MEMORANDUM

To: Board of Directors

Cc: Bill Boyles, Esquire
Ramesh Patel, M.D.

From: George Mikitarian
President/CEO

Subject: Board/Committee Meetings – March 1, 2021

Date: February 22, 2021

The Investment Committee will meet at 10:30 a.m. in the Executive Conference room.

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

The Quality Committee will convene at 12:00 p.m., which will be followed by the 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.

Investment Committee:
Jerry Noffel, Chairperson
Peggy Crooks
Stan Retz, CPA

TENTATIVE AGENDA
INVESTMENT COMMITTEE
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, MARCH 01, 2021, 10:30 AM
EXECUTIVE CONFERENCE ROOM

CALL TO ORDER

I. Public Comment

II. Review and approval of minutes August 25, 2020.

Motion: To recommend approval of the August 25, 2020 meeting minutes as presented.

III. Allocations and Rebalancing of Investment Portfolios – Anderson Financial Partners

IV. Adjournment

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
INVESTMENT COMMITTEE
AUGUST 25, 2020
TELECONFERENCE

The Investment Committee of the North Brevard County Hospital District Board of Directors met on August 25, 2020 via teleconference at 3:00 p.m. The following members, representing a quorum, were present:

Jerry Noffel, Chairperson
Stan Retz
Peggy Crooks

Others present:
Kent Bailey, Vice President-Finance
Pam Perez, Administrative Assistant
Tim Anderson, Anderson Financial Partners
John Anderson, Anderson Financial Partners
Douglas Lozen, Foster & Foster

Call to Order

Mr. Noffel called the meeting to order at 3:06 p.m.

Public Comment

No public comments presented.

Review and Approval of Minutes

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

Action Taken: Motion to approve the minutes of the March 02, 2020 meeting as presented.

Operating Funds Performance Summary

Tim Anderson, Anderson Financial Partners, gave a brief economic commentary and presented the committee with three questions they are asking of all their clients:

- Are your asset allocations where they need to be?
- Are your portfolios out of balance, do you need to consider a rebalance?
- Do you foresee a cash need in the future? Markets are high, this would be the time to raise the cash.

John Anderson, Anderson Financial Partners reviewed the quarterly summary for the Operating Funds in addition to the summary of performance from the fund managers. The fund managers are performing well and no recommendations to change anything at this time.

The committee addressed the target allocations in regards to the policy and discussion ensued regarding a rebalancing of target allocations and the following motions was made by Mr. Retz, seconded by Ms. Crooks, and approved without objection.

Action Taken: Motion to approve moving $5 mil from equities to fixed income, and allow for management to work with Anderson Financial Partners on the details in regards to timing to maximize year end plan and ensure continuing compliance with debt covenant requirements.

Pension Plan Assumption Rate

Mr. Bailey brought back to the committee the need to lower the assumption rate.

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

Action Taken: Motion to approve reducing the pension assumption rate for the defined benefit plan from 7.35% to 7.10% for the 10/1/2020 valuation.

Adjournment

There being no further business the meeting adjourned at 4:04 p.m.

_____

Jerry Noffel, Chairperson

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE
MONDAY, MARCH 1, 2021
12:00 P.M.
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Election of Chairperson & Vice Chairperson

II. Approval of Minutes

Motion to approve the minutes of the January 4, 2021 meeting.

III. Vision Statement

IV. Public Comment

V. "My Story"

VI. Dashboard Review

VII. Care of our Stroke patients

VIII. Other

IX. Executive Session (if necessary)

ADJOURNMENT

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

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE

A regular meeting of the Quality Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on January 4, 2021 in Conference Room 2/3/4/5, First Floor. The following members were present.

Elizabeth Galfo, M.D., Chairperson
Herman A. Cole, Jr., Vice Chairperson (remote)
Peggy Crooks
Billie Fitzgerald
Maureen Rupe
Robert L. Jordan, Jr., C.M.
Stan Retz, CPA (remote)
Ashok Shah, M.D.
Jerry Noffel
Ramesh Patel, M.D., President/Medical Staff
Christopher Manion, M.D.
Gregory Cuculino M.D.
George Mikitarian (non-voting)

Members absent:
Jeram Chapla, M.D. (excused)
Kiran Modi, M.D. (excused)

CALL TO ORDER

Dr. Galfo called the meeting to order at 12:04 p.m.

REMOTE PARTICIPATION

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

ACTION TAKEN: **MOTION TO RECOMMEND THE QUALITY COMMITTEE OF THE BOARD OF DIRECTORS TO ALLOW, DUE TO EXTRAORDINARY CIRCUMSTANCES RELATED TO COVID-19, HERMAN COLE AND STAN RETZ TO PARTICIPATE REMOTELY AND VOTE ON MATTERS COMING BEFORE THIS JANUARY 4, 2021 MEETING OF THE QUALITY COMMITTEE.**

REVIEW AND APPROVAL OF MINUTES

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

ACTION TAKEN: **APPROVE THE NOVEMBER 2, 2020 MEETING MINUTES, AS PRESENTED.**

VISION STATEMENT

Mr. Loftin summarized the committee's vision statement.

