well versed in proper moving turning and lifting techniques, with and without equipment.

EMERGENCY MANAGEMENT PLAN 2022

David Marquez, Security Manager

I. MISSION

To provide Parrish Health Care's (PHC) response to emergencies consistent with its mission, vision, and values.

II. PURPOSE

To outline the organization's high-level response to situations that pose an immediate danger to the health and safety of all who enter PHC doors; to provide organizational planning for the return to normal status; and to comply with regulatory requirements in all phases of such situations.

III. SCOPE

Applies to any emergencies that may be acts of nature or events humans occurrences within or outside the organization and affects the safety and security of PHC property and care partners.

IV. RESPONSIBILITIES AND REPORTING STRUCTURE

- The PHC Hospital Board approves all the Comprehensive Management Plan (CEMP) elements based on regular reporting of emergency management activities by the Environment of Care Committee (EOCC).

- The leadership within the medical staff leadership would provide a physician as an active member of the Incident Command (IC) team.

- Medical Staff Leadership provides a physician leader as an active member of the Incident Command (IC) team who participates in planning activities as part of development, updating or revision of the Emergency Management Plan, including implementation of the plan and actively participating in drills and actual events as the CEMP requires.

- The PHC CEO receives and reviews reports of the CEMP drills and the actual implementation of the CEMP for an event. The PHC CEO works with the executive management team to determine needs and actions in support of the CEMP
- The EOCC Chairperson leads the EOCC activities relevant to emergency management and reports on drills and events pertinent to the CEMP to the CEO and hospital board.

- The EOCC, in conjunction with the PHC Safety Officer, develops, revises, and maintains the PHC CEMP assuring coordination with Brevard County's CEMP. Additionally, EOCC ensures available resources and assets to address the various events under the CEMP.

- The Safety Officer advises the EOCC regarding emergency management issues that affect PHC, requiring supplies, personnel, orientation, and CEMP procedures.

- The Safety Officer oversees the implementation of the CEMP in drills and actual events events, evaluating the CEMP before during and after drills and/or actual events, and provides recommendations regarding any and all aspects of the CEMP.
- Department leaders are responsible for assuring departmental staff are educated and oriented to their role during the implementation of the CEMP during any event with such education and orientation provided upon hire and annually.
- All Care Partners participate in education regarding the CEMP and their response to the events within it by participating in the educational activities and participating in drills/actual events following policy and procedure.

V. PHC EMERGENCY MANAGEMENT PROCESSES and Plans

- **Hazard Vulnerability Analysis (HVA)**
  Assess the impact of likely emergencies to guide the EOCC in updating/revision of the Emergency Management Program. Such analysis is done by the EOCC on an annual basis by:
    - reviewing the prior year's HVA on an annual basis
        - Determine any changes in likely emergencies
        - Collaborate with Brevard County Emergency Management in prioritization of emergencies
    - Communicate needs and vulnerabilities to Brevard County Emergency Management and identify capabilities of all involved to meet the organization's needs
    - Based on the HVA, define mitigation activities and preparedness activities
    - Emergency Response Plans are developed and maintained for each of the emergencies identified as priorities in the HVA, and are annually compared to the Brevard County Emergency Management plan(s) to assure consistency and coordination of PHC's role in those plans.

- **Comprehensive Emergency Management Plan (CEMP)**
  The CEMP contains the PHC's overall emergency plan**,** including the resources available and the individual emergency response plans. EOCC evaluates the CEMP annually and submits the CEMP to Brevard County Emergency Management for review and approval according to State Statute. The CEMP may be amended as necessary, based on changing conditions, regulations, standards, and identified needs.
- **Notification to Governmental Authorities**
  The CEMP includes a current list of governmental and commercial organizations to be notified of plan implementation and identifying any immediate or long-term needs, as known.

- **Alternate Roles for Care Partners during Emergencies**
  PHC uses the CEMP and the particular emergency plan in any specific emergency, which defines the Incident Command Staff who supersede routine PHC management.

  Senior staff, as available, is assigned responsibilities using the EOP and ensuring critical tasks are completed based on the needs to help mitigate an appropriate response. Most care partners perform their usual duties; however, in the emergency at hand, care partners may assume additional responsibilities or carry out other obligations based on organizational need

and care partner competency.

- **Conducting drills to test emergency management**
  PHC tests the response phase of its emergency management plan at least twice a year, either in response to an actual emergency or in planned drills. Emergency event documentation follows the same method used for planned exercises.

  Following the findings from the HVA, drills are planned to test various elements of a particular Emergency Response Plan and the overall CEMP. When practical, full-scale exercises (FSE) are planned in conjunction with local Emergency Management Agencies and healthcare coalitions.

  FSE's are preplanned tests at least four months apart to maintain training and readiness and allow time to integrate the findings and opportunities to improve plans for plans and emergency responses. One FSE is used to determine PHC's ability to function for 96 hours without outside assistance of any kind.

- **Emergency Communications Plan**
  As part of the Emergency Response Plan, PHC includes communications during emergency situations. Elements addressed related to communications when the Emergency Management Plan is implemented include, but are not limited to:

  - Notification to affected staff regarding the initial implementation of the Emergency Management Plan and regular updates via overhead announcements, telephones, cell phones, text, employee hotline, email, and iCare communications board.
  - Notification of Brevard County Emergency Management Office, local law enforcement agencies regarding the situation with regular updates regarding new information and conditions
  - Communication with the media and the community
  - Process to communicate with suppliers and vendors of essential supplies
  - Communication with any alternative care site
  - Informing entities assisting with disaster services regarding general condition and location of patients
  - Process to notify families/patient representatives/health care surrogates in the event of an evacuation of patient(s)
  - Current listing of names and contact information for the following:
    - Employees
    - Physicians
    - Hospital Auxillians
    - Other hospitals
    - Organizations with whom PHC has a Memorandum of Understanding or contract for goods and services
    - Relevant federal, state and local emergency preparedness staff
    - Other sources of assistance
  - The Safety Officer with the assistance of the EOCC assures the following is up to date
    - Contact lists as identified above
    - Criteria for calling staff to assist with any emergency response
    - Assures up to date contact list for all known emergency response organizations

- **Goals and Performance Management**
  - 2021 Goals and outcomes
    - PHC undertook seven (7) goals in an effort to test the knowledge of staff for multiple events. The pandemic and its associated issues provided little time to appropriately test them all. Of the seven goals, two (2) were not conducted, specifically Any other test that may appear on the HVA, and Participation in any Brevard County Emergency Management Drill. These were not conducted as the HVA did not identify any additional testing and Brevard County Emergency Management did not conduct a drill in 2021.
    - Of the remaining Five (5) events, three (3) were accomplished: Internal Code Black at the hospital, Code Pink at the hospital, and the ongoing Code Green for COVID-19, The Code Green varied from a Level III to a Level I throughout the year ending as a Level I.
    - The events planned at the Port St. John and Titus Landing facilities were not accomplished, but are a part of the goals in 2022.
  - 2022 Goals
    - Perform one Code Black drill at each of the off-site medical offices during calendar year 2022.
    - Have the annual review with any revisions to the Comprehensive Emergency Management Plan prepared for review and delivery to the Brevard County Emergency Management office not later than July 31, 2022.

2022 Hazardous Materials Waste Management Plan

By

Taylor Ray, Director of EVS

January 26, 2022

I. SCOPE

Parrish Healthcare's Hazardous Materials and Waste Management Plan covers all operations owned, leased, or operated by Parrish Healthcare (PHC).

II. MISSION

Parrish Healthcare's mission is "Healing Experiences for Everyone All the Time." A part of this mission involves improving the health of North Brevard by providing cost-effective, quality health and hospital services. PHC's Hospital Board, Executives and Care Partners (employees, clinical staff, physicians, volunteers), support PHC's Hazardous Materials and Waste Plan.

PHC's Hazardous Materials and Waste Management Plan covers material that may cause harm to humans or the environment, and includes processes to minimize risk. Care Partner education includes a Hazard Communication Program based on the *Globally Harmonized System of Chemical Classification,* and the safe use, storage, disposal, and management of spills and chemical exposures. PHC is committed to minimizing the use of hazardous materials. PHC ensures hazardous waste is properly segregated, and disposal is consistent with applicable law and regulations.

PHC promotes a safe, controlled, and comfortable *Environment of Care* that is in compliance with Federal, State, County, and Local regulations and laws for hazardous material and waste management and disposal.

MSDS Online®, an internet-accessible program, is part of PHC's Hazard Communication Program, and provides Safety Data Sheets (SDS) from suppliers/manufacturers. *MSDS Online*® may be accessed from PHC's iCare web page, or by phoning the PHC Communication Center at 321-268-6565. *MSDS Online*® is managed by the Safety and Security Officer.

III. PLAN FUNDAMENTALS

A. PHC's Safety & Security Manager is the Hazardous Materials Officer (HMO).

B. PHC utilizes the *Globally Harmonized System of Classification &Labeling of Chemicals (GHS).*

C. PHC's Environmental Services department (EVS) collects hazardous waste and materials.

D. PHC Care Partners who may be exposed to hazardous materials and waste are educated as to the nature of those hazards, and the proper use of personal protective equipment (PPE) when working with or around hazardous materials and waste.

E. In the event of a spill, release, or exposure of hazardous materials or waste, rapid effective response helps to minimize injuries.

F. Hazardous waste segregation at the point of generation is the preferred means of controlling exposures and spills.

G. Special monitoring systems are required to manage some hazardous gases, vapors, or radiation undetectable by humans.

IV. PLAN OBJECTIVES

A. Define procedures to safely transport, store, use, and dispose of hazardous materials.

B. Maintain a Hazardous Communication Plan and a hazardous chemical materials inventory.

C. Define safe handling practices for the following hazardous materials:

1. Chemical waste
2. Radioactive waste
3. Pharmaceutical waste
4. Chemotherapeutic waste
5. Bio-hazardous waste, including sharps and physical hazards
6. Resource Conservation & Recovery Act (RCRA) Hazardous Waste items.

D. Monitor gases, vapors, glutaraldehyde, and waste anesthetic gases, and report the results of involved areas/departments to the Environment of Care Committee (EOCC).

E. PHC's HMO conducts regular inspections of areas which store hazardous waste to ensure correct space and separation from clean or sterile goods and other hazardous chemicals.

F. PHC's HMO reports number, frequency, severity, releases, and exposures to hazardous chemicals and waste to the EOCC.

G. Care Partners who handle hazardous materials and waste are trained about the dangerous nature of these materials, PPE required, and proper spill/exposure responses. PPE training is conducted for PHC Care Partners by involved departments, and reported to the EOCC. PHC's HMO assists when requested.

H. PHC's HMO reports the Hazardous Materials and Waste Performance Indicator (PI) to the EOCC each quarter.

I. Care Partners who may be involved with emergency spills are provided appropriate departmental training to recognize when spills require outside agency response, and their knowledge is refreshed annually using PHC's *Net Learning* program.

J. PHC's HMO annually evaluates the Hazardous Materials Waste Management Plan performance, and makes recommendations to the EOCC.

V. GOALS

A. 75% of care partners questioned during environmental rounds will be able to speak correctly concerning actions to take when a Code Orange (hazardous spill/event) occurs.

B. Reduce the number of hazardous waste disposal deficiencies by 10 percent as reported through the monthly audit of same.

VI. ORGANIZATION

A. PHC's CEO and Hospital Board receive regular reports on the activities of the Hazardous Materials and Waste Management Plan from the EOCC. Concerns about identified issues and regulatory compliance issues are forwarded to the EOCC.

B. PHC's CEO and the Hospital Board support ongoing activities of the Hazardous Materials Waste and Hazard Communication Plans.

C. PHC Leadership collaborates with the HMO to establish operating and capital budgets for

the Hazardous Materials Waste Management and the Hazardous Communication Plans.

D. PHC's HMO works under the direction of PHC's Senior Vice President, Integrated and Acute Care/CNO.

E. PHC Department Heads are responsible for orienting Care Partners in their department concerning departmental uses of hazardous material or waste. The HMO provides assistance as requested.

F. PHC Care Partners must learn and follow job specific procedures for the safe handling and use of Personal Protective Equipment (PPE) , and hazardous materials and waste.

VII. RISK MANAGEMENT PROCESSES

A. PHC Department Managers are responsible for evaluating hazardous materials SDS's before purchase, maintaining departmental inventories, safe storage, handling, use, and hazardous material disposal. Department Managers may request HMO assistance to identify safe hazardous materials handling procedures. Materials Management will not release new hazardous materials until each SDS is evaluated, and approved by the HMO.

B. The Environmental Services Director, the Director of Diagnostic Imaging (DI), and Director of the Clinical Laboratory (CL), share responsibility for the disposal of bio-hazardous, radioactive or chemical hazardous waste, respectively. Only Florida State licensed contractors may transport chemical chemotherapeutic, and bio-hazardous waste. Radioactive waste is segregated in HMO approved & designated areas until it decays below background radiation levels, and then is disposed of as ordinary waste.

