MEMORANDUM

To: Board of Directors

Cc: Bill Boyles, Esquire
Aluino Ochoa, M.D.

From: George Mikitarian
President/CEO

Subject: Board/Committee Meetings – April 1, 2024

Date: March 28, 2024

The Pension Committee will meet at 11:00 a.m. in the first-floor conference room.

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

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

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

The Planning Committee meeting has been canceled.

Pension Administrative Committee:
Stan Retz, Chairperson (January 1, 2023 - December 31, 2025)
Dan Aton (April 1, 2024- April 1, 2026)
Chris McAlpine (February 4, 2022 – January 31, 2025)
Leigh Spradling (March 1, 2024 – March 1, 2026)
Casey Crouch (March 2, 2023 – March 1, 2026)

PARRISH MEDICAL CENTER
PENSION ADMINISTRATIVE COMMITTEE MEETING
APRIL 1, 2024 @ 11:00 A.M.
FIRST FLOOR CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Review and approval of minutes (February 5, 2024).

Motion: To recommend approval of the February 5, 2024 meeting minutes as presented.

II. Update on Pension Plan and Trust – Mr. McAlpine

III. Membership Renewal for Leigh Spradling

Motion: To recommend the Finance Committee approve the appointment of Leigh Spradling to the Pension Committee for a two-year term beginning March 1, 2024, through March 1, 2026.

IV. Membership Appointment for Dan Aton

Motion: To recommend the Finance Committee approve the appointment of Dan Aton to the Pension Committee for a two-year term beginning April 1, 2024, through April1, 2026.

V. Other

VI. Adjournment

PARRISH MEDICAL CENTER
PENSION ADMINISTRATIVE COMMITTEE MEETING
FEBRUARY 5, 2024

The members of the Pension Administrative Committee met on February 5, 2024 at 11:07 a.m. The following representing a quorum, were present or participating via phone:

Pension Administrative Committee:
Stan Retz, Chairperson
Chris McAlpine
Leigh Spradling (absent-excused)
Casey Crouch (absent-excused)

Others Present:
Robert Jordan, Chairman, Board of Directors
Natalie Sellers Sr. Vice President, Communications, Community and Corporate Services
Mike Sitowitz, Interim Controller
Pamela Perez, Recording Secretary
Stephanie Parham, Executive Office Manager Administration
Christina Moats, Benefits Coordinator
Wendy Warner, Manager, Human Resources

Call to Order

The meeting was called to order by the Chairperson at 11:07 a.m.

Review and Approval of Minutes

Approval of the January 8, 2024 minutes has been tabled to the next meeting due to not having a quorum present.

Update on Pension Plan and Trust

Mr. McAlpine provided a brief update, adding that the actuary along with Human Resources are working to ensure the records are accurate. Communication to plan participants is on track.

Adjournment

There being no further business, the meeting was adjourned at 11:12a.m.

_____
Stan Retz, Chairperson

QUALITY COMMITTEE
Elizabeth Galfo, M.D., Chairperson
Robert L. Jordan, Jr., C.M. (ex-officio)
Billy Specht
Billie Fitzgerald
Herman A. Cole, Jr.
Dan Aton
Stan Retz, CPA
Maureen Rupe
Ashok Shah, M.D.
Aluino Ochoa, M.D., President/Medical Staff
Greg Cuculino, M.D.
Alphonse Pecoraro, M.D., Designee
Nimish Naik, 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 1, 2024, at 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 5, 2024 meeting.

II. Vision Statement

III. My Story

IV. Dashboard

V. Leapfrog Measures Review – Ms. Cottrell

VI. New Quality Structure – Ms. Cottrell, Mr. McAlpine, Dr. Ochoa

VII. Executive Session (if necessary)

ADJOURNMENT

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

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

DRAFT
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 5, 2024, in Conference Room 2/3/4/5, First Floor. The following members were present.

Elizabeth Galfo, M.D., Chairperson
Robert L. Jordan, Jr., C.M.
Stan Retz, CPA
Herman A. Cole, Jr.
Ashok Shah, M.D.
Dan Aton
Billie Fitzgerald
Billy Specht
Christopher Manion, M.D.
Maureen Rupe
Gregory Cuculino, M.D.
Aluino Ochoa, M.D., President/Medical Staff
George Mikitarian (non-voting)

Members absent:

CALL TO ORDER

Mr. Jordan called the meeting to order at 12:05 p.m.

ELECTION OF OFFICERS

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

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

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

***ACTION TAKEN*: APPROVED MOTION TO ELECT MAUREEN RUPE AS VICE-CHAIRPERSON OF THE QUALITY COMMITTEE.**

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Mr. Cole, seconded by Dr. Shah, and approved (12 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO APPROVE THE DECEMBER 4, 2023 MINUTES OF THE QUALITY COMMITTEE, AS PRESENTED.**

VISION STATEMENT

Ms. Cottrell summarized the committee's vision statement.

MY STORY

Ms. Cottrell shared the story of Robert, and the healing experience he received from the stroke team at Parrish Medical Center as well as his positive outcome.

QUALITY DASHBOARD REVIEW

Ms. Cottrell reviewed the Quality Dashboard discussing each indicator score as it relates to clinical quality and cost. Ms. Cottrell answered questions and received comments from committee members concerning the dashboard and her comments. Copies of the Power Point slides presented are appended to the file copy of these minutes.

STROKE UPDATE AND SURVEY RESULTS

Ms. Cottrell reviewed the recent stroke survey on January 19, 2024, noting that PMC received recertification with zero findings for improvement.

APPOINTMENT OF SAFETY OFFICERS

Discussion ensued and the following motion was made by Mr. Cole, seconded by Ms. Rupe, and approved (12 ayes, 0 nays, 0 abstentions).

ACTION TAKEN**: MOTION TO APPROVE THE APPOINTMENT OF MR. GREGORY GEORGE, DIRECTOR OF SECURITY, AS PARRISH MEDICAL CENTER'S SAFETY OFFICER.**

Discussion ensued and the following motion was made by Mr. Specht, seconded by Mr. Cole, and approved (12 ayes, 0 nays, 0 abstentions).

ACTION TAKEN**: MOTION TO APPROVE THE APPOINTMENT OF MS. LEIGH SPRADLING, EMERGENCY SERVICES SPECIALIST, AS PARRISH MEDICAL CENTER'S SAFETY LIAISON.**

Discussion ensued and the following motion was made by Mr. Cole, seconded by Dr. Shah, and approved (12 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO APPROVE THE APPOINTMENT OF MS. LEEANN COTTRELL, ASSISTANT VICE PRESIDENT NURSING ADMINISTRATION/CNIO, AS PARRISH MEDICAL CENTER'S PATIENT SAFETY OFFICER, AS REQUIRED BY THE AGENCY FOR HEALTHCARE ADMINISTRATION.**

SURGICAL QUALITY PARTNERS

Ms. Sellers shared the recent engagement with the America College of Surgeons Surgical Quality Partners, noting the operative standards and promotion plan.

OTHER

There was no other business brought before the committee.

ADJOURNMENT

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

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

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Quality Agenda

April 1, 2024

1. Approval of Minutes
2. Vision Statement
3. Dashboard
4. Leapfrog Measures Review
5. New Quality Structure

Quality Committee

Vision Statement

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

Dashboard

Performance dashboard

Description	Definition	Nov 23-Jan 24	Feb 23–Jan 24	Goal
Stroke	Stroke management compliance	80%	79%	Goal: 100%
Sepsis	Severe Sepsis and Septic Shock Management bundle compliance	40%	55%	Goal: 60%
Readmission	All cause 30-day readmissions	9.6%	8.7%	Goal: 8.0%
Person Centered flow	emergency department throughput	215	220	101 minutes
Person Experience	Top box HCAHPs domain score for overall rating	68.8%	61.3%	Target: 78%

Performance dashboard

Description	Definition	Jan 23–Dec 23	National Rate
CLABSI	Central Line Associated Bloodstream Infection	1.974	0.772
CAUTI	Catheter Associated Urinary Tract Infection	1.091	0.610
MRSA bacteremia	Hospital onset MRSA bacteremia	2.023	0.800
C. difficile infection	Hospital onset *C. difficile* infection	0.418	0.448
SSI	Combined Abdominal hysterectomy and colon procedures	1.047	0.893

Leapfrog Measures Review

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Leapfrog safety grade

What it is:

A composite score

- 30 national composite performance measures
- indicates how well hospitals protect patients from preventable errors, injuries and infections.

Leapfrog safety grade

What does it measure?

Outcome Measures include:

- infections
- falls and trauma, very severe pressure ulcers
- preventable complications from surgery

Leapfrog safety grade

What does it measure?