PUBLIC COMMENTS

There were no public comments.

MY STORY

Mr. Loftin shared the story of Larry, who during his journey has shown strength in the most difficult times.

QUALITY DASHBOARD REVIEW

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

PATIENT SAFETY INDICATOR – 3 FOCUS

Mr. Loftin reviewed the Patient Safety Indicator for Hospital Acquired Pressure Injuries. Mr. Loftin shared that PMC has developed mandatory Braden Score education program for all care partners, noting improvements are already observable.

JOINT COMMISSION TRIENNIAL REVIEW

Mr. Loftin shared that PMC was asked to be the first hospital to participate in a virtual joint commission survey. This joint commission survey, expected this week, will be similar to the in-person surveys, and will be followed by a one day in- person Life Safety Accreditation survey on the premises. Mr. Loftin added that PMC was last surveyed January 3-5, 2018.

OTHER

There was no other business brought before the committee.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 12:34 p.m.

Elizabeth Galfo, M.D.
Chairperson

FINANCE COMMITTEE
Peggy Crooks, Chairperson
Robert L. Jordan, Jr., C.M., (ex-officio)
Stan Retz, CPA
Herman A. Cole, Jr.
Jerry Noffel
Christopher Manion, M.D.
George Mikitarian, President/CEO (non-voting)
Ramesh Patel, M.D., President/Medical Staff

TENTATIVE AGENDA
FINANCE COMMITTEE MEETING - REGULAR
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, MARCH 01, 2021
FIRST FLOOR CONFERENCE ROOMS 2/3/4/5
(IMMEDIATELY FOLLOWING QUALITY COMMITTEE)

CALL TO ORDER

I. Public Comments

II. Election of Vice Chairperson

III. Review and approve minutes of (January 04, 2021)

Motion: To recommend approval of the January 04, 2021 minutes as presented.

IV. Financial Review – Mr. Bailey

V. Disposal

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

VI. Executive Session (if necessary)

ADJOURNMENT

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

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

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NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
FINANCE COMMITTEE

A regular meeting of the Budget and Finance Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on January 4, 2021 in Conference Room 2/3/4/5, First Floor. The following members, representing a quorum, were present:

Stan Retz, Chairperson (remote)
Peggy Crooks, Vice Chairperson
Herman A. Cole, Jr. (remote)
Elizabeth Galfo, M.D.
Robert Jordan, Jr., C.M.
Billie Fitzgerald
Jerry Noffel
Ramesh Patel, M.D.
Christopher Manion, 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. Retz called the meeting to order at 12:36 p.m.

REMOTE PARTICIPATION

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

ACTION TAKEN: **MOTION TO RECOMMEND THE FINANCE COMMITTEE OF THE BOARD OF DIRECTORS ALLOW, DUE TO EXTRAORDINARY CIRCUMSTANCES RELATED TO COVID-19, HERMAN COLE AND STAN RETZ TO PARTICIPATE REMOTELY IN THE FINANCE COMMITTEE MEETING AND VOTE ON MATTERS COMING BEFORE THE JANUARY 4, 2021 MEETING OF THE FINANCE COMMITTEE.**

At this time, Mr. Retz handed chairing the meeting over to Ms. Crooks since he was participating remotely.

REVIEW AND APPROVAL OF MINUTES

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

ACTION TAKEN: **MOTION THAT THE FINANCE COMMITTEE OF THE BOARD OF DIRECTORS APPROVE THE NOVEMBER 2, 2020 MEETING MINUTES, AS PRESENTED.**

PUBLIC COMMENTS

There were no public comments.

FINANCIAL REVIEW

Mr. Bailey summarized the November 2020 financial statements.

PARRISH MEDICAL CENTER V. METRUS SETTLEMENT

Messrs. Boyles and Brennan summarized the settlement reached between Parrish Medical Center and Metrus Energy in regard to ongoing litigation. Discussion ensued and the following motion was made by Mr. Jordan, seconded by Dr. Galfo and approved (9 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO RECOMMEND THE BOARD OF DIRECTORS APPROVE THE PROPOSED SETTLEMENT RELATED TO THE METRUS ENERGY DISPUTE AND AUTHORIZE THE PRESIDENT AND CHIEF EXECUTIVE OFFICER TO FINALIZE THE TERMS AND EXECUTE THE SETTLEMENT AGREEMENT AND ALL DOCUMENTS NECESSARY TO IMPLEMENT THE SETTLEMENT AGREEMENT.**

DISPOSALS

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

ACTION TAKEN: **MOTION TO RECOMMEND THE BOARD OF DIRECTORS TO DECLARE THE EQUIPMENT LISTED IN THE REQUESTS FOR DISPOSAL OF OBSOLETE OR SURPLUS PROPERTY FORMS AS SURPLUS AND OBSOLETE AND DISPOSE OF SAME IN ACCORDANCE WITH FS274.05 AND FS274.96.**

AUDIT REPORTS

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

ACTION TAKEN: **MOTION: TO RECOMMEND TO THE BOARD OF DIRECTORS TO ACCEPT THE FISCAL YEAR 2020 AUDIT RESULTS AND REPORTS:**

- **AUDITED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION**
- **REPORT ON INTERNAL CONTROL AND COMPLIANCE**
- **COMMUNICATIONS WITH THE BOARD OF DIRECTORS AND AUDIT COMMITTEE**
- **MANAGEMENT LETTER**

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 1:29 p.m.