C. PHC identifies, selects, uses, handles, stores, disposes, and transports hazardous materials waste from receipt or generation through final disposal.

D. PHC's major waste stream of chemical hazardous waste products is the Clinical Lab. The Clinical Lab Safety Officer manages the Clinical Lab Chemical Hazardous Waste collection Process. Hazardous waste storage is a shared responsibility of the CL Safety Officer and HMO who jointly conduct weekly safety inspections of the Haz Waste Holding Rooms.

E. All departments maintain appropriate storage space for chemical materials, which is reviewed during EOC Rounds. Chemicals are maintained in containers with GHS labels. Care Partners are trained in GHS SDS methodology, and safe handling of hazardous chemicals.

F. Chemical, chemotherapeutic, bio-hazardous, and radioactive waste, is handled by trained Care Partners and placed in the correct holding room. Only licensed contractors pack chemicals, complete manifests, and remove hazardous waste. Disposal copies of **all** manifests are returned to Director, Environmental Services and retained for 3 years.

G. Chemotherapeutic (antineoplastic) medications, and the materials used to prepare and administer these materials are controlled substances which are held in a hazardous storage room until disposal. Care Partners who process, prepare, or administer these materials are trained in proper handling, PPE use, and emergency spill response. Chemotherapeutic residual waste is handled as part of the *Regulated Medical Waste* stream, with proper GHS labeling to assure timely final destruction. Container volumes of more than 3% (liquids) are RCRA hazardous waste.

Chemotherapeutic waste is segregated into either soft items or sharps at PHC. Soft items include, gloves, gowns, medication packaging, Foley catheters, etc., and are packaged in yellow plastic bags which meet the *Dart and Sharps* Florida State Department of Health (FLDOH) guidelines. Sharps are disposed of in reusable plastic containers serviced by Trilogy.

H. Radioactive materials are handled under PHC's NRC License. PHC's DI Director is responsible for safe radioactive materials storage, and is listed on PHC's facility license. Radioactive waste is held in a PHC holding room until it decays to background levels, when the waste is handled at the hazard level of the original materials being disposed of. PHC's DI Director determines when the materials are no longer hazardous.

I. Infectious and Regulated Medical Wastes, such as sharps, are found throughout PHC. Bio-hazardous materials must be identified, separated, collected, and controlled. PHC Care Partners are trained to handle materials in the regulated medical wastes program per the Bio-medical Waste Operating Plan. Training is conducted for new hire Care Partners during orientation, and annually, thereafter. Specialized labeled containers are used to collect and transport these wastes. Waste is packaged for disposal at the point of generation. Regulated Medical Waste, including sharps, are picked up by Environmental Services care partners in patient care areas and transported to the correct holding room in dedicated 96 gallon waste carts, and held for a licensed waste contractor to pick up. All waste removed from PHC must be manifested before shipment. A disposal contractor completes the manifests, removes the waste, gives a disposal manifest copy to the ES Director. After final disposal a copy is returned to the facility with empties, packaged in approved waste transport containers, manifested, and shipped for processing**. Trilogy** reusable sharps containers are utilized throughout PHC facilities. Detailed procedures are available in PHC's Biohazard Waste Management Plan which may be found on PHC's iCare page.

J. DOH/DOT guidelines require that Category "A" infectious waste must be triple bagged. The 1st bag will be a red biohazard bag tied closed with a "gooseneck" knot. A plastic zip strip located at the base of the knot is then cinched tight. The red bag neck is doubled over the knot in U-Shape fashion and secured with tape. The 1st bag is then sprayed with a hospital-grade disinfectant, placed in a 2nd 3 mil plastic liner, which is closed, sealed, sprayed with hospital-grade disinfectant. The 2nd bag is then placed in a 3rd bag, a 6 mil red outer liner, closed and sealed. Finally, the 3rd bag is placed inside of a poly barrel, the final waste barrier. Each poly barrel is disinfected and stored away from the point of generation.

K. The HMO determines if storage conditions for holding/storing and hazardous materials waste meets guidelines for safe handling, space requirements, and separation from clean areas. Report findings are provided to the EOCC. Needed follow up is conducted by EOC Rounding. PHC department heads are responsible for initiating corrective actions on reported findings in their areas. PHC's Hazardous Waste room and its contents are inspected weekly by the HMO. The Hazardous Waste room checklist is completed and documented. Deficiencies are immediately corrected by the responsible manager. The HMO maintains inspection records for 3 years.

L. Department Heads are responsible for managing programs to monitor departmental gases and vapors. Air contaminants found in Parrish Healthcare include formaldehyde, glutaraldehyde (i.e., Cidex), xylene, ethylene oxide (ETO), & waste anesthetic gases. When monitored results reach actionable levels, testing is performed to identify needed steps to return PHC to safe levels.

M. PHC's HMO develops emergency procedures for the Hazardous Materials and Waste Management Plan. PHC has spill procedures that determine when outside assistance is necessary. Minor (incidental) spills that can be cleaned up by trained Care Partners using PPE does not require outside agency response. Potential spills that requires spill kits are kept in each department. Spills that exceed the capability of the Care Partners to neutralize must be reported to the Safety & Security department at extension 6565. For large spills,

dial “11”, evacuate the spill area and ensure Code Orange is initiated. Titusville Fire Department (TPD) will take control upon site arrival, and initiate cleanup. When TFD has determined an area is safe, PHC’s ES department will finish any remedial cleaning. PHC ES Care Partners are trained to recognize when spills are potentially not safe to handle, and will contact the ES manager, and the HMO. During off-shift times, PHC’s AOC will determine spill documentation level necessary.

N. PHC maintains permits and licenses for handling, storage, and disposal of hazardous, chemical, radioactive, chemotherapeutic, bio-hazardous, and infectious medical waste from federal, state, municipal, and local agencies.

O. Federal regulation requires each hazardous waste shipment from PHC to be manifested. A manifest copy is retained at the time of hazardous waste removal, another copy travels with the waste, and is returned to PHC ES department after disposal, cross-matched with the 1st copy. The DOT, EPA, and EOCC must be notified of manifests not returned within 120 days.

P. Hazardous wastes are labeled from generation to removal. Biohazardous wastes, such as Potential Infectious Medical Waste (PIMW) are labeled by placement in red or orange bags; other wastes are labeled with specific GHS labels.

Q. Biohazardous Waste is put in red or orange bags, and then placed into cardboard boxes, or plastic bins with external labeling as biohazardous wastes, or in a labeled roll-away container provided by the vendor, and are also labeled with the OSHA Biohazardous labeling and DOT required placarding. The red and orange labeled bags must display PHC’s address. These bags may not be used for any other purpose. Any material placed in a red or orange bag is treated as biohazardous waste, and the bags may never be opened. All biohazardous waste is to be treated in accordance with Florida Administrative Code 64C-16.

R. Chemotherapeutic wastes are placed in containers labeled with OSHA and GHS symbols for carcinogenic wastes, and handled along with red bag waste, but packaged separately, and labeled for “Incineration Only”. Bulk quantities are handled as chemical waste, and must be dated while held in the PHC chemical storage room. PHC’s chemotherapeutic waste program has been converted to reusable sharp containers.

S. Yellow liners are utilized for all soft wastes generated during treatment of patients with Chemotherapeutic agents, and results in the elimination of using disposable containers, a cost reduction for less soft waste disposal.

T. Hazardous Chemical Materials and Waste are labeled during their use and handling in PHC, and dated upon storage in the PHC back dock holding area. Labels are placed on containers filled or mixed within the hospital. Labeling and dating is checked for legibility. Chemical waste containers are labeled and dated. In many cases the waste is labeled with the original chemical name. At other times, especially when collection cans or containers are used, the container itself is labeled. These labels must meet the requirements of the DOT and GHS for shipment of hazardous and universal waste materials so they are identified for proper handling and disposal. The date on the container must reflect the actual date the container was placed in the storage/holding area.

U. Black RCRA hazardous pharmaceutical waste containers and white, universal pharmaceutical waste containers with blue lids have been placed in PHC medication rooms and dispensing areas. Full black containers are moved to Hazardous Waste storage, as are Universal pharmaceutical waste containers on PHC’s back dock.

Both waste streams are disposed of at least every 6 months as required by PHC's registered hazardous generator status.

V. Radioactive materials are labeled with the magenta and yellow symbols, required by OSHA. These materials are handled and stored in accordance with PHC's NRC regulations and license. Wastes are held to decay to background levels, and when the labels are removed or covered, the wastes are handled, as required.

W. PHC has separate hazardous waste handling and storage areas to minimize contamination of clean and sterile goods, contact with care partners, or patients.

Hazardous wastes are moved through PHC using covered and closed containers from holding areas to designated storage space for processing. Hazardous material storage spaces are regularly inspected to ensure correct equipment and PPE is available, and that the areas are clean, orderly, and safe.

Hazardous materials transport routes are designed to minimize contact with patients, visitors, care partners, and protect PHC from contamination. When food, clean and sterile materials, and care partners are moved by the same transportation vehicle as the hazardous waste stream, scheduling helps minimize potential cross contamination. regular storage areas and transport route inspections are included as part of EOC rounding when problems are identified and documented.

VIII. PHC care partners must attend new employee orientation within 30 days of hire which addresses the seven (7) EOC areas, and where to obtain copies of the management plans. New PHC employees receive departmental safety orientation in their respective work areas regarding hazards and their EOC responsibilities. All care partners must take annual EOC refresher training. New care partner orientation, includes education on waste segregation and the pharmaceutical waste programs.

IX. REFERENCES

The Joint Commission 2016 Hospital Accreditation Standards. (2016). EC.02.02.01.EP 1 & 2.p.EC-8

The Joint Commission 2016 Hospital Accreditation Standards. (2016). LD.04.01.01.p.LD-21

The Joint Commission 2016 Hospital Accreditation Standards. (2016). LD.03.01.01.EP 1.p.LD-16

The Joint Commission 2016 Hospital Accreditation Standards.(2016). EC.01.01.01.p.EC-5

The Joint Commission 2016 Hospital Accreditation Standards.(2016). EC.02.02.01..EP4,5,9.p.EC-8,9

The Joint Commission 2016 Hospital Accreditation Standards.(2016). EC.02.02.01.p.EC-8,9

The Joint Commission 2016 Hospital Accreditation Standards.(2016) EC. 04.01.01.EP1.p.EC-33

The Joint Commission 2016 Hospital Accreditation Standards.(2016). LD.04.01.05 EP 3.p.LD-23

The Joint Commission 2016 Hospital Accreditation Standards.(2016). EC.02.02.01.p.8-9

Occupational Safety and Health Administration's Blood Borne Pathogens & Hazard Communications Standards.(2016)

The National Fire protection Association.(2012)

The Joint Commission 2016 Hospital Accreditation Standards.(2016). EC.01.01.01 EP1

The Joint Commission 2016 Hospital Accreditation Standards.(2016). PI.01.01.01.p.PI-4

LIFE SAFETY/FIRE SAFETY MANAGEMENT PLAN

2022

MISSION:
The Life Safety/Fire Safety Management Plan of the Parrish Healthcare serves to minimize the risk of fire and to protect patients, personnel, physicians, and others from fire, smoke, and the products of combustion by cooperating with firefighting authorities.

SCOPE:
The hospital is a healthcare occupancy that may also include sections and locations that are classified as business occupancies. This Life Safety/Fire Safety Management Plan covers the activities of the hospital and licensed off site locations including:

Parrish Medical Center, Parrish Healthcare, Parrish Medical Croup

The hospital adopted and will adhere to Life Safety Code, NFPA 101, 2012 Edition, and the NFPA 99, 2012 Edition. This management plan conforms to these code requirements. References for all NFPA standards are found in NFPA 101 and 99, 2012 edition section 2.2

RESPONSIBILITY:
The Director of Facilities/Safety Officer is responsible for the implementation and maintenance of this Life Safety/Fire Safety Management Plan and all regulatory requirements. The Safety Officer is appointed by the President/CEO and is the Chairperson of the Environment of Care (EOC) Committee. The Safety Officer is responsible for coordination of the environment of care and emergency management and works in collaboration and cooperation with the Parrish Healthcare Senior Leadership Team.

Department Directors are responsible for development, provision, and documentation of department and job-specific fire safety training, and maintenance of policies, procedures, and plans affecting their area(s) of responsibility.

Each individual staff member is responsible for maintaining current knowledge of hospital policies and procedures for fire safety and to be familiar with any specific fire emergency procedures for their work area.

GOALS & PERFORMANCE MANAGEMENT:

- The hospital will reduce correction time of fire system deficiencies on a quarterly bases from 60 days from the time we receive inspection report to 45 days. This will be monitored and documented monthly through our work order system and deficiency tracking log.