Process/Structural Measures include:

- strong nursing leadership and engagement
- computerized physician order entry systems to prevent medication errors
- safe medication administration
- hand hygiene policies
- the right staffing for the ICU

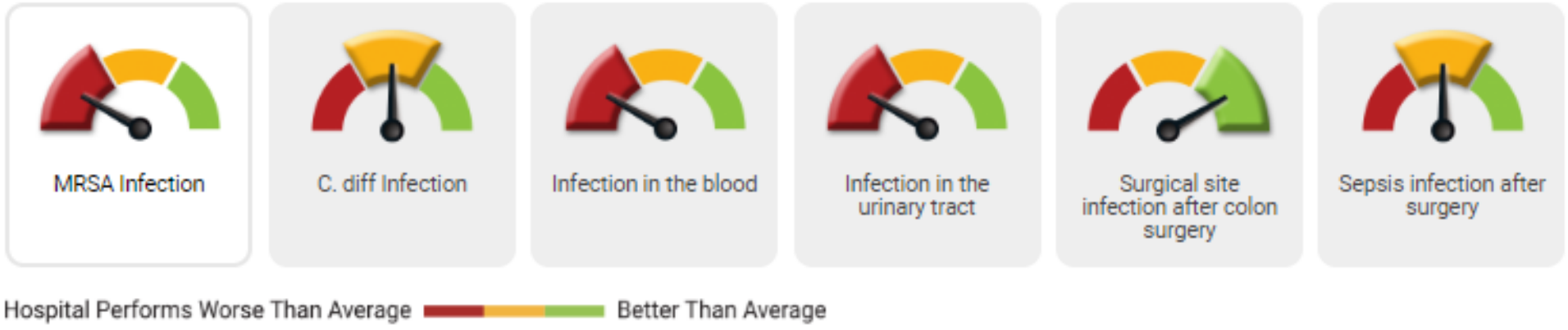
2023 Leapfrog Survey

Results

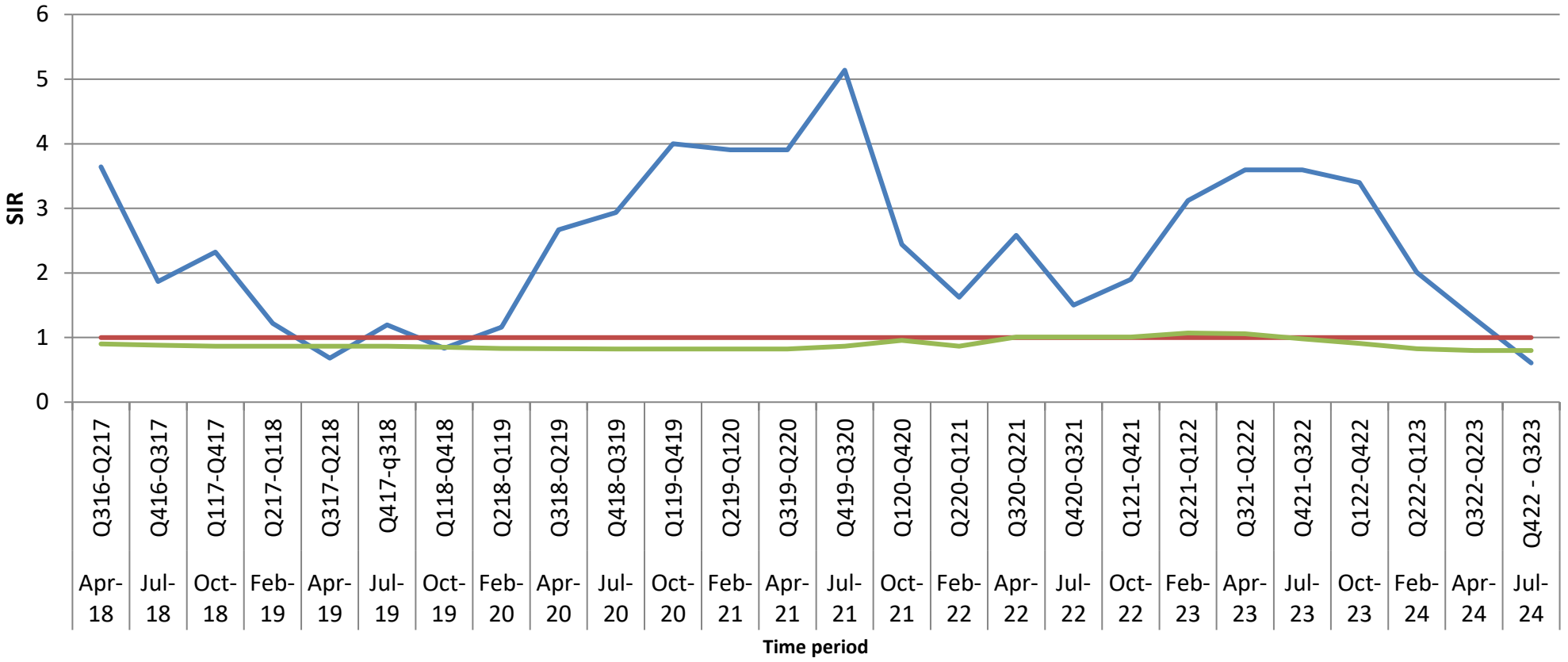
- Safe medication ordering
- Safe medication administration
- Specially trained doctors care for critical care patients
- effective leadership to prevent errors
- Staff work together to prevent errors
- Handwashing