- The hospital will achieve compliance with the fire drill program; this will include training on departmental responsibilities with respect to the Fire Response Plans. Training to be

accomplished during new hire orientation, CBL and quarterly fire drills. Our goal for this task would be to test the knowledge of 5 care partners weekly during Environment of Care Rounds. This will be monitored and tracked via rosters and monthly monitoring through 12-31-2022.

Written Management Plan

The hospital has developed and implemented this Life Safety/Fire Safety Management Plan in compliance with regulatory requirements and adherence to Life Safety Code (LSC), NFPA 101, 2012 Edition. The plan describes the processes involved to effectively provide fire safety for all who use the facility.

Protecting Individuals and Property

Fire safety policies and procedures are developed and implemented in accordance with current regulations, codes, and standards. They provide a system for protecting patients, staff, visitors, and property from fire, smoke, and the products of combustion. Components of this process include:

- Identification and maintenance of all required structural features of fire protection as defined by the *Life Safety Code*®, NFPA 101- 2012 edition
- Inspection, testing, and maintenance of all fire protection systems
- Purchasing only those products that meet appropriate standards to decrease the potential of combustion
- Cooperating and collaborating with firefighting authorities
- Staff education in their roles in the event of a fire

Patients, staff, and visitors are required to comply with the hospital smoking policy. Environmental tours evaluate compliance with the policy and procedure requirements.

Inspection, Testing, and Maintenance

All fire protection and life safety systems, equipment, and components at the hospital are tested according to the applicable regulatory requirements for Fire Safety Maintenance, Testing and Inspection standards and the associated NFPA standards, which include, but are not limited to:

- NFPA 72 – 2010 edition: *National Fire Alarm Code*®
- NFPA 25 – 2011 edition: Inspection, Testing, & Maintenance of Water Based Fire Protection Systems
- NFPA 96 – 2011 edition: Commercial Cooking Operations
- NFPA 10 – 2010 edition: Portable Fire Extinguishers
- NFPA 90A – 2012 edition: Installation of Air Conditioning & Ventilating Systems
- NFPA 80 – 2010 edition: Fire Doors and Fire Windows
- NFPA 105 – 2010 edition: Smoke Door Assemblies
- NFPA 1962, Fire Hose Care, Use, and Service Testing, (if applicable and occupant fire hoses are in use).

Documentation of all maintenance, testing, and inspection includes:

- Name of activity
- Date of activity
- Inventory
- Required frequency
- Name, contact information, and affiliation of individual performing the activity
- NFPA standards referenced for the activity
- Results

The maintenance requirements and schedule for preventative maintenance are maintained in the facility/maintenance department, along with the documentation of their completion. All LSC deficiencies will be managed with the hospital's Computerized Maintenance Management System (work order system).

The hospital has annual inspection and testing of fire door assemblies by individuals who can demonstrate knowledge and understanding of the operating components of the door being tested. Testing begins with a pre-test visual inspection; testing includes both sides of the opening.

Elevators with fire fighters' emergency operations are tested monthly. The test completion dates and results are documented.

Fire Response Plan

The hospital maintains a fire response plan. A written copy of the fire response plan can be found in Security and with the Hospital Mission Control Center. This plan contains information on the response actions expected of the hospital workforce including physicians and Licensed Independent Practitioner's (LIPs) at or remote from a fire's point of origin and:

- When and how to sound and report fire alarms
- How to contain smoke and fire
- How to use a fire extinguisher
- How to assist and relocate patients
- How to evacuate to areas of refuge

The fire response plan for business occupancies at the hospital is included in the Fire Response Plan.

Departmental fire response plans include appropriate fire evacuation routes based on building compartmentalization and occupancy classification.

The hospital has a fire response plan specific to Surgical Services.

All employees are trained and will cooperate with the local fire departments or the Authority Having Jurisdiction in any fire event.

At least six spare sprinkler heads of each type used, with associated wrenches, are kept in a cabinet that will not exceed 100°F.

Review of Acquisitions

Materials Management is responsible for requiring evidence of fire safety review for all hospital acquisitions of bedding, draperies, furnishings, wall coverings, decorations, and other appropriate equipment. All of these materials will adhere to the requirements of NFPA 101, the *Life Safety Code*®, 2012 Edition for issues of flammability and flame spread.

***Life Safety Code*®**

The hospital, an acute care hospital, is considered to be a health care occupancy. This facility complies with NFPA 101, the *Life Safety Code*®, 2012 edition. Any areas of non-compliance are identified in a current electronic database document, along with a Plan for Improvement. The hospital partners with an external life safety vendor/consultant who is familiar with the *Life Safety* Code®, who works with the hospital facility director to produce accurate drawings and an assessment of areas needing improvement annually. Life Safety documents are reviewed on an ongoing basis by the Director of Facilities, who is qualified by education and experience, to ensure its accuracy and timeliness of corrective action.

Those sections of the building that are classified as business occupancies are maintained in a fire-safe condition. Free and unobstructed access is maintained to all exits in these areas.

Fire Drills

In the acute care hospital, fire drills will be conducted once per shift per quarter in buildings identified as a healthcare occupancy, and quarterly in buildings defined as ambulatory healthcare care occupancy by the Life Safety Code.

The hospital conducts fire drills every 12 months from the date of the last drill in all free-standing buildings classified as business occupancies and in which patients are seen or treated.

Drills are designed to test the effectiveness of the fire response plan. They will be conducted in various areas and will reflect actual fire situations. They will be conducted in various areas and will reflect actual fire situations. The scheduled time of drills are greater than 1 hour from the previous 8 quarters in order to ensure drills are not scheduled in a pattern and continue to be unanticipated by staff. All members of the workforce will be expected to participate as outlined in the fire plan. Response to a drill will include alarm activation, transmission of the fire alarm signal and simulation of emergency fire conditions including, but not limited to containment of smoke and fire by shutting doors, planning for and practicing patient evacuation to areas of refuge (without moving actual patients). Those individuals remote from the site of the drill may not be required to take any action; however, all staff will be trained in appropriate fire response. An attendance sheet will be created, and written critiques will be conducted following each fire drill.

In the business occupancies, fire drills will be done as exit drills. It will be required that one staff member go all the way out of each path of egress to ensure that it is not blocked or locked.

Interim Life Safety Measures (ILSM)
Interim life safety measures are part of a program that is implemented to temporarily compensate for *Life Safety Code*® deficiencies that occur for any reason, such as construction, renovation, cable installations, normal building operations, or any time the normal fire detection and/or suppression systems are inoperable or non-compliant. All deficiencies noted on the Plan for Improvement are also evaluated for potential ILSM implementation. An ILSM policy is in place to determine which safety measures are implemented based on the type and duration of a construction project or other deficiency. All assessments are documented.

The Director of Facilities is responsible for accurately representing the need to implement ILSM to construction and hospital staff. Any ILSM that is implemented will be reported to the EOC Committee and are in place for the duration of the deficiency or hazard.

Reporting Process
Life Safety/Fire Safety deficiencies, problems, failures, and user errors are identified through environmental tours and fire drill observations. They are reported directly to the Department Director, who is expected to take immediate action.

Annual Evaluation
There will be an annual evaluation of this Life Safety/Fire Safety Management Plan in terms of its objectives, scope, performance, and effectiveness. This annual evaluation will be completed by the Director of Facilities/Safety Officer during the first quarter of the calendar year and reviewed by the EOC Committee. The report will be forwarded to the respective Board of Directors of the hospital.

Orientation and Education
All members of the hospital workforce, including but not limited to physicians and Licensed Independent Practitioners (LIPs), participate in an orientation and education program that includes:

- Area-specific evacuation routes
- Specific roles at and away from a fire's point of origin, including cooperation with firefighting authorities
- Use and functioning of fire alarm systems
- Specific roles and responsibilities in preparing for building evacuation
- Location and use of equipment for evacuation or transportation of patients to areas of refuge
- Building compartmentalization procedures for containing smoke and fire

New members of the hospital workforce receive fire safety training as part of the general new hire orientation and departmental orientation. All members of the hospital workforce receive annual fire safety education.

Staff training records are kept in the Human Resource Department.

Orientation and education on environment of care issues for physicians and LIPs is accomplished through the following:

- House staff participation in hospital new hire orientation
- Annual education achieved through Net Learning
- Safety issues are communicated to physicians and LIPs through e-mail and written hospital publications

Approval Required by EOC Committee

Date: _____

_____

Signature
EOC Committee Chairperson

MEDICAL EQUIPMENT MANAGEMENT PLAN

2022

MISSION STATEMENT

Parrish Health Care (PHC) is committed to providing high quality healthcare to the citizens of Brevard County and surrounding areas. Our mission is to continuously improve the care we are able to provide and to exceed the expectations of our patients and customers.

Medical Equipment Policy Mission Statement - The mission, value and purpose of PHC Clinical Engineering department is to create and operate a comprehensive medical equipment program that will ensure the safety and integrity of all medical equipment. To engage a comprehensive plan to manage the medical devices that will provide healthcare and related services including education and research for the benefit of the people it serves that is consistent with the mission, values and purpose that the Hospital Board of Directors, Medical Staff, and Administration have established. To provide ongoing support for the Safety Management Program described in this plan.

PURPOSE

The purpose of the Medical Equipment Management Plan is to reduce the risk of injury to patients, employees, and visitors of PHC and its Affiliate Facilities. The plan establishes the parameters within a safe environment of care is developed, maintained and improved. This plan also addresses specific responsibilities, general safety, and employee education programs.

SCOPE

The Medical Equipment Plan establishes the parameters in which all medical equipment including, but not limited to new, loaned, demo or patient-owned medical equipment that is used to treat, diagnose or monitor patients that enter the hospital system is deemed safe to use through policies and procedures. The plan will minimize clinical and physical risks of equipment through an effective program that provides guidelines for the inspection, testing, and maintenance of medical equipment.
The equipment will be inventoried and tracked while in the hospital system and will be managed for the duration of the life of the equipment while active in the hospital system. The Medical Equipment Plan includes the following locations:

Parrish Medical Center
Titus Landing
Port St. John Healthcare Center
Other freestanding medical offices as may be leased by PHC

OBJECTIVE

The Objectives for the Medical Equipment Program are developed from information gathered during risk assessment activities, annual evaluation of the previous year's program, performance measures, and environmental tours. The Objectives for this Plan are:

A. To define the process for selection and acquisition of medical equipment. This process has been reviewed within the past year.
B. To establish criteria used to define equipment and maintenance strategies included in the medical equipment management program. These criteria are applied to all equipment used to diagnose, treat, monitor or provide care to patients and the result becomes the medical equipment inventory.
C. To monitor medical equipment recalls and hazard alerts through the use of appropriate resources, to track corrective actions related to those recalls, and to report the results to the Recall Coordinator, who reports open items and actions to the Environment of Care (EOC) Committee (EOCC) as required.
D. To provide a process for identifying incidents that may involve the Safe Medical Devices Act and reporting in accordance with the Hospital's designated procedure. Appropriate staff training, related to this procedure, is provided through new employee orientation and ongoing education to staff based on educational assessments of educational needs.
E. To provide summaries of medical equipment problems, such as equipment failures or malfunctions, and user errors are aggregated, evaluated and reported to the Safety Committee at least quarterly.
F. To provide preventive maintenance programs used to schedule testing and inspection of equipment in the program to minimize potential risks to patient care and staff safety, and ensure patient care staff that medical equipment is tested on a regular basis. All medical equipment alarms are tested for accurate settings, audibility and proper operation at every preventative testing interval. The percentage of equipment inspections completed versus those devices scheduled is reported to the EOCC on a quarterly basis.
G. To provide an annual summary of effectiveness that provides an evaluation of the scope and objectives of this plan, as well as effectiveness and results against performance indicators, is reported to the Safety Committee annually.
H. The orientation of new employees includes the capabilities, limits and uses of that equipment in their role, the basic operation, emergency procedures, and process to obtain assistance and repair for all staff that use medical equipment. Clinical managers assess the skills and competency of their staff, and their knowledge of systems to report and evaluate information about problems, malfunctions, and user errors. Clinical Engineering reports user errors to department heads and summarizes statistics for the Safety Committee on quarterly reports to the Committee

I. Equipment whose failure represents a significant threat to the patient's life or medical condition have plans for emergency response to a failure or malfunction of that equipment, including clinical response to such emergencies. These procedures have been reviewed in the past year.
J. Results of performance monitoring for Medical Equipment Management are reported to the EOCC at each meeting.
K. Patient safety issues are reported to Leadership.

ORGANIZATION & RESPONSIBILITY

The Board of Directors receives regular reports of the activities of the Medical Equipment program from the EOCC. The Board reviews and, as appropriate, communicates concerns about identified issues and regulatory compliance. The Board provides support to facilitate the on-going activities of the Medical Equipment Program.

The Vice President of Acute Care Services receives regular reports of the current status of the Medical Equipment program through the EOCC. The Vice President of Acute Care Services reviews the reports and communicates concerns about key issues and regulatory compliance to the Executive Council, the medical staff, nursing, clinical engineering, and other appropriate staff.