Leapfrog

Infections domain score



MRSA standardized infection ratio



Leapfrog

Safety problems domain score

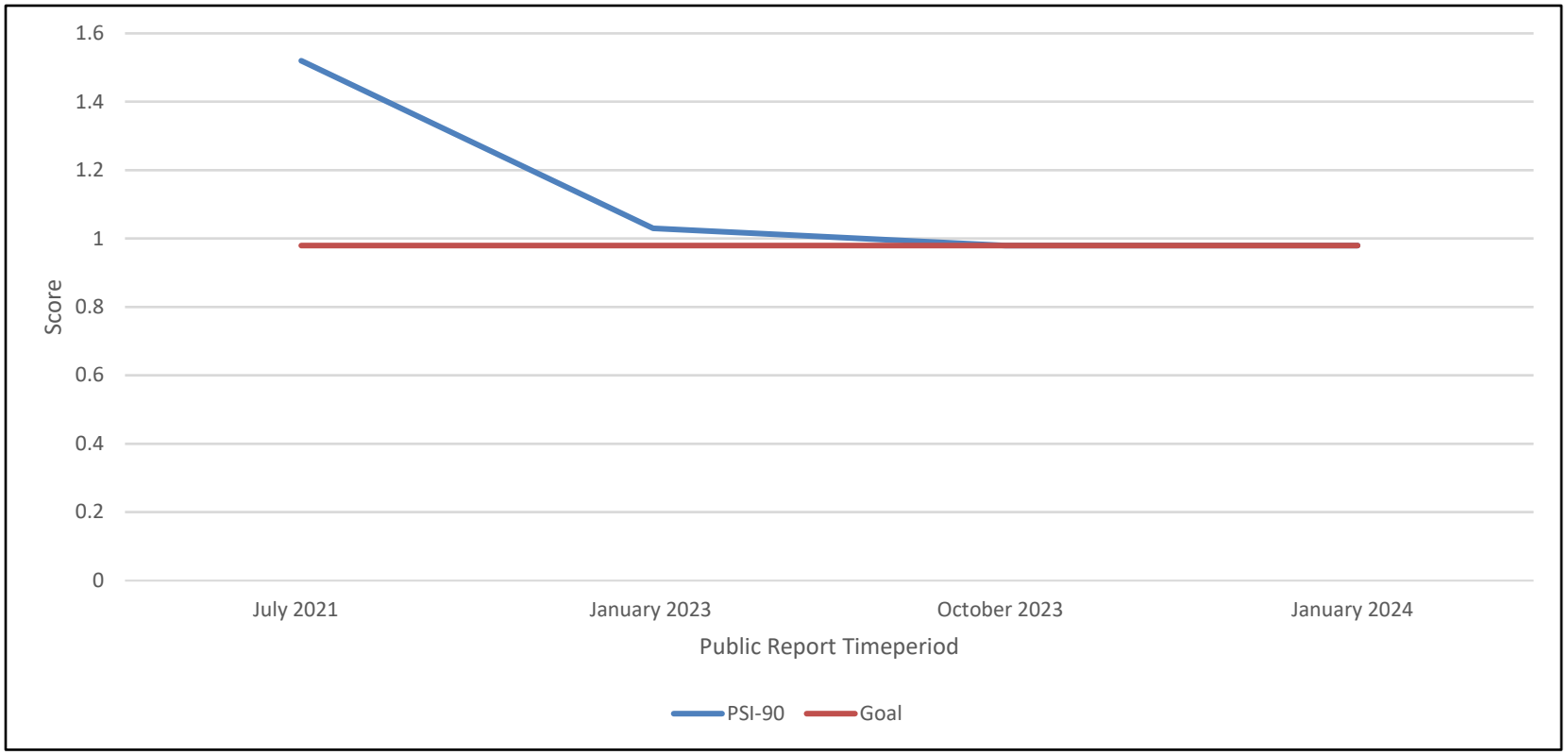
Harmful events

Dangerous blood clot

Dangerous bed sores

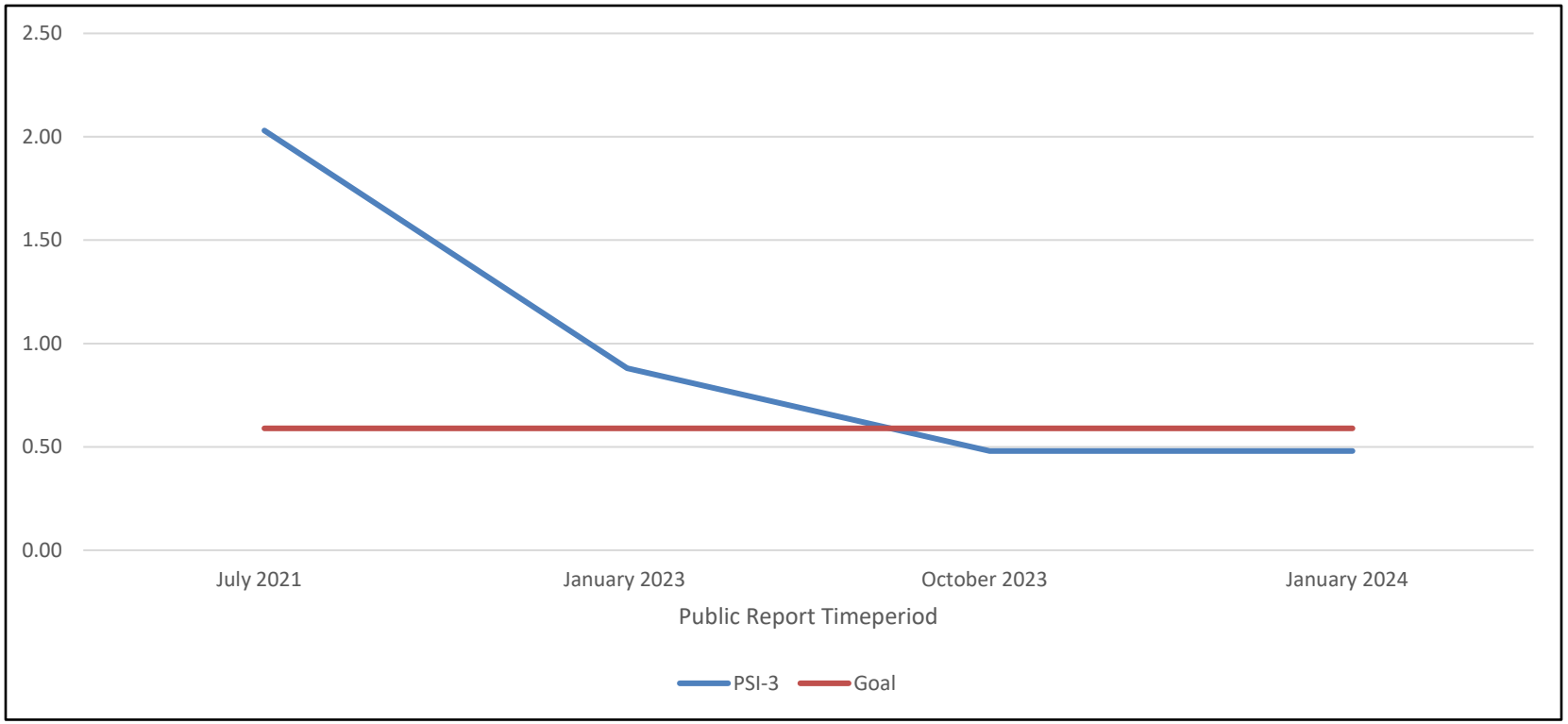
Patient Safety Indicators

Composite measure



Patient Safety Indicators

Pressure injuries



Leapfrog safety score

Spring 2024

- Released May 1st
- 2023 hospital survey
- 2020-2023 data

New Quality Structure

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Questions?

FINANCE COMMITTEE
Herman A. Cole, Jr. Chairperson
Stan Retz, CPA, Vice Chairperson
Robert L. Jordan, Jr., C.M., (ex-officio)
Billie Fitzgerald
Maureen Rupe
Dan Aton
Christopher Manion, M.D.
Aluino Ochoa, M.D., President/Medical Staff
George Mikitarian, President/CEO (non-voting)

FINANCE COMMITTEE MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT OPERATING
PARRISH MEDICAL CENTER
MONDAY, APRIL 1, 2024
FIRST FLOOR CONFERENCE ROOMS 2/3/4/5
(IMMEDIATELY FOLLOWING QUALITY COMMITTEE)

CALL TO ORDER

I. Approval of minutes.

Motion: To recommend approval of the February 5, 2024 meeting.

II. Financial Review – Mr. Sitowitz

III. Pension Update – Mr. McAlpine

IV. Membership Re-Appointment for Leigh Spradling

Motion: To recommend the Finance Committee approve the re-appointment of Leigh Spradling to the Pension Committee for a two-year term beginning March 1, 2024 through March 1, 2026.

V. Membership Appointment for Dan Aton

Motion: To recommend the Finance Committee approve the appointment of Dan Aton to the Pension Committee for a two-year term beginning April 1, 2024 through April1, 2026.

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.

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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 5, 2024, 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.
Billie Fitzgerald
Maureen Rupe
Dan Aton
Christopher Manion, M.D.
Aluino Ochoa, 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 12:49 p.m.

ELECTION OF VICE CHAIRPERSON

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

***ACTION TAKEN*: APPROVED MOTION TO ELECT STAN RETZ AS VICE CHAIRPERSON OF THE FINANCE COMMITTEE.**

REVIEW AND APPROVAL OF MINUTES

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

***ACTION TAKEN:* MOTION THAT THE FINANCE COMMITTEE OF THE BOARD OF DIRECTORS APPROVE THE DECEMBER 4, 2023, MEETING MINUTES OF THE FINANCE COMMITTEE, AS PRESENTED.**

PUBLIC COMMENTS

There were no public comments.

AUDIT UPDATE

Mr. Retz provided a brief update, noting that recent meetings with the auditors were very productive.

ANDERSON FINANCIAL UPDATE

Mr. Tim Anderson presented a quarterly performance update concerning the Operating Funds investment performance.

FINANCIAL REVIEW

Mr. Sitowitz (interim Controller) summarized the December financial statements of the North Brevard County Hospital District and the year-to-date financial performance of the Health System. Mr. Sitowitz answered questions and received comments from the members of the committee.

OTHER

There was no other business to come before the committee.

ADJOURNMENT

There being no further business to come before the committee, the Finance Committee meeting adjourned at 1:13 p.m.

Herman A. Cole, Jr.,
Chairman

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Finance Committee

FYTD February 29, 2024 – Performance Dashboard

Indicator	FYTD 2024 Actual	FYTD 2024 Budget	FYTD 2023 Actual
ED Visits	12,733	12,752	12,577
IP Admissions	1,787	2,069	1,873
Surgical Cases	2,001	2,537	2,229
LOS	5.5	4.3	4.8
OP Volumes	34,605	36,550	34,495
Hospital Margin %	4.69%	8.13%	-0.20%
Investment Income $	$3.7 Million	$3.5 Million	$5.8 Million

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 1, 2024
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 5, 2024 meeting.

II. Reading of the Huddle

III. Attorney Report – Mr. Boyles

IV. Other

V. Executive Session (if needed)

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.

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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 5, 2024, 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.
Maureen Rupe
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 12:40 p.m.

CITY LIAISON

City Manager Larese provided the latest edition of Titusville Talking Points and addressed questions from the committee regarding the city of Titusville. The Executive Committee recessed at 12:49 p.m. for his report.

REVIEW AND APPROVAL OF MINUTES

The Executive Committee reconvened at 1:14 p.m. to continue its agenda. Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Cole, and approved (5 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO APPROVE THE DECEMBER 4, MEETING MINUTES OF THE EXECUTIVE COMMITTEE OF THE BOARD, AS PRESENTED.**

READING OF THE HUDDLE

Dr. Galfo presented the Weekly Huddle.