Clinical Engineering manages the biomedical equipment program in all key clinical areas. This includes inspection and inventory of incoming medical equipment, lease or rental equipment, patient owned equipment, contracted services, and other departments such as surgery, anesthesia, respiratory care, laboratory, etc.

Department heads are responsible to orient their new staff to the department and task specific uses of medical equipment. When requested, Clinical Engineering provides assistance in the form of a technical orientation.

Individual staff members are responsible for learning and following job and task specific procedures for safe medical equipment operation.

PERFORMANCE ACTIVITIES

The performance measurement process is one part of the evaluation of the effectiveness of the Medical Equipment Program. Performance measures have been established to measure at least one important aspect of the Medical Equipment Program.

The performance measures for the Medical Equipment Program are:

- Electrical safety and preventive maintenance completion rate for high risk equipment.
- Electrical safety and preventive maintenance completion rate for non-high-risk equipment.

- Medical equipment user errors divided by total correctives for the month (Goal is less than or equal to 10 %)
- Medical Equipment user abuse (Goal is less than or equal to 10 %)
- Medical Equipment battery failure divided by total correctives for the month (Goal is less thatn or equal to 10%)

MANAGEMENT PLAN

PHC develops and maintains the Medical Equipment Management Plan to effectively manage the medical equipment risks of the staff, visitors, and patients at PHC.

PROCESSES FOR MANAGING MEDICAL EQUIPMENT RISKS

Selection & Acquisition

PHC solicits input from individuals who operate and service equipment when it selects and acquires medical equipment.

Medical Equipment Inventory

PHC maintains a written inventory of all medical equipment.

Equipment is considered a medical device if it is used in the diagnosis, care, treatment, life support or monitoring of a patient. All other equipment is considered non-medical equipment.

Identify High Risk Equipment

The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail. Note: High-risk medical equipment includes life-support equipment.

Maintenance strategies

PHC identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of the alternative equipment maintenance (AEM) program. The strategies of the AEM program does not reduce the safety of equipment and is based on accepted standards of practice.

Maintaining, Inspecting, & Testing Frequencies

PHC monitors activities and frequencies for inspecting, testing, and maintaining the following items are in accordance with manufacturers' safety and performance guidelines:

- Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining must be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements - Medical laser devices
- Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes) - New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies

Qualified persons

A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following:

- How the equipment is used, including the seriousness and prevalence of harm during normal use.
- Likely consequences of equipment failure or malfunction.
- Maintenance requirements of the equipment.

Equipment in the Alternative equipment program

PHC identifies medical equipment on its inventory that is included in an alternative equipment maintenance program.

Safe Medical Devices Act

The Risk Manager is responsible for managing the Safe Medical Devices Reporting process.

The Risk Manager collects information about potentially reportable events through the incident reporting and investigation process. Clinical Engineering provides support to the Risk Manager in the investigation of medical equipment incidents to determine if the incident is reportable under criteria established by the Food and Drug Administration.

A device that has been identified as causing patient harm or in some way brings into play the "Safe Medical Devices Act of 1990" must be immediately removed from service. The Risk Manager, Safety Officer and Clinical Engineering must be notified whenever an incident occurs. The device is sequestered and removed from service to avoid further use. All ancillary equipment used with the device must be sequestered as well. An incident report by the user is prepared detailing the incident. Clinical Engineering will inspect the defective equipment and notify the Risk Manager and Safety Officer of the findings. Documentation of the inspection and findings are sent to the Risk Manager and Safety Officer. A work order is generated and the results entered into the Clinical Engineering Service Request (SR) database for service history and incident information.

The Risk Manager uses the Incident Reporting Forms to investigate and document reportable incidents and reports quarterly to the Safety Committee on those incidents determined to be reportable. The Risk Manager is also responsible for completing all reports and handling other communications with medical equipment manufacturers and the FDA required by the Safe Medical Devices Act. Each potentially reportable SMDA event is also processed through the Sentinel Event analysis and reporting process.

Emergency Procedures

Utilizing a chart of emergency procedures, staff is provided with information to address:

Specific procedures in the event of equipment failure. What to do if the equipment you are using malfunctions and how to remove it from service.

When and how to perform emergency clinical interventions when medical equipment fails. Explains to the clinical users what steps should be taken to continue patient care until a replacement unit arrives.

Availability of back-up equipment. Where back up equipment is located and how to get it.

How to obtain repair services. How to get in touch with Clinical Engineering during regular business hours, after hours, weekends and holidays.

The head of each department using high risk or other life-critical medical equipment develops and trains their staff about the specific emergency policies to be used in the event of failure or malfunction of equipment whose failure would cause immediate death or irreversible harm to the patient dependent on such equipment.

The emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying the appropriate administrative staff of the emergency action(s) to take in order to protect patient safety.

Contacts for spare equipment or repair services.

Each department head reviews department specific medical equipment emergency procedures annually. The Director of Clinical Engineering may assist department heads on request.

Identification of QC and Maintenance for CT, PET, MRI, and Nuclear Medicine

The Medical Physicist has identified the method for the quality control and maintenance activities for maintaining the quality of the diagnostic computed tomography (CT),

magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. They are performed annually.

Hazard Notices and Recalls

Risk Management manages the medical equipment hazard notice and recall process. Clinical Engineering assists Risk Management in their activities along with Safety Management and Materials Management.

Product safety alerts, product recall notices, hazards notices, etc., are received from a variety of external resources such as manufacturers, National Recall Alert Center, ECRI, etc. When a notice is received, Clinical Engineering, as requested, searches for the device(s) in the medical equipment computer management program database for that facility to identify if the facility has any affected equipment. When a piece or type of equipment, subject to a hazard notice or recall is identified, the equipment is handled in accordance with the recall and the proper disposition determined that ensures patient safety. Repairs are made in accordance with the recall or hazard notice, or the equipment is returned to the manufacturer for repair.

PROCESS FOR INSPECTING, TESTING, AND MAINTAINING MEDICAL EQUIPMENT

Testing medical equipment prior to initial use

The Clinical Engineering Department will test all medical equipment on the inventory before initial use. PHC Clinical Engineering Department performs safety, operational, and functional checks. The inventory includes, equipment owned by the PHC, leased, and rented from vendors. The inspection, testing and maintenance documents are maintained in the Clinical Engineering Department for review. The Director of Clinical Engineering manages the program of planned inspection and maintenance.

Testing of High-Risk Equipment

The Director of Clinical Engineering assures that scheduled testing of all high-risk equipment is performed in a timely manner. Reports of the completion rates of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Director of Clinical Engineering will also present an analysis to determine what the root cause of the problem and make recommendations for addressing it.

Testing of non-High-Risk Medical Equipment

The Director of Clinical Engineering assures that scheduled testing of all non-high-risk equipment is performed in a timely manner. The inspection completion goal for nonhigh-risk equipment is 100% completion of all scheduled devices which can be located and removed from use for inspection. Inspections are completed within a +/- 30-day window of time, which begins on the first of the month in which a device's inspection is scheduled. At the end of this 30-day window, a listing of any and all devices which could not be located for inspection will be created by the Manager of Clinical Engineering and provided to the device owning department. This list will serve as a request for assistance from the device owning department in locating the listed device(s), and/or determining the device status (i.e. retired, relocated, off-site).Clinical Engineering personnel will utilize feedback provided by the device owner department to ensure that missed inspections are completed, and/ or device status is updated within the CE database. The Director of Clinical Engineering will present an analysis to the Safety Committee for review.

Testing of Sterilizers

Testing and maintenance of all type of sterilizers is performed on a timely basis. This may be accomplished by internal staff or by contract with manufacturer representatives. Service records are maintained by the department, monitored by Infection Control, and administratively audited by Clinical Engineering. Any improper results are documented and reported to the Safety Manager for evaluation and action.

Testing of Dialysis Equipment

Responsibility for maintenance and maintenance records for dialysis equipment is conducted by PMC Clinical Equipment Staff. The program of maintenance includes, regular cleaning and disinfection of all dialysis equipment, and testing for compliance with biological and chemical standards for the dialysis water supply. Documentation of the testing and maintenance activities is maintained in the Dialysis Department for review.

Electrical Equipment in Patient Care Vicinity

PHC meets all code requirements for electrical equipment in the patient care vicinity related to NFPA 99-2012: Chapter 10.

Inspect, test and calibrate Nuclear Medicine Equipment Annually-

All Equipment used in Nuclear Medicine will be inspected, tested, and calibrated at the intervals recommended by both the United States Nuclear Regulatory Commission and the Department of Environmental Protection, this is coordinated by the Radiation Safety Officer and Clinical Engineering.

Quality Control of CT, MRI, and Nuclear Medicine

The quality of the diagnostic computed tomography (CT), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced is maintained.

CT Radiation Dose Measurement

The Medical Physicist measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted. The Medical Physicist verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented.

Performance Evaluation of CT

For diagnostic computed tomography (CT) services: Annually, the Medical Physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics:

- Image uniformity
- Slice thickness accuracy
- Slice position accuracy (when prescribed from a scout image)
- Alignment light accuracy
- Table travel accuracy
- Radiation beam width
- High-contrast resolution
- Low-contrast resolution
- Geometric or distance accuracy
- CT number accuracy and uniformity
- Artifact evaluation

Performance Evaluation of MRI

Annually, the Medical Physicist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics

- Image uniformity for all radiofrequency (RF) coils used clinically
- Signal-to-noise ratio (SNR) for all coils used clinically
- Slice thickness accuracy
- Slice position accuracy
- Alignment light accuracy
- High-contrast resolution
- Low-contrast resolution (or contrast-to-noise ratio)
- Geometric or distance accuracy
- Magnetic field homogeneity
- Artifact evaluation

Performance Evaluation of Nuclear Medicine

Annually, the Medical Physicist conducts a performance evaluation of all nuclear medicine imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics:

- Image uniformity/system uniformity
- High-contrast resolution/system spatial resolution
- Sensitivity
- Energy resolution
- Count-rate performance
- Artifact evaluation

Testing of Image Acquisition Monitors

For computed tomography (CT), nuclear medicine (NM), or magnetic resonance imaging (MRI) services: The annual performance evaluation conducted by the Medical Physicist includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution, and spatial accuracy.

Defibrillators

All defibrillators located at PMC and affiliated facilities will be plugged into emergency outlets as available.

Annual Evaluation

The Medical Equipment Management Plan and all components will be reviewed and evaluated annually by the EOCC to ensure that it continues to meet the needs of the hospital and its staff. The appraisal will identify components of the plan that may need to be initiated, revised or deleted. Policies and procedures supporting this plan will be changed as necessary to ensure compliance with changes to Local, State and Federal regulatory requirements. The annual evaluation will also include the objectives scope, performance & effectiveness of the plan. Data and reports from January 1 to December 31 will be consolidated the following January, reported to the EOCC and Senior Leadership.

PARRISH MEDICAL CENTER

951 North Washington Avenue, Titusville, Florida 32796
Department: 321-268-6565 **Fax:** 321-268-6878

SECURITY MANAGEMENT PLAN

[2022]

SECURITY MANAGEMENT PLAN 2022

David Marquez, Safety and Security Manager

INDEX

I. PURPOSE

The purpose of the Security Management Plan is to provide an effective security program through crime prevention, protection and prevention, effective response towards aggressive behaviors, and the ongoing methods to promote a safe and secure environment within the premise.

II. SCOPE

The scope of the Security Management Plan is the continuance in providing a safe and secure environment for Parrish HealthCare patients, visitors, and care partners that is accessible. The overall intent of this plan is to establish an efficient and effective program that incorporates the training and development of care partners on de-escalation, the use of technology, and crisis intervention planning. To accomplish our strategy, we will organize a combination of trained Safety and Security personnel as in-house instructors on **MOAB:** Management of Aggressive Behavior, Handcuffing, Oleoresin Capsicum (OC Spray) use, Taser, and P24 Baton, and additional Crisis Intervention training, enhanced emergency technology, closed-circuit television, Human Resource policies and procedures, and prevention training programs. To continue promoting the idea, "See something, say something.) These plans apply to all Parrish Healthcare facilities (JC: EM.12.02.07, NFPA: 13.1.1).

III. DEFINITION:

1. Parrish Medical Center (**PMC**)
2. Parrish Healthcare (**PHC**)
3. Titus Landing **(TL)**
4. Port St. John **(PSJ)**
5. Port Canaveral **(PC)**
6. Joint Commission: **(JC)**
7. Emergency Management **(EM)**
8. Vulnerability Assessment **(VA)**
9. Standard Operating Procedure **(SOP)**
10. Safety/Security Vulnerability Assessment **(SVA)**
11. Officer In Charge **(OIC)**

12. Agency for Health Care Administration: **(AHCA)**
13. National Fire Protection Association: **(NFPA)**
14. **Safe and Secure Environment:** a facility in which care partners have the freedom to pursue their daily activities without fear of politically motivated, persistent, or large-scale violence.
15. **Care Partners:** any person who works for Parrish Medical Center/Parrish Healthcare.
16. Management of Aggressive Behavior (**MOAB**).
17. **In-House Instructors:** Care partners trained and certified to teach a specific topic.
18. Agency For Health Care Administration (**AHCA).**
19. **De-Escalation:** a tactic used to help maintain and control aggressive behavior.
20. **Threat Assessment:** the practice of determining the credibility and seriousness of a potential threat, as well as the probability that the threat will become a reality.
21. **Vulnerability Assessment (VA):** the process of identifying, defining, and classifying vulnerabilities to our facility, training, and the security program through testing (Physically or Desk-Top) or hiring a company that can assess and review the program to help mitigate a proactive VA plan.

IV. 2021 GOALS AND OBJECTIVE PREVIEWS

In 2021, compared to previous Safety and Security Management Plans, we met some of our goals and objectives, while others we could not complete due to the pandemic, the lengthy hiring process, and our limitations based on staffing issues. Our goals and objectives were as follows:

- Ninety percent (90%) of all bags, purses, suitcases, duffels, etc., entering through the Main and ER entrances will have thorough bag checks done before entering the building. This is accomplished by reviewing cameras at each location for a minimum of 4 bags/persons by each officer.
- Loading dock rounds are completed every two (2) hours at a minimum of 90% (11 every 24 hours).
- Ninety percent (90%) of active care partners will receive education on de-escalation techniques by December 31, 2021.

2021 GOALS RESULTS: *Although we did maintain the required security level to protect all who may enter our facilities, due to the COVID-19 pandemic and limited applicants for several open positions* ***we did not meet our goals.***

V. SECURITY MANAGEMENT GOALS AND OBJECTIVES 2022

2022 GOALS

- Ninety percent (90%) of all bags, purses, suitcases, duffels, etc., entering through the Main and ER entrances will have thorough bag checks done before entering the building.

  MEASURED: *Evaluation of officer's work will be conducted via CCTV or through physical observation at each location for a minimum of four (4) bags per officer per month.*

- Rounds within the Loading dock are completed every two (2) hours at a minimum of 90% (12 every 24 hours), to include CCTV observations by dispatchers.

  MEASURED: *As part of the routine patrol procedures, officers will conduct patrols within the loading dock area to report safety concerns, suspicious activities, cleanliness, and unattended packages or items. When officers are not available, our dispatchers will monitor the activities within the loading dock and document any issues or concerns, sending an officer to investigate their findings when necessary.*

2022 OBJECTIVES

1. The objectives for 2022 would be to maintain a higher standard within the Safety and Security operation necessary for the protection of our care partners, patients, and visitors.

2. Our safety and security members' consistent training and development in "Crisis Intervention and De-escalation," Practical and Tactical Handcuffing, Baton, firearm safety, and Taser use under our policies, procedures, and SOP (**EM. 15.01.01**).

3. To define Safety and Security members who qualify to become In-House Instructors on various crisis intervention programs offered within Parrish Medical Center.

4. Having Safety and Security Officers maintain their certification requirements and ensure officers have the knowledge and skills necessary to achieve their safety and security objectives.

5. Assess areas of vulnerability within Parrish Healthcare facilities by utilizing periodic vulnerability audits and notification processes to inform key departments about any hazardous violations or areas of concern that involved life safety.

6. To audit, reorganize, and maintain cohesive access and critical control program and a documentation system geared in maintaining control and accountability within Parrish Medical Center and associated facilities.

7. To continue the practice of auditing areas of vulnerability that requires consistent attention, maintenance, or areas identified as "Soft Target" for criminal activities (Pharmacy, Business Office, Operating Rooms, Emergency Department, etc.).

8. To provide, educate, and train care partners on de-escalating techniques and assess and respond to a possible aggressive behavior before an event. Having Safety and Security officers and care partners trained on mitigating aggressive behavior will empower care partners to manage such events and reduce the risk of harm.

9. To prevent and reduce criminal activities by using "Threat Assessments" and effective collaboration between care partners and Safety and Security personnel in reviewing encounters and creating a safety plan based on the event.

10. The Safety and Security department will collaborate with care partners regarding patient assistance and visitor issues that pose a safety concern to any care partner. Security would conduct a detailed investigation to any report of threats, and when necessary, Safety and Security will notify Titusville Police Department for assistance.

11. To continue the upgrade process of our CCTV system, Communication system, two-way radios, and security equipment.

VI. SAFETY/SECURITY VULNERABILITY ASSESSMENT 2022 (SVA) NFPA 13.2

AHCA requires hospitals in Florida to hire an independent contractor certified to evaluate organizational safety and security measures to determine their vulnerabilities and identify areas that need improvements, or have improved, on an annual basis. PMC Safety and Security contract Phantom Services to determine our proficiency and effectiveness. Phantom Services assesses our security program annually, provides a detailed report with recommendations to mitigate any issues or concerns, defines areas that have improved and reasons for the improvement, and guidance on how to continue operational enhancements.

SEE ATTACHED PHANTOM SERVICES REPORT **(APPENDIX-1)**

VII. SAFETY AND SECURITY LEADERSHIP STRUCTURE (RESPONSIBLE LEADER) NFPA 13.3

Within the Safety and Security Leadership Structure, the Safety and Security Manager is responsible for all security management activities, which consist of policy, awareness, access control, monitoring compliance, strategy, and training development [**NFPA 99 (13.3.1)**; See **Figure 1**

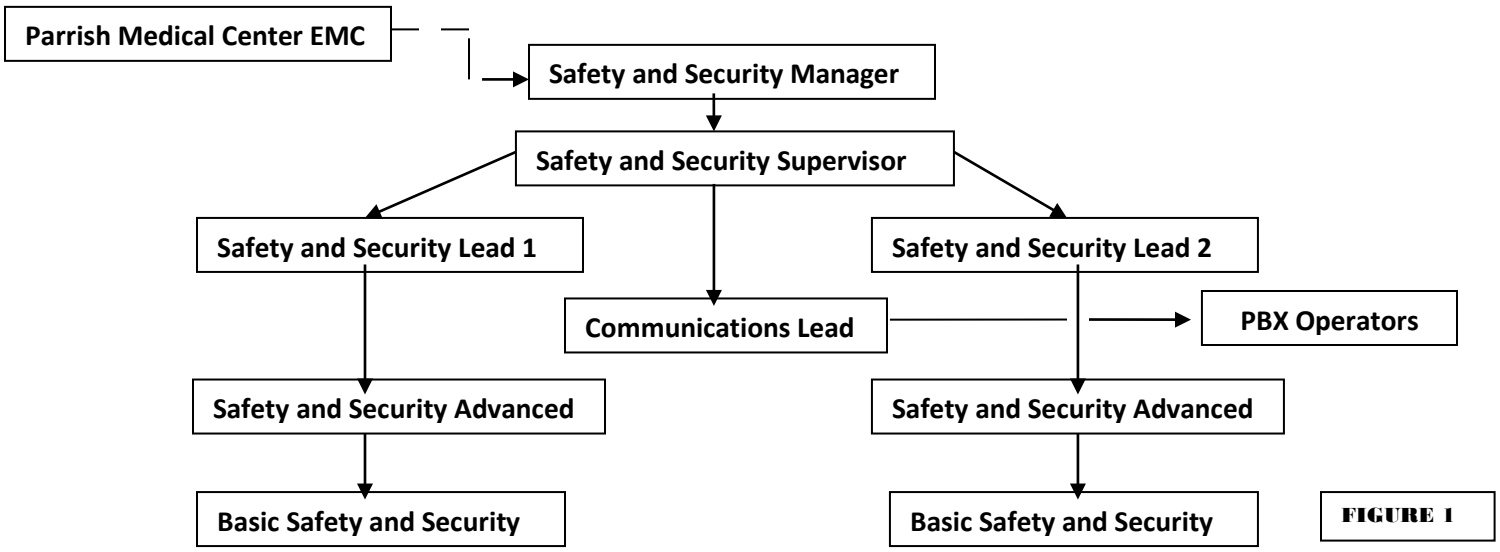


FIGURE 1

VIII. INCIDENT COMMAND SYSTEM

PolicyStat ID: 10046886 governs our Incident Command System readiness plan and our response practices to various events we may encounter. When to active the Incident Command System for event-specific incidents that warrant EMC response and leadership in managing any significant event.

1. **Security Incident**: An event indicating the organization's systems or data may be compromised or that measures put in place to protect them have failed or any attempted or actual unauthorized access, use, disclosure, modification, or destruction of information, including interference with information technology operation and violation of campus policy, laws or regulations [***Department Communication Process, 8800-P028***]

2. **Hostage Situation:** When a person has been abducted or not allowed to leave an area and seized by an abductor to force the victim to comply with their demands, usually under threat of severe physical harm if they do not follow their directions. In this situation, Safety and Security will follow the Code White response policy [***Code White, PolicyStat ID: 4617962***]

3. **Bomb (explosive device or threat):** It is unlawful for any person to make a false report, with intent to deceive, mislead, or otherwise misinform any person, concerning the

placing or planting of any bomb, dynamite, other deadly explosive, or weapon of mass destruction as defined in **Florida Law: S.790.166**; and any person convicted thereof commits a felony of the second degree. Safety and Security response will be to notify care partners of a Code Black event and to determine [***Code Black (PolicyStat ID: 4565719)***]

4. **Criminal threat:** is the criminal act of intentionally or knowingly putting another person in fear of bodily harm or injury [***Code Gray, PolicyStat ID: 7859202; Prevention of Violence in the Workplace, 9500-221***].

5. **Labor action:** In such an event, the activation of the hospital's "Incident Command" would go into effect, and Security would include discussion to determine the safety and security response level [***SAFETY.EP.002.O***] and to consider actions if the situation becomes aggressive or violent, a Code Gray situation (Violent Disturbance) [***PolicyStat ID: 7859202***].

6. **Disorderly conduct:** Any person who recklessly, knowingly, or intentionally engages in fighting or tumultuous conduct, making unreasonable noise, and continues to do so after being asked to stop [***Code Gray, PolicyStat ID: 7859202***].

7. **Workplace violence** (WPV): is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior at the worksite. WPV ranges from threats and verbal abuse to physical assaults and even homicide [***Prevention of Violence in the Workplace, 9500-221***].

8. **Restraining order**: Guidelines as to when it is appropriate to restrain a patient and the right level of restraint to utilize [***Use and Management of Patient Restraint PolicyStat ID: 8785999***]

9. **Prevention of, and response to, infant or pediatric abduction**: Intended to provide security strategies and protocols to support and enhance the protection and Security of our infants and pediatric patients from the act of kidnapping based on Joint Commission and IAHSS security guidelines [***Abduction of Infant/Minor (0-17 Years)-Code Pink, 9500-211***; ***Concierge Code Pink-Infant/Pediatric Abduction*** (***PolicyStat ID: 4010467***)];

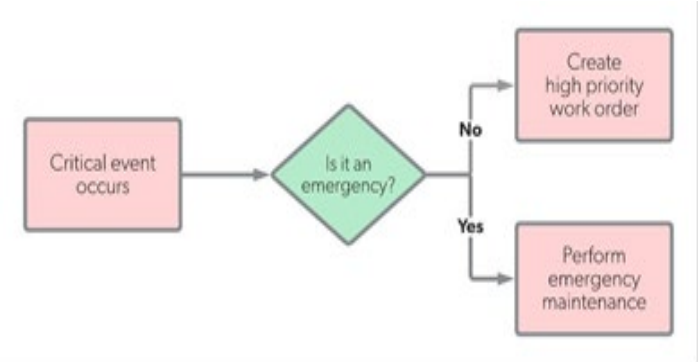
   [https://www.missingkids.org/content/dam/missingkids/pdfs/ForHealthCareProfessionals_10thEdition.pdf**]**

10. **Situations involving VIPs or the media**: The protection of patient privacy is critical when dealing with any patient, but more so for patients considered as "VIP." It is the healthcare's responsibility to ensure the confidentiality of such patients' is not compromised, including but not limited to health information or photos. The Safety and Security Department is committed to all patients, visitors, and care partners do not

experience any privacy breach, per the HIPAA Privacy Rule [***Consumer Generated Media (CGM) and Social Media Guidelines, PolicyStat ID: 4921652; Protected Health Information Safeguards on Nursing Units, 20.1.10***].

11. **Maintenance of access to emergency areas (Emergency Management):** This is the process of evaluating vulnerabilities of sensitive areas. Immediate care is necessary when lives, property, or assets harm the hospital's operation. The EM is applied to keep a facility safe and operational and protect the health and safety of our patients, care partners, and vendors.

Emergency maintenance workflow FIGURE:2



12. **Civil disturbance (Disorder):** A civil disorder occurs when three or more people violently or intimidators cause property damage or injury to others. In such a situation, Safety and Security will immediately call for a Code Yellow response (Hospital Lock-down) [***SAFETY.EP.002.O***] to a Code Gray situation (Violent Disturbance) [***PolicyStat ID: 7859202***].