ATTORNEY REPORT

Mr. Boyles noted that the state legislature continues to be in session, and that one bill is pending that could impact the Hospital District. This bill would increase the sovereign immunity limits to $400,000 per incident and $600,000 per episode. Mr. Boyles noted that Gray Robinson is monitoring these activities and will provide updates as needed.

OTHER

There was no other business to come before the committee.

ADJOURNMENT

There being no further business to discuss, the committee adjourned at 1:34 p.m.

Stan Retz, CPA
Chairman

EDUCATION COMMITTEE
Billie Fitzgerald, Chairperson
Maureen Rupe, Vice Chairperson
Robert L. Jordan, Jr., C.M. (ex-officio)
Elizabeth Galfo, M.D., Chairperson
Billy Specht
Herman A. Cole, Jr.
Dan Aton
Stan Retz, CPA
Ashok Shah, M.D.
Aluino Ochoa, M.D.
George Mikitarian, President/CEO (Non-voting)

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE
MONDAY, APRIL 1, 2024
IMMEDIATELY FOLLOWING EXECUTIVE SESSION
FIRST FLOOR CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Review and Approval of Minutes

Motion to approve the minutes of the February 5, 2023 meeting.

II. Semi-Annual Update to City Council

III. Other

IV. Executive Session (if necessary)

ADJOURNMENT

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

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

A regular meeting of the Educational, Governmental and Community Relations Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on February 5, 2024, at 1:30 p.m. in Conference Room 2/3/4/5, First Floor. The following members were present:

Billie Fitzgerald, Chairperson
Maureen Rupe, Vice Chairperson
Robert L. Jordan, Jr., C.M.
Dan Aton
Ashok, Shah, M.D.
Stan Retz, CPA
Billy Specht
Herman A. Cole, Jr.
Aluino Ochoa, M.D.
Elizabeth Galfo, M.D.
George Mikitarian (non-voting)

Member(s) Absent:
None

CALL TO ORDER

Ms. Fitzgerald called the meeting to order at 1:44 p.m.

ELECTION OF CHAIRPERSON AND VICE CHAIRPERSON

Ms. Fitzgerald opened the floor for nomination of the Chairperson of the Committee. Mr. Jordan nominated Ms. Fitzgerald; Ms. Rupe seconded the nomination and moved to close the nominations which was unanimously approved.

***ACTION TAKEN*: MOTION TO APPROVE THE APPOINTMENT OF BILLIE FITZGERALD AS CHAIRPERSON OF THE EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE.**

Ms. Fitzgerald opened the floor for nomination of the Vice Chairperson of the Committee. Mr. Jordan nominated Ms. Rupe; Mr. Cole seconded the motion and moved to close the nominations which was unanimously approved.

***ACTION TAKEN*: MOTION TO APPROVE THE APPOINTMENT OF MAUREEN RUPE AS VICE CHAIRPERSON OF THE EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE.**

REVIEW AND APPROVAL OF MINUTES

The following motion was made by Mr. Jordan seconded by Mr. Specht, and approved (10 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO APPROVE THE MINUTES OF THE DECEMBER 4, 2023, EDUCATION COMMITTEE MEETING, AS PRESENTED.**

NEW REHAB SERVICES

Ms. Roberson presented on the new rehabilitation programs offered at Parrish Medical Center and how it has been effective in assisting members of the community.

OTHER

No other items were presented for consideration by the committee.

ADJOURNMENT

There being no further business to come before the committee, the Educational, Governmental and Community Relations Committee meeting adjourned at 2:12 p.m.

Billie Fitzgerald
Chairperson

DRAFT AGENDA
BOARD OF DIRECTORS MEETING - REGULAR MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
APRIL 1, 2024
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. Recognitions(s)

A. New Providers (memo included)

V. Review and Approval of Minutes (February 5, 2024 Regular Meeting)

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

X. Medical Staff Report Recommendations/Announcements

A. Motion to approve to deactivate the delineated privileges for Mayo Clinic Telestroke.

B. Motion to approve the additions to the delineated privileges for Allied Health – Surgery:

- Assist in positioning and taking of fluoroscopic imaging.
- Placing and maintaining limb tourniquet.
- Assist in reduction of fracture.
- Assists in placement of orthopedic hardware and implants.

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

XII. Consent Agenda***

A. Finance

1. **Motion to recommend the Finance Committee approve the re-appointment of Leigh Spradling to the Pension Committee for a two-year term beginning March 1, 2024, through March 1, 2026.**

2. **Motion to recommend the Finance Committee approve the appointment of Dan Aton to the Pension Committee for a two-year term beginning April 1, 2024, through April1, 2026.**

. ***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. Budget and 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

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.

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.

PARRISH®

MEDICAL CENTER

PARRISH HEALTHCARE

Healing Families – Healing Communities®

parrishhealthcare.com

Welcome New Providers

Carlos Franco-Palacios, MD – Critical Care/ICU

Medical School:
Universidad Nacional de Asuncion, Paraguay

Residency: Wayne State University, Detroit, MI

Fellowship: Critical Care, Jackson Memorial Hospital, Miami

Welcome New Providers

Jan Berrios-Colon, MD – Hospitalist

Medical School:

Universidad Central del Caribe, School of Medicine, Bayamon, PR

Residency:

Orlando Health, Internal Medicine

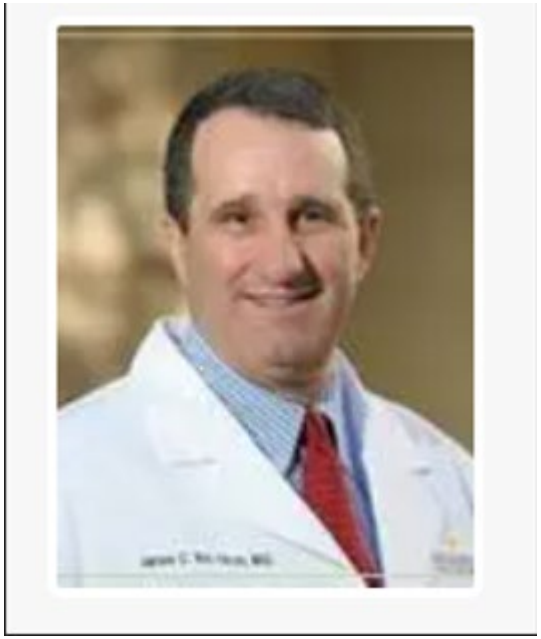
Fellowship: University of South Florida School of Medicine, Rheumatology

Welcome New Providers

James von Thron, MD – OB/GYN (clinic only)

Medical School: University South Florida College of Medicine

Residency: Tampa General Hospital



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DRAFT
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 (the District) was held at 2:23 p.m. on February 5, 2024 in Conference Room 2/3/4/5, First Floor. The following members were present:

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

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 2:23 p.m. and determined a quorum was present per Article 1.1.4 of the District Bylaws.

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 MEETING AGENDA

Mr. Jordan requested approval of the meeting 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 MEETING AGENDA OF THE BOARD OF DIRECTORS OF THE DISTRICT AS PRESENTED.**

RECOGNITIONS

There were no recognitions.

REVIEW AND APPROVAL OF MINUTES

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

ACTION TAKEN: **MOTION TO APPROVE THE MINUTES OF THE DECEMBER 4, 2023, REGULAR MEETING OF THE BOARD OF DIRECTORS OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT DBA PARRISH MEDICAL CENTER, AS PRESENTED.**

OPEN FORUM FOR PMC PHYSICIANS

There were no physician comments.

PUBLIC COMMENTS

There were no public comments.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

There was no new business.

MEDICAL STAFF REPORT RECOMMENDATIONS/ANNOUNCEMENTS

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

ACTION TAKEN**: MOTION TO SEND A FAVORABLE RECOMMENDATION TO THE BOARD OF DIRECTORS TO APPROVE THE DELINEATED PRIVILEGES SPECIFIC TO THE CERTIFIED PROFESSIONAL MIDWIFE, (CPM) AS WRITTEN AND DISTRIBUTED. DELINEATION OF PRIVILEGES IS ATTACHED.**

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

ACTION TAKEN**: MOTION TO SEND A FAVORABLE RECOMMENDATION TO THE BOARD OF DIRECTORS TO UPDATE THE CURRENT TRANSFUSION CRITERIA TO INCLUDE ORTHOPEDIC SURGERY FOR HEMOGLOBIN < 8 G/DL.**

CONSENT AGENDA

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

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

Consent Agenda

A. Quality

1. **Motion to recommend to the Board of Directors approve the appointment of Mr. Gregory George, Director of Security, as Parrish Medical Center's Safety Officer.**

2. **Motion: To approve the appointment of Ms. Leigh Spradling, Emergency Services Specialist, as Parrish Medical Center's Safety Liaison.**

3. **Motion to recommend to the Board of Directors approve the appointment of LeeAnn Cottrell, Assistant Vice President Nursing Administration/CNIO, as Parrish Medical Center's Patient Safety Officer, as required by the Agency for Healthcare Administration.**

COMMITTEE REPORTS

Quality Committee

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

Finance Committee

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

Executive Committee

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

Educational, Governmental and Community Relations Committee

Ms. Fitzgerald reported that all items were covered during the Educational, Governmental and Community Relations Committee meeting.

Planning, Physical Facilities and Properties Committee

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

PROCESS AND QUALITY REPORT

Mr. Mikitarian shared in place of *My Story*, the next Quality meeting will report process improvement, the experiences of the providers, and how those improvements impact and assist the providers.

Hospital Attorney

Legal counsel had no report.

OTHER

There was no other business to come before the Board.

CLOSING REMARKS

There were no closing remarks.

ADJOURNMENT

There being no further business to discuss, the Parrish Medical Center Board of Directors meeting adjourned at 2:33 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
March 19, 2024, @ 5:30pm

Present: K. Patel, MD, G. Cuculino, MD, J. Zambos, MD, R. Patel, MD, A. Ochoa, MD, G. Mikitarian, M. Navas, MD, C. McAlpine, B. Mathews, MD, P. Carmona, MD, H. Cole

Absent: C. Manion, MD, L. Stuart, MD, C. Fernandez, MD, C. Jacobs, MD

A meeting of the Medical Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was called to order on March 19, 2024 at 5:30pm in the Conference Center. A quorum was determined to be present.

CALL TO ORDER.

Dr. Ochoa called the meeting to order at 5:45pm.

I. REVIEW AND APPROVAL OF MINUTES

Motion to approve the Regular Session minutes of February 20, 2024 as written and distributed ***was made by Dr. Carmona, seconded by Dr. Cuculino and unanimously approved.***

2. **Old Business:** None

3. New Business:

Policies for Review/Approval:

1. **Primary Stroke Center Admin Support**." – ***Edits*** *to initiator, as well as the leadership roles in which the stroke program reports up through*

2. "**Teleneurology for Stroke**." – ***Edits*** *relate to the changes associated with the transition to Cleveland Clinic, references updated, new process map was attached*

MOTION TO APPROVE THE POLICIES AS WRITTEN AND DISTRIBUTED (IN BLOCK) WAS MADE BY DR. CUCULINO, SECONDED BY DR. CARMONA AND UNANIMOUSLY APPROVED.

b. Moderate Sedation: The policy regarding moderate sedation was reviewed. The policy notes one procedure per month (average) if not, the practitioner will perform 2 hours of CME review.

- Dr. Cuculino requested that the policy make no reference to the actual number of procedures month/annually.

Dr. Ochoa requested Dr. Cuculino to make any proposed edits to the current policy and return with it to MEC April 16, 2024.

c. MOTION TO DEACTIVATE THE DELINEATED PRIVILEGES MAYO CLINIC TELESTROKE BE DEACTIVATED WAS MADE BY DR. CARMONA, SECONDED BY DR. K. PATEL AND UNANIMOUSLY APPROVED.

d. MOTION TO ACCEPT THE EDITS (ADDITIONS) MADE BY DR. MUSTO TO THE DELINEATED PRIVILEGES – ALLIED HEALTH – S URGERY WAS MADE BY DR. K. PATEL, SECONDED BY DR. ZAMBOS AND UNANIMOUSLY APPROVED.

14. Assists in positioning and taking of fluoroscopic imaging
15. Placing and maintaining limb tourniquet
16. assists in reduction of fracture
17. assists in placement of orthopedic hardware and implants

e. <u>CONSENT AGENDA - STANDING ORDERS</u>

- CVC Port Placement Revision Post - Procedure (E3703) - New Order Set
- CVC Port Placement Revision Pre - Procedure (E3702ab) - New Order Set.
- Gastrostomy Exchange Replacement Post - Procedure (E3709ab) - New Order Set.
- Lumbar Puncture - Post Procedure (E3715) - New Order Set
- Lung Biopsy Post - Procedure (E3717ab) - New Order Set.
- Superficial Biopsy Post - Procedure (E3719) - New Order Set.
- Thoracentesis Post-Procedure (E3721) - New Order Set
- Thyroid Biopsy Post-Procedure (E3723) - New Order Set.
- Subcutaneous Infusion Port Removal Post - Procedure (E3740) - New Order Set.

MOTION TO APPROVE (IN BLOCK) THE CONSENT AGENDA AS WRITTEN AND DISTRIBUTED WAS MADE BY DR. R. PATEL, SECONDED BY DR. J. ZAMBOS AND UNANIMOUSLY APPROVED.

f. Report from the Administration:

Mr. Mikitarian thanked the Medical Staff for their support noting that it is in large part because of their commitment to providing quality care to our community that the House bill died.

Dr. Carmona asked about the relationship with Cleveland Clinic and will it

further expand? Mr. Mikitarian noted that it will expand, and that he expects the regional representation from Cleveland Clinic to be on site to meet with the Medical Staff in the near future. More to come.

g. Report from the Board: None

h. Open Forum:

Dr. Ochoa took the opportunity to ask that we each keep Dr. David Bhola in our prayers as he faces a difficult unforeseen challenge. Dr. K. Patel elaborated noting that Dr. Bhola is "one of our own", an exceptional clinician, and father.

Dr. Carmona asked about the possibility of having Committee meetings via TEAMS to encourage participation from the medical staff who are a) not always on site, or b) rarely have reason to come to the hospital although they are active on the Medical Staff. Dr. Zambos raised concerns regarding CONFIDENTIALITY, Dr. Carmona agreed that for certain meetings this would not be viable but for others, we should look into it. Mr. Mikitarian agreed to research "Best Practices" among other entities.

There being no further business the meeting adjourned at 6:02 pm.

Aluino Ochoa, MD	Christopher Manion, MD
President, Medical Staff	Secretary/Treasurer

NEXT MEETING APRIL 16, 2024

North Brevard County Hospital District
Environment of Care (EOC) Committee Report:
Annual Report for Calendar Year 2024
Executive Summary

Emergency Management

2023 Goals

- Participate in full scale Hospital Medical Surge Exercise with Central Florida Disaster Medical Coalition (CFDMC). **MET**
- Expand on fire drill matrix and perform additional tabletop drills in departments not on Fire Matrix within the hospital. Focusing on the patient and care partners head counts, riley points, evacuation routes. **MET**
- Perform infant/child abduction, hazardous spill. **MET**
- Hostage situation drill at main campus. **UNMET**
- Perform Code Black drill at offsite buildings. **UNMET**
- Coordinating additional Decontamination training, optimally having 50 care partners training in the process. **MET**

2024 Goals

- Train 100% of House Supervisors on activation and initial priorities in an emergency incident, this will be achieved by in person training and compiling checklist by 12-31-2024.
- Participation of select Care Partners in training at the Center for Domestic Preparedness by 12-31-2024
    - Healthcare Leadership (HCL): CNO; Director of Emergency and Women's Services; Emergency Services Specialist
    - Hospital Emergency Response Team (HERT)- Clinical Engineering Service Technician
    - Highly Infectious Disease (HID)- Infection Prevention Professional
- Perform emergency drills to include:
    - Participate in full scale Hospital Medical Surge Exercise with Central Florida Disaster Medical Coalition (CFDMC) by 12-31-2024
    - Cyber-attack Tabletop by 12-31-2024

North Brevard County Hospital District
Environment of Care (EOC) Committee Report:
Annual Report for Calendar Year 2024
Executive Summary

Hazardous Materials

2023 Goals

- 70% of five Care Partners questioned during environmental rounds will be able to speak correctly concerning actions to take when a Code hazardous spill occurs. **UNMET**
- Reduce the number of hazardous waste disposal deficiencies by 5 percent as reported through the monthly audit of same. **UNMET**

2024 Goals

- 80% of five Care Partners questioned during environmental rounds will be able to speak correctly concerning actions to take when a Facility Alerts, Hazardous Material Spill Internal occurs.
- Hazardous waste disposal deficiencies will be reduced in OR, PACU and Special Procedure areas. Comparing monthly deficiencies from monthly audits reports and reporting to EOCC. This will be achieved through departmental in-service training and updating computer-based learning modules.