13. **Forensic patients:** A forensic patient is a patient who may have displayed behaviors that are abnormal or unacceptable by society and may need medical or mental health treatment (i.e., Altered Mental Status). The Attending Physician would evaluate and decide if the patient is a danger to themselves or others. There may be a need to restrict the patient for further medical and psychiatric evaluation and treatment (BAKER/MARCHMAN ACT). [***Use and Management of Patient Restraint PolicyStat ID: 8785999***]

14. **Patient Elopement:** a patient who has decided to leave the hospital when the medical who may present as an imminent threat to the patient's health or their safety, or based on the patient deemed as severely ill or impaired to make a rational decision, but does not meet the criteria necessary to be considered as a "Baker Act" patient, and levels the unit. One Safety and Security Officer would respond to the floor and obtain a complete description of the patient, direction of travel, and any other pertinent information to Safety and Security Officers on duty. Contingent

to the Attending Doctor's orders, Safety and Security would contact the patient to convince the patient to return (verbal de-escalation.

15. **Homeland Security Advisory System (threat level changes):** This system was initially a color-coded terrorist threat advisory scale that triggered specific actions by the federal, state, and local governments, which affected the security level of public, municipal facilities, and transportation (i.e., airports and public transit). On April 27, 2011, the system is now called the National Terrorism Advisory System (NTAS). The system consists of four levels: **Red** (Top-down) ***SEVERE RISK OF TERRORIST ATTACK***; **Gold** (Second-down) ***HIGH RISK OF TERRORIST ATTACKS***; **Light Blue:** (Third-down) ***GENERAL RISK OF TERRORIST ATTACK***; Green (Bottom of the scale) ***LOW RISK OF TERRORIST ATTACK***. with red as the most serious and located at the top of the scale, and green defined as the lowest level, and located at the bottom of the scale.

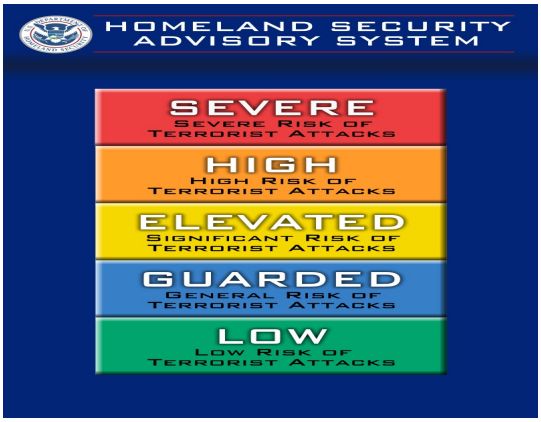


FIGURE: 3

16. **Suspicious powder or substance:** The procedures contained within policy: 9500-4014, Hazardous Materials and Waste Management Plan, is the guidance for responding to an event involving suspicious substances which may pose a public health and safety threat. A response to a suspicious substance is fluid, and procedures may need to be changed to fit the incident and appropriate response.

17. **Use of Force Policy:** Parrish Healthcare is dedicated to "Causing no further harm," which provides guidelines regarding "reasonable use of force." When attempting to defuse a physically violent situation, there is no way to specify the amount of reasonable force applied in every case. Safety and Security dedicated to following the guidelines provided on ***PolicyStat ID: 8384883*** [*Crisis Intervention and De-Escalating Levels*], designed to help make professional, impartial, and reasonable decisions regarding methods and levels defuse a situation.

18. **Security staff augmentation:** Promptly address specific weaknesses, vulnerabilities, or complete Safety and Security project or testing. Security staff augmentation involves close collaboration between other departments, outside agencies, and our contracted security advisory team (Phantom Services).

X. PERFORMANCE MONITORING 2022

Performance measurements monitor the actual and potential risks concerning the following issues:

1. Care Partners knowledge and skill set when dealing with violent or aggressive encounters with confidence.

2. We will continue monitoring and inspecting sensitive areas, avoiding vulnerabilities, and reviewing and evaluating emergency and incident reports to determine the best case practices.

3. Review and evaluate emergencies and incident reports to measure the frequency and severity of such events and develop best practice measures.

NOTE: *When we compare the Performance Monitoring and Performance Indicators for 2021, there are elements in the Performance Indicator that we could not achieve because of the Covid crisis and CDC guidelines, but working to adapt those indicators to our 2022 plan.*

XI. PERFORMANCE INDICATORS 2022

1. Phantom Services reviews overall departmental operations compared to policies and procedures as an independent safety and security contractor. In addition, our department leadership conducts a periodical audit of our process, reviews our department's training and staff levels, and evaluates our department's policies, procedures, and protocols as to our physical security improvement and any additional needs for improvement. These audits and reviews are then analyzed to determine any deficiencies and to adjust our daily operation and program to meet Joint Commission and AHCA security standards (EM.12.02.07).

2. To continue maintaining and updating our patrol procedures based on the daily operational needs, which incorporates physical assessment and technology to prevent unauthorized access or bringing into our facility any items that we identify as "Contraband."

3. Safety and Security constantly monitors and inspection sensitive areas of vulnerabilities a minimum of four (4) times, per officer, per shift.

4. Safety and Security conduct routine checks of all bags, purses, suitcases, duffle bags, etc. at a minimum of ninety (90%) percent for the following locations: Parrish Medical Center's Main Campus and the Emergency Triage entrances, in addition to Titus Landing and Port St. John main entrance.

5. Consistent review and evaluate our department incident reports to determine the best case practices and how we can improve our response by assessment and care partner's prevention education, i.e., Debriefing, Management of Aggressive Behavior.

6. Safety and Security participate in weekly surveillance rounds and EOC meetings to review and constantly re-evaluate our Hospital's Emergency Management Program and Security Management Program to ensure and assist the readiness of the hospital at all times (EM.09.01.01).

7. To participate and assist in disaster recovery physically and when necessary with technology (EM.14.01.01).

XII. PERIMETER PROTECTION 2022

1. The first line of defense for physical Security is perimeter protection. Reviewing the threat assessment of the facility and the risk management strategy determines the need for perimeter protection in the security management plan. Perimeter security varies from simple signage to more sophisticated high-level perimeter configurations involving multiple barriers with numerous detection systems, permanent surveillance, and continuous patrols.

2. Physical barriers will discourage an undetermined intruder but only delay a determined person, which requires a combination of other security controls for an integrated security solution.

XIII. SENSITIVE AREAS 2022

Parrish Medical Center is equipped with state-of-the-art Security cameras, working on advanced access control systems, and recently updated our infant system to provide a secure environment. These systems are monitored at all times by Communications Center staff in direct radio contact with Security Officers.

1. **Pharmacy** – Updating Pharmacy's bio-reader to a better Security locking system that will restrict access to pharmacy staff only, in addition to installing new cameras that will help provide additional security measures.

2. **Emergency Department** – Security devices control entry to the Emergency Treatment area from the patient waiting and triage rooms. The Communications Center staff monitors cameras within the site. Access control to the unit is limited to those identified as "essential care partners" who may need access to the Emergency Department. The inner core of the Emergency Department can be locked down with one button activation by Communications. A Security Officer will be posted in the Emergency Department when possible, and patrols will frequently be daily**.**

3. **Nursery** – Installed the new electronic infant protection system to prevent infant abductions.

    a. Care partners conduct a daily test to endure its integrity and function.

    b. Care partners (Nursing Staff) manage the Nursery and the access control to the unit. Each newborn child is issued a tracking device. When the tracker reaches the red zones, this triggers an automatically locked down of the department, with audible alarms and visual strobes, preventing a possible infant abduction.

    c. An updated camera system has been installed and constantly monitored, in addition to Code Pink drills.

4. **Health Information Services**- Care partners control HIS during the day and locked during non-working hours with high Security locking devices, but monitored by camera surveillance**.**

5. **Information Systems** – This is controlled and managed through Halifax and IT Security.

XIV. Emergency Security Procedures 2022

1. Educate care partner responsibility in response to a drill (Code Gray, Black, Pink, etc.), contained in the Incident Command policy (Parrish Healthcare Incident Command System, **PolicyStat 10046886, pg. 3-6**).
2. The Emergency Management Plan and the Crisis Emergency Management Plan are where you can find information and instructions for dealing with VIP and media events.

    a) Lockdown procedure of facility includes the ability to secure all ED entrances or all entrances in the entire facility. All emergency codes include lockdown procedures designed to preserve the integrity of the building within the department emergency plans.

    b) Lockdown procedure solely for the Emergency Department access ways and entrances based on the safety factors about an incoming patient who was a victim of violence, and where retaliation might be a factor.

XV. VEHICLE ACCESS TO EMERGENCY DEPARTMENT 2022

The driveway to the ambulance entrance is a posted area restricting access to emergency service vehicles only. The walk-in is a "**No Parking/Loading and Unloading of Passengers Only**." Cameras monitored this location and patrolled frequently.

XVI. SECURITY EQUIPMENT 2022

1. ***Basic Security Equipment***: Safety and Security Officers undergo extensive training and re-training on the issued equipment. Some of the essential standard equipment issued is as follows:

a. Two (2) Basic Uniform Shirts (Black/Gray) with a U.S. Flag patch and Security Department patch.

b. Two (2) Black Tactical bloused trousers

c. One (1) black baseball cap, a black duty belt with primary non-tactical attachments, and one (1) Ballistic Vest (***Vest needs to be upgraded due to age***).

NOTE: *The Safety and Security Officers are responsible for buying their footgear (Black without any other colors or logos), black socks, and black t-shirt, and required to adhere to hospital policies about the dress code* (Dress Code, 8800-004, **PolicyStat:** 7859191).

2. ***Protective Equipment:*** Protective equipment is issued based on training and certifications. The equipment issued will be as follows:

a. One (1) Hand-cuff and carry case

b. One (1) OC Pepper Spray and carry case

c. One (1) P24 Baton and carry holster

d. One (1) glove case

e. One (1) Tourniquet and carry case

f. One (1) Taser and holster

XVII. EMPLOYMENT PRACTICES 2022

Under the laws enforced by EEOC, it is illegal to discriminate against someone (applicant or employee) because of that person's race, color, religion, sex (including gender identity, sexual orientation, and pregnancy), national origin, age (40 or older), disability or genetic information. It is also illegal to retaliate against a person because they complained about discrimination, filed a charge of discrimination, or participated in an employment discrimination investigation or lawsuit. The law forbids discrimination in every aspect of employment.

1. All newly hired Safety and Security Officers who attend the general Human Resource orientation understand their responsibilities within the hospital. However, throughout their ninety-day probation, Safety and Security continue their training and education

through the NET LEARNING system, printed materials, and physical classroom training by certified in-house instructors.

2. Care Partners receive a yearly update during their mandatory training. The Education Department provides this training in collaboration with the Manager, Safety and Security. Care Partners receive training that includes:

    a) Security risks and hazards

    b) General security measures (**Security Management Plan: SMP**)

    c) Emergency security procedures

    d) Active Shooter/Bomb Threat training (**CODE SILVER/BLACK**)

    e) Reporting of security issues

    f) Identification and access control procedures

    g) Emergency Management Plans (**EMP**)

    h) Establish a Hospital emergency response team (**HERT**)

    i) **Drills:** Code Red, Code Pink, Code Yellow, Code Black, Code White

    j) **Haz-Mat** situations

    k) **IAHSS** certifications

XVIII. SECURITY OPERATION 2022

1. Through various forms of communications, the Safety and Security Manager is made aware of safety and security concerns regarding patients, visitors, care partners, and property brought to the Security Manager's attention. Security policies, security post instructions, and other procedures address specific patient, personnel, and property security. Safet and Security respond to all calls regarding eloped patients and proactively assist in the search. Safety and Security will advise the reporting party of the patient's whereabouts.
2. Once we find an elope patient, Safety and Security will require instructions from the nursing staff to determine the next step. Safety and Security will make a reasonable effort to encourage the patient to return to the unit.
3. If the eloped patient appears to have an altered mental status, Safety and Security will make every effort to maintain the patient within the areas. Still, they will require the approval of the Attending Doctor to bring the patient back to the floor physically.
4. Safety and Security have categorized incident reporting in three parts:

a. ***None Reportable Events*:** Events that can be resolved immediately and do not potentially impact our daily operation (Example: Security discovered a cracked tile.

b. ***Reportable*:** Events involve events that can disrupt our daily operation (Example: criminal events, environmental events, or events that threaten hospital safety and Security of hospital).

5. **RL Resource Solution:** Our in-house reporting system allows care partners to report violations, concerns, and issues that must be peer-reviewed and resolved. Risk Management conducts the reviews and provides instruction as to the next step.
6. **The CAD System**: the department's computer-aided dispatch software helps organize our investigative reports and provides variance reports and data that helps to identify areas of concern. The Safety and Security Manager, Security Supervisor, or Safety Officer reviews these reports and recommends appropriate action and follow-up.
7. **Identification Procedures**

a. ***Visitor Identification*** -access to the hospital is controlled and monitored by the Safety and Security Department. A Visitor Pass is required and displayed at all times.

b. ***Care Partner Identification* –** Care Partners, volunteers, and physicians are issued photo identification badges. These badges are displayed at all times while on duty or in restricted areas.

c. ***Patient Identification*** - a wristband is fitted to the patient at admission, which helps identify patients.

d. ***Vendor Identification* -** Vendors are required to sign in and are issued a vendor badge to be worn at all times while on hospital premises.

e. ***Contractor Identification*** – All sub-contractors and workers are issued a PMC Identification Badge and are required to display them while on-premises. Unless they comply with our identification policy, service contractors who refuse to wear their badges appropriately cannot work within the premises.

XIX. PROGRAM EVALUATION 2022

Annually the Security Management Plan is peer-reviewed and evaluated. The overall program's objectives, scope, performance, and effectiveness are assessed, including care partner knowledge and skills, monitoring and inspection activity, emergency procedures and incident reporting, level of care partner participation, inspection, preventive maintenance, and equipment testing.

XX. SUMMARY (2021 v. 2022)

The Parrish Medical Center Safety and Security management plan provides a framework that incorporates all other organizational security functions. The security management plan organizes our program and helps maintain operational effectiveness internally and externally through security methodology. The Security Management Plan provides an overall process that integrates our security department's diverse tasks by systematically providing defined inputs, security transformation in various functions, and measurable outputs or deliverables. Inputs include tactical and strategic direction, leadership, governance, accountability, ethics, culture, and resilience. Transformations are the many functions of Security, such as risk management, business continuity, personnel, physical, and technology security. To enhance our safety and security plan, we systematically compare our 2021 performance and indicators to what we are looking to achieve in 2022 and determine the best practices necessary to achieve our 2022 goals through personal, technology, and processes (policies). In addition, many of the goals and objectives also include more general business and management functions, such as finance, budgeting, and performance management. The security management plan has been designed, operated, and managed within our organizational culture and considering our mission, vision, and values by utilizing a strategic security framework approach, meeting the organization's working environment.

XXI. APPENDIX

Abduction of Infant/Minor (0-17 Years)—Code Pink, 9500-211, **PolicyState ID:** 5159697

Code Black, **PolicyStat ID:** 4565719

Code White, **PolicyStat ID:** 4617962

Consumer Generated Media (CGM) and Social Media Guidelines, **PolicyStat ID:** 10608205

Crisis Intervention and De-Escalating Levels, **PolicyStat ID:** 8384883

Handling of Patients under Custody of Law Enforcement Agency, 116**, PolicyStat ID:** 6783582

Incident Command Structure (**HICS 207**) Chart

Parrish Healthcare Functional Organization Chart

Phantom Services Safety and Security Assessment.

Security Management Plan, 8800-009, **PolicyStat ID:** 5260850

Use and Management of Patient Restraints, **PolicyStat ID:** 8785999

UTILITIES MANAGEMENT PLAN

2022

MISSION:
The Utilities Management Plan of Parrish Healthcare provides for a safe, controlled, and comfortable environment of care by provision and maintenance of adequate and appropriate utility services and infrastructure and plans to continue in operation during partial or complete system failure.

SCOPE:
This Utilities Management Plan pertains to the activities of the hospital and off-site licensed locations:

The utility systems addressed by this plan include:

- Electrical distribution
- Emergency power
- Vertical and horizontal transport
- Heating, ventilating, air conditioning (HVAC), and refrigeration
- Plumbing
- Boiler and steam
- Piped medical gas and vacuum systems, including waste anesthetic gas disposal
- Communication systems
- Data exchange systems

Facilities/Maintenance personnel are either on site or on call on all shifts.

The hospital does not utilize an Alternative Equipment Maintenance (AEM) strategy for utilities equipment.

At a minimum, the hospital utilizes the manufacturers recommended standards or the ASHE Maintenance Management for Health Care Facilities plans (where manufacturers guidelines are not available).

The hospital adopts and will comply with the NFPA Life Safety Code 101, 2012 Edition and the NFPA 99, 2012 Edition, effective as of July 5, 2016.

RESPONSIBILITY:
The Director of Facilities is responsible for the implementation and maintenance of this Utilities Management Plan. He/she is appointed Safety Officer by the hospital President/CEO and is a member of the Environment of Care (EOC) Committee. The Facility Director is responsible for identifying and providing regular status reports outlining facility and life safety conditions that need an action plan for repair or replacement. As the Safety Officer, the Facilities Director is responsible for/oversees the coordination of the six functional areas of the Physical Environment of Care and Emergency Management.

Those responsible for telecommunications management are responsible for telephone, wireless, cellular, and data communications systems. Department Directors are responsible for development, provision, and documentation of department and job-specific utilities training, and maintenance of policies, procedures, and plans affecting their area(s) of responsibility.

Each individual member of the work force is responsible for maintaining current knowledge of hospital policies and procedures for utilities and to be familiar with any specific utilities emergency procedures for their work area.

GOALS AND PERFORMANCE MANAGEMENT:

- The hospital will reduce downtime due to waste water system failures by 10% from last year's data. The results will be monitored and documented through our CMMS system monthly through 12-31-2022.

- The hospital will reduce downtime due to elevator failures by 10% from last year's data. The results will be monitored and documented through 12-31-2022.

ELEMENTS OF THIS PLAN INCLUDE:

Written Management Plan
The hospital has developed and implemented this Utilities Management Plan in compliance with all regulatory requirements to describe the processes involved with this function and to manage the safe, effective, and reliable operation of all utility systems.

Design and Installation
In accordance with the purpose and objectives of this plan, the hospital provides for utility systems that are designed and installed to meet patient care and operational needs. Building systems are designed to meet the National Fire Protection Association's Categories 1–4 requirements. An NFPA 99-2012: Chapter 4 risk assessment for existing and new is completed. (For full text, refer to NFPA 99-2012: Chapter 4 for descriptions of the four categories related to gas, vacuum, electrical systems, and electrical equipment).

Inventory Inclusion
All utility systems components are included in the utility systems management program. Utility components are listed in the inventory, which is separated into high-risk, infection control, and non-high-risk components for calculation of maintenance completion rates.

Utility Systems Maintenance
Maintenance of utility components is included in the hospital's work order program. Maintenance strategies include:

- Preventative Maintenance (PM): The scheduled activities designed to extend equipment reliability based on performing activities prior to equipment failure based on manufacturer's recommendations, risk levels and organization experience

- Interval Based Maintenance: The scheduled activities are based on a preset schedule that is established regardless of need
- Determine Interval Time: Manufacturer's guidelines, accepted industry practices, internal risk assessments, regulatory code requirements and the organization's past experiences
- Corrective Maintenance (CM): Unscheduled activities are undertaken as the result of a component failure or a reported or measured degradation in performance
- Predictive Maintenance: Used to help determine the condition of in-service equipment in order to predict when maintenance or repairs should be performed. By using predictive strategies, it allows convenient scheduling of corrective maintenance, and helps prevent unexpected equipment failures.

The following equipment is maintained on a predictive maintenance strategy:

- Electrical components – thermal scan

Hospital will achieve 100% completion rate for critical equipment.

Maintenance intervals for the utility components are maintained, documented and controlled in the hospital maintenance work order system. Documented procedures are available in the Facilities offices for all maintenance, testing, and inspection activities, as well as in the hospital's maintenance work order system to be printed on all work orders.

Emergency Procedures

The hospital maintains emergency procedures to be used in the event of utility systems disruption or failure, as well as alternate sources of essential utilities.

For all systems, the extent of the utility failure is evaluated, affected areas are identified, and workforce members are notified prior to any planned shutoff and again when the system is functional. Interim Life Safety Measures (ILSM) are conducted for life safety deficiencies or utility risk assessment are completed when warranted.

Piped oxygen and medical gas may only be shut off in an emergency Charge Nurse or Designee. Clinical interventions are unique and dependent upon each type of utility system failure and the clinical situation.

Repair services for utility systems are obtained by submitting work orders to the Facilities Department. Urgent requests are handled by submitting high priority request and contacting House Supervisor at ext 6666.

The hospital's procedures address performing emergency clinical interventions during utility system disruptions.

Mapping Distribution & Labeling Controls
Current technical drawings of utility systems are maintained in the facility department. These include the controls for partial or complete emergency shutdown. Maintenance workforce members are trained to know where emergency shutoff controls are located and what areas they serve.

The fire alarm system's circuit is clearly labeled as Fire Alarm Circuit. The circuit breaker is marked in red and access is restricted to authorized personnel. Information regarding the dedicated branch circuit is clearly marked in the fire alarm panel.

Waterborne Pathogens
The hospital minimizes pathogenic biological agents in cooling towers, domestic hot- and cold-water systems, and other aerosolizing water systems.

To manage pathogenic biological agents in cooling towers, the hospital implements a water treatment program to minimize:

- Sediment and deposition of airborne solids on heat transfer surfaces
- Scale
- Corrosion
- Microbial growth

Organic and inorganic inhibitors are used to chemically control sediment, scale, and corrosion, and maintain appropriate pH. A broad-spectrum biocide is used to kill and control bacteria. In addition, the system is inspected routinely and flushed and washed out at least annually.

The Infection Prevention/Control Practitioner will advise the EOC Committee of either a suspected or confirmed case of nosocomial illness from waterborne pathogens when identified. If an outbreak related to the water systems was to occur, it would be managed by the Facilities Department working in conjunction with Infection Prevention/Control. Water sampling may be initiated at that time. The causative agent would be identified, as well as the contributing portion of the domestic hot water system, through appropriate tests and selective culturing of the system.

Hot water in the domestic water system is delivered at a maximum temperature of 120^{o}F. This water temperature serves to minimize pathogens in the system as well as minimize the risk of scalding. Abandoned piping and dead legs are removed when discovered to further reduce pathogens.

Cold water systems can grow bacteria when the temperature exceeds 67°F and becomes stagnant. Insulating pipes, installation of automatic drain devices and recirculation can minimize growth.

Seldom used hot and cold-water lines in faucets, showers, flush sinks, emergency eyewash and safety shower units need to be routinely flushed to prevent stagnation.

Boilers are tested and treated weekly for pH, P alkalinity, M alkalinity, chlorides, hardness, phosphate, sulfite, and hydrates. An oxygen scavenging agent is used to keep the boilers cleaned in warmer weather. Closed loop systems are similarly tested at a quarterly interval.

Airborne Contaminants
Appropriate maintenance of the heating, ventilation, and air conditioning systems is critical to the control of airborne contaminants. Maintenance of the appropriate pressure relationships, air exchange rates, and filtration efficiencies is part of this process.

While important throughout the facilities, particular attention is paid to those areas where patients may be more susceptible to these contaminants due to the nature of their illness or procedure performed or in areas where certain equipment is processed or stored.

These areas include, but are not limited to:

- Operating Rooms
- Special Procedure Rooms, including Caesarean Section rooms, Catheterization Labs, Interventional Labs, Endoscopy Rooms, Bronchoscopy Procedures rooms.
- Airborne Infectious Isolation Rooms
- Laboratories
- Pharmacy
- Sterile Supply Rooms
- Central Sterile Processing (clean and dirty)
- Clean Supply rooms
- Soiled Utility Rooms

Maintenance of these systems is tracked and documented through the electronic work order system.

Air exchanges in these areas are measured at least annually and pressure gradients in these areas are checked at intervals set by the EOC Committee. Pressure gradients in isolation rooms are checked at intervals set by the EOC Committee when there is an isolation patient in the room. The building air balance and proper exchange ratios are maintained by a combination exhaust fan/damper control system. Operating rooms, Catheterization Labs, Special Procedure Rooms, Central Sterile Processing Endoscopy Procedure Rooms, and Sterile Storage are maintained at temperature and humidity ranges and are monitored at intervals set by the EOC Committees

Parrish Healthcare use the FGI Guideline to maintain compliance, we manage to the year each facility was designed and built. Temperature and/or humidity requirements can change for products used or stored in identified rooms and risk assessments are conducted for those areas. The guidelines in use for each area are identified on the testing documentation. A link to the current adoption of edition guidelines by state can be found at the following website:
https://www.fgiguidelines.org/guidelines/state-adoption-fgi-guidelines/

Emergency Power Source
For facilities that were constructed, or had a change in occupancy type, or have undergone an electrical system upgrade since 1983, the hospital has a Type 1 or Type 3 essential electrical system in accordance with NFPA 99, 2012 edition. This essential electrical system must be divided into three

branches, including the life safety branch, critical branch, and equipment branch. Both the life safety branch and the critical branch are kept independent of all other wiring and equipment, and they transfer within 10 seconds of electrical interruption. Each branch has at least one automatic transfer switch.