North Brevard County Hospital District
Environment of Care (EOC) Committee Report:
Annual Report for Calendar Year 2024
Executive Summary

Life Safety

2023 Goals

- 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. **MET**
- 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 12-31-2023. **MET**

2024 Goals

- Increase Care Partner knowledge of the proper use of fire extinguishers during events. Education for proper use of Fire extinguishers is to be discussed during EOC rounding and quarterly fire drills. Our goal for this task would be to test the knowledge of five Care Partners weekly during Environment of Care Rounds with use of fire extinguisher training checklist. 80% of the Care Partners asked must understand the proper use of the fire extinguisher and locations of extinguishers in their area. This will be monitored and tracked monthly through 12-31-2024.
- 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, computer-based learning (CBL) and quarterly fire drills. Our goal for this task is to test the knowledge of five Care Partners weekly during Environment of Care Rounds and during fire drills. 80% of the Care Partners asked must understand their responsibility during an event. This will be monitored and tracked via rosters and monthly monitoring through 12-3

North Brevard County Hospital District
Environment of Care (EOC) Committee Report:
Annual Report for Calendar Year 2024
Executive Summary

Medical Equipment

2023 Goals

- ICU Plum 360 IV pumps will be plugged in to maintain battery. The numbers will be pulled mid-week and averaged monthly with goal being greater than or equal to 60 %. **MET** (Started with less than 50% and completed the year with 77.96% average units plugged in)
- Medical Equipment battery failure divided by total correctives for the month with goal being less than or equal to 10%. **MET**
  (Average monthly battery failure shows less than 2%)

2024 Goals

- Medical Equipment battery failure divided by total correctives for the month (Goal is less than or equal to 5%) Will continue to tracking until 12-31-2024. Trending will show if battery issues begin increasing.
- Medical Equipment alert documentation – Documentation for all medical alerts that pertain to any medical equipment used at Parrish Medical Center facilities. Risk management and affected departments to be notified within 5 days of receipt until 12-31-24.

Safety and Security

2023 Goals

- De-escalation training for care partners in Security and high-risk areas (Emergency Department, ICU and Women's Center). **UNMET**
- Scanning by means of bag checks, metal detectors, wands of 75% of patients and visitors walking through Emergency Department and Main doors. **MET**

2024 Goals

- Conduct Security Assessments for all PHC locations, two per month with a Goal of 100% completion. To be completed by December 31, 2024.
- Complete WELLE (de-escalation training for healthcare) for PMC Security Officers and PMC staff. Training is scheduled monthly. Goal is to train 28 care partners a month by December 31, 2024.

North Brevard County Hospital District
Environment of Care (EOC) Committee Report:
Annual Report for Calendar Year 2024
Executive Summary

Utilities Management

2023 Goals

- Proper Storage of Full and Empty O2 (E) Cylinders. This will be checked during Environment of Care (EOC) rounds. 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 monthly and monitored through 12-31-2023. **UNMET**
- Increase Care Partner Knowledge of Med Gas zone valve box locations and shut down procedures during events. Education for Med Gas valve boxes will be discussed during EOC rounding 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 monthly and monitored through 12-31-2023. **UNMET**

2024 Goals

- Proper Storage of Full and Empty O2 (E) Cylinders. Our goal for this task would be to test the knowledge of 5 care partners weekly during Environment of Care Rounds, 75% of the care partners asked must have working knowledge of the proper storage of O2 storage process. Note: departments that do not have interactions with oxygens usage are exempted. This will be monitored and tracked monthly through 12-31-2024.
- Increase Care Partner Knowledge of Med Gas zone valve box locations and shut down procedures during events. Education for Med Gas valve boxes will be discussed during EOC rounding 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, 80% of the care partners asked must understand the shutdown process and locations. Note: departments that do not have interactions with oxygens usage are exempted. This will be monitored and tracked monthly through 12-31-2024.

Worker Safety

2023 Goals

- One Hundred percent (100%) of Care Partners with musculoskeletal injuries during 2023 were referred to Rehabilitation for strengthening and training in proper movement and lifting skills; monitored by scheduled appointments and documented completion by MD notes. **MET**
- Reduce the number of Care Partners injuries from prior year. **UNMET**
  Care Partner injuries during 2023 increased 7.45%.

2024 Goals

- 85% of active Care Partners that have direct patient contact will be trained in person on lift training for bariatric patients with hospitals lift equipment within the competency period (2-1-24 to 6-30-24).

EMERGENCY MANAGEMENT PLAN

2024

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 Parrish Healthcare (PHC) doors; to provide organizational planning for the return to normal status; and to comply with regulatory requirements in all phases of such situations.

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.

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 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 Emergency Services Specialist, 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 Emergency Services Specialist advises the EOCC regarding emergency management issues that affect PHC, requiring supplies, personnel, orientation, and CEMP procedures.

- The Emergency Services Specialist 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 department Care Partners 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.

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. The CEMP is submitted annually 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 leadership, 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.
.

- **Emergency Communications Plan**
  As part of the Emergency Operation 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 Care Partners regarding the initial implementation of the Emergency Operation 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 Auxilians
        - 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 Emergency Services Specialist with the assistance of the EOCC assures the following is up to date
        - Contact lists as identified above
        - Criteria for calling Care Partners to assist with any emergency response
        - Assures up to date contact list for all known emergency response organizations

2023 GOALS AND PERFORMANCE MANAGEMENT

- Expand on fire drill matrix and perform additional tabletop drills in every department within the hospital. Focusing on the patient and Care Partners head counts, riley points, evacuation routes- **Met**
- Perform infant/child abduction, hazardous spill- **Met**
- Hostage situation drills at main campus-**Unmet**
- Perform Code Black drill at offsite buildings-**Unmet**
- Coordinating additional Decontamination training, optimally having 50 Care Partners training in the process -**Met**

2024 GOALS AND PERFORMANCE MANAGEMENT

- Train 100% of House Supervisors on activation and initial priorities in an emergency incident, this will be achieved by in person training and compiling checklist by 12-31-2024.
- Participation of select Care Partners in training at the Center for Domestic Preparedness by 12-31-2024
    - HCL: CNO; Director of Emergency and Women's Services; Emergency Services Specialist
    - HERT- Clinical Engineering Service Technician
    - HID- Infection Prevention Professional
- Perform emergency drills to include:
    - Participate in full scale Hospital Medical Surge Exercise with CFDMC by 12-31-2024
    - Cyber-attack Tabletop by 12-31-2024

Hazardous Materials Waste Management Plan

2024

SCOPE

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

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 follows 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.

PLAN FUNDAMENTALS

- PHC's Environmental Services Manager is the Hazardous Materials Officer (HMO).
- PHC utilizes the *Globally Harmonized System of Classification &Labeling of Chemicals (GHS).*
- PHC's Environmental Services department (EVS) collects hazardous waste and materials.
- 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.
- In the event of a spill, release, or exposure of hazardous materials or waste, rapid effective response helps to minimize injuries.
- Hazardous waste segregation at the point of generation is the preferred means of controlling exposures and spills.
- Special monitoring systems are required to manage some hazardous gases, vapors, or radiation

undetectable by humans.

PLAN OBJECTIVES

- Define procedures to safely transport, store, use, and dispose of hazardous materials.
- Maintain a Hazardous Communication Plan and a hazardous chemical materials inventory.
- Define safe handling practices for the following hazardous materials:
    - Chemical waste
    - Radioactive waste
    - Pharmaceutical waste
    - Chemotherapeutic waste
    - Bio-hazardous waste, including sharps and physical hazards
    - Resource Conservation & Recovery Act (RCRA) Hazardous Waste items.
- Monitor gases, vapors, glutaraldehyde, and waste anesthetic gases, and report the results of involved areas/departments to the Environment of Care Committee (EOCC).
- 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.
- PHC's HMO reports number, frequency, severity, releases, and exposures to hazardous chemicals and waste to the EOCC.
- 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.
- PHC's HMO reports the Hazardous Materials and Waste Performance Indicator (PI) to the EOCC each quarter.
- 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 *eLearning* program.
- PHC's HMO annually evaluates the Hazardous Materials Waste Management Plan performance, and makes recommendations to the EOCC.

2023 GOALS AND PERFORMANCE MANAGEMENT

- 70% of five Care Partners questioned during environmental rounds will be able to speak correctly concerning actions to take when a Code hazardous spill occurs. **Unmet**
- Reduce the number of hazardous waste disposal deficiencies by 5 percent as reported through the monthly audit of same. **Unmet**

2024 GOALS AND PERFORMANCE MANAGEMENT

- 80% of five Care Partners questioned during environmental rounds will be able to speak correctly concerning actions to take when a Facility Alerts, Hazardous Material Spill Internal occurs.

- Hazardous waste disposal deficiencies will be reduced in OR, PACU and Special Procedure areas. Comparing monthly deficiencies from monthly audits reports and reporting to EOCC. This will be achieved through departmental in-service training and updating computer-based learning modules.

ORGANIZATION

- 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.

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

- PHC Leadership collaborates with the HMO to establish operating and capital budgets for the Hazardous Materials Waste Management and the Hazardous Communication Plans.

- PHC's HMO works under the direction of PHC's Assistant VP of Operations.

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

- 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.

RISK MANAGEMENT PROCESSES

- 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.

- 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.

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

- 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.

- 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.

- 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.

- 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.

- Radioactive materials are handled under PHC's NRC License. PHC's Radiation Safety Officer (RSO) 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 RSO determines when the materials are no longer hazardous.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- Black RCRA hazardous pharmaceutical waste containers have been placed in PHC medication rooms and dispensing areas. Full black containers are moved to Hazardous Waste storage on PHC's back dock. RCRA pharmaceutical waste are disposed of at least every 6 months as required by PHC's registered hazardous generator status.

- 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.

- 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.

LIFE SAFETY/FIRE SAFETY MANAGEMENT PLAN

2024

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. 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 and the 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 the Board of Directors.
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.

2023 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. Goal was **Met**. We succeeded in bringing our deficiencies to a closer time line in order to maintain compliance.

- 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, computer-based learning (CBL) and quarterly fire drills. Our goal for this task would be to test the knowledge of five Care Partners weekly during Environment of Care Rounds. This is to be monitored and tracked via rosters and monthly monitoring through 12-31-2023. Goal was **Met**, and will continue this goal for FY 24

2024 GOALS & PERFORMANCE MANAGEMENT:

- Increase Care Partner knowledge of the proper use of fire extinguishers during events. Education for proper use of Fire extinguishers is to be discussed during EOC rounding and quarterly fire drills. Our goal for this task would be to test the knowledge of five Care Partners weekly during Environment of Care Rounds with use of fire extinguisher training checklist. 80% of the Care Partners asked must understand the proper use of the fire extinguisher and locations of extinguishers in their area. This will be monitored and tracked monthly through 12-31-2024.

- 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, computer-based learning (CBL) and quarterly fire drills. Our goal for this task is to test the knowledge of five Care Partners weekly during Environment of Care Rounds and during fire drills. 80% of the Care Partners asked must understand their responsibility during an event. This will be monitored and tracked via rosters and monthly monitoring through 12-31-2024.

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
- Care Partner education in their roles in the event of a fire

Patients, Care Partner, 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 Care Partners 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 by the Security team 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's Security team 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. The scheduled time of drills are greater than one hour from the previous eight quarters in order to ensure drills are not scheduled in a pattern and continue to be unanticipated by Care Partners. 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 Care Partners 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 Care Partner 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 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 electronic education systems. .

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
- Safety issues are communicated to physicians and LIPs through e-mail and written hospital publications

MEDICAL EQUIPMENT MANAGEMENT PLAN

2024

MISSION

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 all of location sites of Parrish Healthcare

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:

- To define the process for selection and acquisition of medical equipment. This process has been reviewed within the past year.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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

- 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.
- Results of performance monitoring for Medical Equipment Management are reported to the EOCC at each meeting.
- 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.

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.

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, ~~t~~he 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 Mobile Dialysis 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.

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.

GOALS and 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.

2023 Medical Equipment Program Goals:

- Electrical safety and preventive maintenance completion rate for high risk equipment.
- Electrical safety and preventive maintenance completion rate for non-high-risk equipment.
- ICU Plum 360 IV pumps will be plugged in to maintain battery. The numbers will be pulled mid-week and averaged monthly (Goal is greater than or equal to 60 %). **Met**(Started with less than 50% and completed the year with 77.96% average units plugged in)

- Medical Equipment battery failure divided by total correctives for the month (Goal is less than or equal to 10%) **Met(**Average monthly battery failure shows less than 2%)

2024 Medical Equipment Program Goals:

- Medical Equipment battery failure divided by total correctives for the month (Goal is less than or equal to 5%) Will continue to tracking until 12-31-2024. Trending will show if battery issues begin increasing.
- Medical Equipment alert documentation – Documentation for all medical alerts that pertain to any medical equipment used at Parrish Medical Center facilities. Risk management and affected departments to be notified within 5 days of receipt until 12-31-24.

SAFETY AND SECURITY MANAGEMENT PLAN

2024

PURPOSE

To establish an annually updated plans towards the processes and goals for the Safety and Security Department within all Parrish Healthcare facilities to provide protection for our patients, visitors, care partners and the continuance in promoting a safe and secure environment of care.

SCOPE

The Safety and Security Management Plan is based on the mission, vision, and values of Parrish Healthcare (PHC). This is accomplished by using a combination of safety and security officers, electronic security, closed circuit TV systems, policy and procedures, and care partner education and training. This plan applies to the hospital and all buildings within the main campus and Parrish Healthcare facilities.

POLICY STATEMENT

To provide an effective and efficient protection plan for our patients, visitors, care partners throughout PHC.

DEFINITIONS

- Parrish Healthcare **(PHC)**
- Environment of Care **(EOC):** Any site where patients are treated, including inpatient and outpatient settings, to provide a safe, functional & effective environment for patients, staff members, and others
- Practical and Tactical Handcuffing **(PATH)**
- WELLE: Behavioral Safety Management de-escalation training for Healthcare workers
- TASER: Device used to defuse a hostile situation (person) that has become physically violent and out of control.

PROCEDURES

To establish and maintain security to protect patients, visitors, and care partners from harm, their property from theft or damage and to deter criminal activity and to safeguard the assets of the organization.

- Conduct safety and security patrols throughout the main campus, PHC facilities. These patrols are an integral and effective element of the safety and security plan. It is a necessary and effective method to detect, deter, and prevent property damage, unsafe conditions, and criminal acts.
- Conduct training and improve the level of knowledge, capabilities and performance levels of the Safety and Security Department in handling violence and de-escalating violent situations. Safety and Security Officers are trained and retrained in WELLE (Behavioral Safety Management for Healthcare), PATH (Handcuff Use and care), Taser use, Defensive Training, Patient Restraint Training.
- Educate care partners in areas of violent situations, active shooters, parking lot vulnerability and security sensitive areas. Continued coordination with the Education Department and Department has a positive impact with care partners. We will continue to have focus on patient violence de-escalation (WELLE), drills to train on active shooter events, Infant Abduction, Fire Safety, Bomb Threat, and other drills pertaining to weather conditions and potential lock down events.

- Metal Detectors (Magnetometers)in operation at the ED Entrance 24/7 to detect prohibited contraband from being brought into Parrish Medical Center. Wanding is also part of the process both enhancing the capabilities of the Parrish Medical Center Safety and Security Department to provide a safe and secure environment for all.
- Track and trend safety and security information. Data tracking provides information, accuracy and opportunities to focus on most urgent or changing needs as a part of our daily responsibilities encompassing WPV Incidents, Contraband form the Magnetometers and data/stats from the Security Operation at Parrish Medical Center.
- Monitor parking areas on campus and areas immediately surrounding the campus. Continue to ensure that ambulance entrance and roadways are kept clear at all times. This objective is effective and will continue as part of our daily responsibilities.
- Monitor Physician, care partner, vendor and visitor entry and access to areas afterwards. All care partners must display proper identification at all times and maintain integrity of secured areas. This objective has proven to be semi effective and going forth is mandatory and will be focused on and closely monitored as part of our security procedures.
- Continue to improve relationships with local law enforcement and fire department. Plan, train, practice and drill together to improve responses and procedures necessary to provide effective response in a real event. We will be conducting quarterly meetings to maintain continuity. This objective has proven to be useful and effective and will continue as part of our security procedures.

2023 GOALS AND PERFORMANCE MANAGEMENT

- De-escalation training for care partners in Security and high-risk areas (Emergency Department, ICU and Women's Center) **Unmet**

- Scanning by means of bag checks, metal detectors, wands of 75% of patients and visitors walking through Emergency Department and Main doors. **Met**

2024 GOALS AND PERFORMANCE MANAGEMENT

- Conduct Security Assessments for all PHC locations, two per month with a Goal of 100% completion. To be completed by December 31, 2024.

- Complete WELLE (de-escalation training for healthcare) for PMC Security Officers and PMC staff. Training is scheduled monthly. Goal is to train 28 care partners a month by December 31, 2024.