3 emergency electrical generators are available on site to provide emergency electrical power to the hospital during a time of commercial power interruption. The hospital provides emergency power within 10 seconds for the following:

- Alarm systems
- Exit route and exit sign illumination
- New buildings equipped with or requiring the use of life support systems (electromechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99
- Emergency communication systems
- Equipment that could cause patient harm when it fails, including life-support systems; blood, bone, and tissue storage systems; medical air compressors; and medical and surgical vacuum systems
- Areas in which loss of power could result in patient harm, including intensive care, emergency rooms, operating rooms, recovery rooms, obstetrical delivery rooms, and nurseries
- Emergency lighting at emergency generator locations

The hospital's emergency power system (EPS) has a remote manual stop station (with identifying label) to prevent inadvertent or unintentional operation. A remote annunciator (powered by storage battery) is located outside the EPS location. The hospital has a policy to provide emergency backup for essential medication dispensing equipment identified by the hospital, such as automatic dispensing cabinets, medication carousels, and central medication robots. The hospital implements a policy to provide emergency backup for essential refrigeration for medications identified by the hospital, such as designated refrigerators and freezers. The hospital provides emergency power for elevators selected to provide service to patients during interruption of normal power (at least one for non-ambulatory patients).

Battery-powered emergency lighting is provided in areas where deep sedation is administered.

Level 1 or Level 2 emergency generator and transfer switch locations shall be equipped with battery-powered emergency lighting.

The emergency power supply system's equipment and environment are maintained per manufacturers' recommendations, including ambient temperature of not less than 40°F; ventilation supply and exhaust; and water jacket temperature (when required).

Maintenance, Testing, and Inspection
Utility Component Equipment Inventories Risk are stratified by High Risk (life support, infection control) and Non-High Risk.

Maintenance, testing, and inspection of all utility components are documented through the electronic work order system. Utility components are categorized on the inventory as High Risk (life support), High Risk (Infection Control), and Non-High Risk. Preventive maintenance of components designated as High Risk (life support) and (Infection Control) and (Non-High Risk) are done at a 100% completion rate.

Dates and results of all testing are documented. If testing fails, repairs are made, and the systems are retested.

Line Isolation Monitors (LIM)
Line Isolation Monitors (LIM) are tested at least monthly by actuating the LIM test switch per NFPA 99-2012, which activates both visual and audible alarms. For LIM circuits with automated self-testing, a manual test is performed at least annually. LIM circuits are tested per NFPA 99-2012 after any repair or renovation to the electrical distribution system. Records are maintained of required tests and associated repairs or modifications containing date, room or area tested and results.

Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment authorized by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection.

Emergency Power Maintenance and Testing
Emergency generators, including all components and batteries, are inspected weekly per NFPA 110-2010. Maintenance, testing, and inspection of the emergency generators are done monthly according to the requirements of NFPA 99-2012. All generators are exercised under load and operating temperature conditions at least monthly for a minimum of 30 continuous minutes. The generators are loaded to at least 30% of the nameplate rating.

At the time of the monthly generator test, all automatic transfer switches are also tested and documented. The transfer switch used to start the generator for that month's test is also documented.

If a generator does not meet 30% of the nameplate rating during any test, then it must be tested once every 12 months using supplemental (dynamic or static) loads of 50% of the nameplate rating for 30 minutes, followed by 75% of the nameplate rating for 60 minutes for a total of 1.5 continuous hours.

At least annually the generator fuel quality is tested to the American Society for Testing and Materials (ASTM) standards, and test results and completion dates are documented.

At least every 36 months, each diesel-powered emergency generator is tested for a minimum of four continuous hours, with a dynamic or static load that is at least 30% of the nameplate rating,

documenting the test results and completion dates. Tests for non-diesel-powered generators need only be conducted with available load. See NFPA 110-2010 for additional guidance.

Battery powered egress lighting is tested monthly for 30 seconds and annually for 90 minutes. All records are maintained in the Facility Department.

There are not SEPSS (Stored Emergency Power Supply System) in use at the Parrish Health Care Facilities. If there were, A functional test of Level 1 SEPSS is performed on a monthly basis and Level 2 SEPSS on a quarterly basis. Test duration is for 5 minutes or as specified for its class (whichever is less). An annual test at full load for 60% of the full duration of its class is performed and test results and completion dates are documented.

If any testing fails, ILSM is assessed and implemented as required by assessment, repairs are made, and the systems are retested.

Medical Gas

Annual inspections, testing, and maintenance of the critical components of piped medical gas and vacuum systems is conducted by an outside contractor according to established protocol and procedure. These activities and results are documented.

Critical components of this testing and maintenance for piped medical gas systems include:

- Source
- Distribution
- Inlets/Outlets
- Master signal panels
- Area alarms
- Automatic pressure switches
- Shutoff valves
- Flexible connectors
- Outlets

When piped medical gas and/or vacuum systems are installed, modified, or repaired, they are tested for cross-connections, piping purity, and pressure. The test results and completion dates are documented. All medical gas piping and verification work is in accordance with the requirements set forth in the 2012 edition NFPA 99 for appropriately certified personnel.

The Facilities Director, Nurse Supervisor or designee in conjunction with Respiratory, is authorized to shut off the medical gas emergency shutoff valves.

Medical gas storage rooms and transfer and manifold rooms comply with NFPA 99-2012.

Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101-2012 and NFPA 99-2012.

Pre-Construction Risk Assessment
The hospital uses a system of a pre-construction risk assessment throughout all projects involving construction, renovation, or demolition. This process is documented on the Pre-Construction Risk Assessment form.

Key individuals involved in this team process (as applicable based on the scope of the project) include:

- Senior Leadership/Administration
- Safety Officer
- Facility Project Manager
- Infection Control Practitioner
- Environmental Services
- Nursing Staff
- Medical Staff
- Architect
- Engineer
- Contractor

For each project, a risk assessment matrix is completed to ensure evaluation of its impact on patient care, based on the type of project and the impacted patient population. Attention is focused on the effect that the proposed activities will have on:

- Air quality
- Infection control
- Utilities
- Noise
- Vibration
- Other hazards that affect care, treatment and services
- Emergency procedures

Controls are implemented and periodically verified over the course of the construction project as appropriate to the outcome of the assessment and/or Feasibility Analysis if one was commissioned.

Hospital Grade Receptacles
Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered are tested after initial installation, replacement, or servicing.

- In pediatric locations, receptacles in patient rooms (other than nurseries), bathrooms, play rooms, and activity rooms are listed tamper resistant or have a listed cover.
- Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking.

Power Strips and Extension Cords
Power strips in a patient care vicinity are only used for components of movable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL

1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363. Power strips are mounted

Extension cords are not used as a substitute for fixed wiring in a building. Extension cords used temporarily are removed immediately upon completion of the intended purpose.

Reporting Process
Any major deficiency, problem, or failure in a utility system will be reported by the observer to the Facilities Department by submitting work request and notifying House Supervisor at ex. 6666 for investigation and determination of appropriate action. The hospital Safety Officer will take immediate and appropriate actions as necessary and make all site and corporate leadership notifications. Repair is accomplished through maintenance work orders. The EOC/PEOC Committee will review serious issues and make appropriate recommendations to hospital leadership.

Annual Evaluation
There will be an annual evaluation of this Utilities Management Plan in terms of its objectives, scope, performance, and effectiveness. This annual evaluation will be completed by the Director of Facilities during the first quarter of the calendar year and reviewed by the EOC Committee. It will be forwarded to the Board of Directors of the hospital.

Orientation and Education
Members of the hospital workforce participate in a new hire orientation and education program that includes:

<u>USERS</u>

- Reporting procedures for problems, failures, and user errors
- Emergency procedures to follow in the event of a system failure
- Location and use of medical gas emergency shutoff controls
- Who to contact in emergencies?

<u>MAINTAINERS</u>

- Knowledge and skill necessary to perform maintenance responsibilities
- Processes for reporting utility systems problems, failures, and user errors
- Location and use of emergency shutoff controls
- Who to contact in emergencies

New members of the workforce receive utilities training as part of the general new hire and departmental orientation. All members of the work force receive utilities training during annual mandatory education on Steward University.

Training records are kept in the Human Resources Department.

Orientation and education on environment of care issues for medical staff members and LIPs is accomplished through the following:

- House staff participation in hospital new hire orientation
- Safety issues are communicated to medical staff members and LIP's through e-mail and organizational publications

Approval Required by EOC Committee

Date: _____

_____

Signature
EOC Committee Chairperson

WORKER SAFETY MANAGEMENT PLAN 2022

Jean Hallett, COHN, Employee Health

I PURPOSE

The Worker Safety Management plan is based on the mission, vision, and values of Parrish Health Care (PHC) and is designed, taught, implememted, measured, assessed for effectiveness, changed and improved to provide a physical environment free of hazards and to decrease the risk of worker injuries.
Consistent with PHC's mission, the governing body in conjunction with the medical staff and administration have established and provide ongoing support for Worker Safety.

II SCOPE

The Worker Safety Management Plan describes the programs used to design, implement and monitor a program to manage safety for all care partners.

This program is applied to all Parrish Health Care and PHC personnel and facilitates.

III FUNDAMENTALS

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

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

Regularly evaluate the environment for work practices and hazards to maintain a current relevant safety program. The program changes as needed to respond to identified risks, hazards and regulatory compliance issues.

IV OBJECTIVES

A. Minimize safety hazards by conducting Safety Surveillance Inspections.

B. Assure worker safety through education, which includes but is not limited to: general safety topics covered at employee orientation, body mechanics, lifting techniques, safe patient handling with use of equipment, and Standard Precautions for infection control. Department specific safety issues and specific job related hazards are covered in department specific employee orientation.

C. Improve worker safety based on organization experience, applicable laws and regulations, as well as accepted best practice. This includes monitoring the

employee occupational health program and implementing a worker injury prevention and investigation program.

V ORGANIZATION AND RESPONSIBILITY

A. It is the responsibility of the Employee Health Nurse and the Safety Officer, to monitor the effectiveness of the Worker Safety program, in line with organizational experience, applicable laws and regulations and accepted best practices. The Employee Health Nurse responsibilities also include maintaining a safe physical environment, reducing the risk of worker injuries during staff activities, monitoring the employee health program and reviewing departmental safety policies and procedures as requested, as well as maintaining an injury prevention and investigation program. The online employee incident form, which is found under "incident Reporting on the organization's intranet page, demands more details of the incident and managers are automatically notified and investigate each employee incident along with the Employee Health Nurse.

B. The objectives, scope, performance and effectiveness of the plan are reviewed annually by the Environment of Care Committee EOCC.

C. The PHC Board of Directors (Board) receives regular reports of the activities of the Worker Safety Program from the EOCC. The Board provides financial and administrative support to facilitate the ongoing activities of the Worker Safety Program.

VI PERFORMANCE MEASURE/MONITORING

A. This plan's effectiveness is measured through the use of the performance measurement process. Annual evaluation of the effectiveness is conducted by the EOCC. Based on the evaluation, performance improvement indicators are established.

1. In 2021, the following performance measures were conducted:
    a. One Hundred percent (100%) of employees with musculoskeletal injuries during 2021 will be referred to Rehab ("back school") for education and training in proper movement and lifting skills. 12 of 12 care partners with musculoskeletal injuries were referred to Rehab ("back school") for education and training.
    b. Reduce the number of injuries to care partners by ten percent (10%). The overall reduction in reported employee injuries during 2021 was 18%
2. For 2022, the following performance measures will be undertaken:
    a. Continue to assure that all musculoskeletal injuries are referred to Rehab for training in proper movement and lifting.
    b. 100% of employees with a job code of transporter will be trained in the use of patient handling equipment, turning and repositioning so that they can assist with our more challenging or disabled patients. The goal is to assure that members of a "transition team"

are well versed in proper moving turning and lifting techniques, with and without equipment.

VII PROCESSES OF THE WORKER SAFETY MANANGMENT PLAN

A. All injuries and occupational illnesses are reported through the hospital incident reporting system. Human Resources, in collaboration with Infection Control, the Safety Officer and an injured employee's manager investigate major incidents and illnesses.

The Employee Health Nurse reviews incidents or illnesses that result in investigation. It is the responsibility of all PHC care partners to report an incident or illness at the time of the occurrence.

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

C. Environmental Tours, Security Rounds, and Maintenance Rounds all proactively monitor and assess buildings, grounds and equipment to reduce risk to the public and workers.

D. Safety issues are examined by the EOCC who has appropriate representatives from administration, nursing, physicians, clinical services and support areas.

E. All incidents are reported through the hospital incident reporting system by the person(s) closes to the event. Staff also report incidents to their immediate Supervisor. The incident report is sent to the Employee Health Nurse and is forwarded to EOCC members who may need to conduct a further investigation or provide follow up information.

F. Any care partner intervenes whenever conditions pose an immediate threat to life or health and threaten damage to equipment or building(s) by reporting such information to the Security Department at extension 6565. The department involved in such situation is authorized to intervene and halt operations when appropriate.