ANNUAL EVALUATION

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

SECURITY MANAGEMENT PLAN PROVIDES FOR:

- ***Security issues concerning patients, visitors, care partners, and property:*** Security issues are brought to the attention of the Security Manager. Security policies, security post instructions, and other procedures address specific patient, personnel, and property security. Eloped patients are reported to the Communication Center and Security Officers are dispatched to assist in the search.
- ***Security incidents are documentation***: Security incidents are documented using the Parrish Healthcare Computer Aided Dispatch Software, Investigation and Variance Reports. The Safety

and Security Manager, Security Supervisor, or Safety Officer reviews these reports and recommends appropriate action.

    - ***Identification Procedures****:* Visitor Identification - Identification is not required in public areas during normal visiting hours. After hours, access to the hospital is controlled and monitored by the Safety and Security Department. A Visitor Pass is required to be displayed after visiting hours.
    - ***Staff Identification*****:** Care Partners, volunteers, and physicians are issued photo identification badges. These badges are required to be displayed at all times while on duty or in restricted areas.
    - ***Patient Identification:*** a wristband that is fitted at the time of admission identifies patients.
    - ***Vendor Identification****:* Vendors are required to sign in and are issued a vendor badge that is to be worn at all times while on hospital premises.
    - ***Contractor Identification****:* All sub-contractors and workers are issued identification badges by the General Contractor and are required to display them while on premises. Service contractors may be issued a PHC identification badge if their contract requires frequent visits.
- ***Identification Procedure:*** Parrish Healthcare is equipped with state-of-the-art security, access control, and closed-circuit television devices to assist in providing a secure environment. These systems are monitored at all times by Communication Center staff in direct radio contact with Security Officers.
    - ***Identification Procedures****:* Visitor Identification - Identification is not required in public areas during normal visiting hours. After hours, access to the hospital is controlled and monitored by the Safety and Security Department. A Visitor Pass is required to be displayed after visiting hours.
    - ***Staff Identification*****:** Care Partners, volunteers, and physicians are issued photo identification badges. These badges are required to be displayed at all times while on duty or in restricted areas.
    - ***Patient Identification:*** a wristband that is fitted at the time of admission identifies patients.
    - ***Vendor Identification****:* Vendors are required to sign in and are issued a vendor badge that is to be worn at all times while on hospital premises.
    - ***Contractor Identification****:* All sub-contractors and workers are issued identification badges by the General Contractor and are required to display them while on premises. Service contractors may be issued a PMC identification badge if their contract requires frequent visits.
- ***Sensitive Area Access Control:*** Parrish Medial Center is equipped with state-of-the-art security, access control, and closed-circuit television devices to assist in providing a secure environment. These systems are monitored at all times by Communication Center staff in direct radio contact with Security Officers'
    - **Pharmacy** - Access to the Pharmacy is controlled by bio-reader access and high security locking devices and is restricted to pharmacy department staff. Alarm and CCTV systems provide additional security measures.
    - **Emergency Department** – Security devices control entry to the Emergency Treatment area from the patient waiting and triage rooms. Communication Center staff monitors CCTV cameras that are used in this area. All access to the Emergency Department and 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 security patrols will be done on a frequent basis daily.
    - **Woman's Center** - The Nursery is staffed at all times and access is controlled security with devices. A CCTV system is installed and is continuously monitored. Infants are protected by an electronic infant protection system that alarms whenever an infant patient is brought within a protected field.

- **Health Information Services**- This area is controlled by care partners during the day and locked during non-working hours with high security locking devices and monitored by CCTV.
- **Information Systems** – Access to this area is controlled by security devices and monitored by CCTV.

- ***Emergency Security Procedures***
  - Instructions for care partner response to security incidents (Code Gray, Black, Pink, etc.) are contained in the Emergency Management Plan, department emergency plans for every department.
  - In the event of a civil disturbance or disaster that affects the hospital, all available security staff are called in for duty; requests for assistance from other departments are made; and the Titusville Police Department will be requested to provide additional assistance for perimeter and building access control.
  - Instructions for care partner response to VIP and media events are contained in the Emergency Management Plan and in the Crisis Emergency Management Plan.
    - Lockdown procedure of facility includes he 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 facility and are included in the department emergency plans.
- ***Vehicular Access to Emergency Department Ambulance and Ambulatory Entrances***
  - The driveway to the ambulance entrance is a posted area restricting access to emergency service vehicles only. The Emergency Department walk-in area is posted "No Parking/Loading and Unloading of Passengers Only". These areas are monitored with CCTV and Security Officers patrol frequently.
- ***Orientation and Education***
  - All new hires are oriented to Security issues during initial orientation. Additional security education is provided through NETLEARNING, email, and printed material and will be distributed periodically throughout the year. All Care Partners, volunteers, and medical staff receive security related information and the Security Management Plan during new employee orientation. Employees receive an annual 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:
  - Security risks and hazards
  - General security measures
  - Emergency security procedures
  - Active Shooter training
  - Reporting of security issues
  - Identification and access control procedures
  - Emergency Management Plans

UTILITIES MANAGEMENT PLAN

2024

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. 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. 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.

FY 2023 GOALS AND PERFORMANCE MANAGEMENT:

- Proper Storage of Full and Empty O2 (E) Cylinders. This will be checked during Environment of Care (EOC) rounds. 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 monthly and monitored through 12-31-2023. **Unmet**

- Increase Care Partner Knowledge of Med Gas zone valve box locations and shut down procedures during events. Education for Med Gas valve boxes will be discussed during EOC rounding 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 monthly and monitored through 12-31-2023. **Unmet**

FY 2024 GOALS AND PERFORMANCE MANAGEMENT:

- Proper Storage of Full and Empty O2 (E) Cylinders. Our goal for this task would be to test the knowledge of 5 care partners weekly during Environment of Care Rounds, 75% of the care partners asked must have working knowledge of the proper storage of O2 storage process. Note: departments that do not have interactions with oxygens usage are exempted. This will be monitored and tracked monthly through 12-31-2024.

- Increase Care Partner Knowledge of Med Gas zone valve box locations and shut down procedures during events. Education for Med Gas valve boxes will be discussed during EOC rounding 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, 80% of the care partners asked must understand the shutdown process and locations. Note: departments that do not have interactions with oxygens usage are exempted. This will be monitored and tracked monthly through 12-31-2024.

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 Respiratory Therapist (RT) 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 Professional 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 and Quality Resource Management. 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 120ºF. 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.

4 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 110-2019. 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 Prevention Professional
- 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 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:

USERS

- 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?

MAINTAINERS

- 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.
Training records are kept in the electronic education systems..

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

WORKER SAFETY MANAGEMENT PLAN

2024

PURPOSE

The Worker Safety Management plan is based on the mission, vision, and values of Parrish Health Care (PHC) and is designed, educated, implememted, measured, assessed for effectiveness, changed and improved to provide a physical environment free of hazards and to decrease the risk of worker injuries and workplace violence. 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.

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 (PHC) Care Partners and facilitates.

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. Training is the most important aspect of a successful workplace violence prevention and response program.

OBJECTIVES

- Minimize safety hazards by conducting Safety Surveillance Inspections, Proper Lift Training with Rehab & Employee Mental Well-Being.

- 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, Standard Precautions for infection control and workplace violence prevention. Establish a threat assessment team to proactively assess and prevent potential workplace violence.

- 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, investigation program, and prevent of workplace violence.

ORGANIZATION AND RESPONSIBILITY

- 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 that incorporates the recognition of workplace violence and reporting warning signs. 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.

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

- 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.

PERFORMANCE MEASURE/MONITORING

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.

2023 GOALS AND PERFORMANCE MANAGEMENT

- One Hundred percent (100%) of Care Partners with musculoskeletal injuries during 2023 were referred to Rehabilitation for strengthening and training in proper movement and lifting skills; monitored by scheduled appointments and documented completion by MD notes. **Met**
- There was an increase the number of injuries to Care Partners by percent (3.2%). The overall reported Care Partner injuries during 2023 increased 7.45%. **Unmet**
- A new bariatric lift has been added to the facility with a focus on training the nurse to work with rehab to better service bariatric patient needs and reduce injuries.
- Workplace violence training occurred to identify potential harm, Care Partner register for course through eLearning.

2024 GOALS AND PERFORMANCE MANAGEMENT

- 85% of active Care Partners that have direct patient contact will be trained in person on lift training for bariatric patients with hospitals lift equipment within the competency period (2-1-24 to 6-30-24).

PROCESSES OF THE WORKER SAFETY MANANGMENT PLAN

- 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, illnesses and mental wellness.

- The Employee Health Nurse reviews incidents, employee attacks or illnesses that result in investigation. It is the responsibility of all PHC Care Partners to report an incident, attacks or illness at the time of the occurrence.

- 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.

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

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

- 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 Department Leadership who may need to conduct a further investigation or provide follow up information.

- 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.