Peggy Crooks
Vice Chairperson

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

Request for Disposal of Obsolete or Surplus Property

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

Asset Description	Asset Control KN #	Purchase Date	Purchase Amount	CE #	Reason for Disposal	Net Book Value (Provided by Finance)	Dept. #
Fresenius 2008K Dialysis machine, 2 units	KN028443	6/1/2005	13200	2910	Unit end of life, no longer supported by manufacturer and unable to be repaired.	-0-	1.344 Dialysis
	KN029057	6/20/2008	13200	4393		-0-	
Dialysis RO machines, 2 units	KN028444	6/1/2005	6000	2911		-0-	
		6/20/2008	6000	2694		-0-	

Requesting Department 1.344 Dialysis — Department Director Matthew F. Carlucci 1/21/21

Net Book Value (Finance) A. Travers 1/21/21 — EMC Member [signature] 1.26.21

Sr. VP Finance/CFO [signature] 1/26/21 — President/CEO _____

Board Approval: (Date) _____ — CFO Signature [signature] 1/22/21

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

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

Request for Disposal of Obsolete or Surplus Property

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

Asset Description Hyperbaric Chamber	Asset Control KN#	CE#	Reason for Disposal	Net Book Value	Code*	Decontamination Complete	
						Y,N,NA	Initial
Sechrist Model 3300H SN33HS0197	KN029932	PMC04290	Surplus	$52,619.96	NA	NA	
Sechrist Model 3300HR SN33HS0195	KN029933	PMC04291	Surplus	$52,619.96	NA	NA	

*Disposition Codes:

Discard after Salvage of Parts - **S** | Discard - **D** | Donate - **N** | Store - **T**

Requesting Department: Administration 1/1,318 PSJ WC | Department Director: Chris Fox

Net Book Value (Finance): 2/3/21 | EMC Member: 2/8/21

Sr. VP Finance/CFO | President/CEO: 2/10/21

Board Approved (CFO Signature)

Requestor Notified Finance

Asset Disposed of or Donated

Removed from Asset List (Finance)

Requested Public Entity for Donation

Entity Contact

Telephone

CC: Risk Manager, Patient Safety Office

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

DRAFT AGENDA
EXECUTIVE COMMITTEE
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, MARCH 1, 2021
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 January 4, 2021 meeting, as presented.

II. Reading of the Huddle

III. Public Comment

IV. Attorney Report – Mr. Boyles

V. CEO Performance Review – Mr. Boyles

VI. Other

VII. 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.

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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 January 4, 2021 in Conference Room 2/3/4/5, First Floor. The following members were present:

Robert L. Jordan, Jr., C.M., Chairman
Herman A. Cole, Jr. (remote)
Peggy Crooks
Stan Retz, CPA (remote)
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. Jordan called the meeting to order at 1:49 p.m.

REMOTE PARTICIPATION

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

ACTION TAKEN: **MOTION TO RECOMMEND THE EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS ALLOW, DUE TO EXTRAORDINARY CIRCUMSTANCES RELATED TO COVID-19, HERMAN COLE AND STAN RETZ TO PARTICIPATE IN THE EXECUTIVE COMMITTEE MEETING REMOTELY AND VOTE ON MATTERS COMING BEFORE THE JANUARY 4, 2021 MEETING OF THE EXECUTIVE COMMITTEE.**

REVIEW AND APPROVAL OF MINUTES

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

ACTION TAKEN: **APPROVE THE NOVEMBER 2, 2020 MEETING MINUTES OF THE EXECUTIVE COMMITTEE, AS PRESENTED.**

READING OF THE HUDDLE

Dr. Galfo read the Weekly Huddle.

PUBLIC COMMENT

There were no public comments.

AMENDED AND RESTATED PMC CORPORATE COMPLIANCE PROGRAM

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

ACTION TAKEN: **MOTION TO APPROVE THE RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT REGARDING THE UPDATED NORTH BREVARD COUNTY HOSPITAL DISTRICT CORPORATE COMPLIANCE PROGRAM.**

ATTORNEY REPORT

No attorney report was presented.

OTHER

There was no other business to discuss.

ADJOURNMENT

There being no further business to discuss, the committee adjourned at 1:55 p.m.

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

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE
MONDAY, MARCH 1, 2021
IMMEDIATELY FOLLOWING EXECUTIVE SESSION
FIRST FLOOR CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Election of Chairperson & Vice Chairperson

II. 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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DRAFT AGENDA
BOARD OF DIRECTORS MEETING - REGULAR MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MARCH 1, 2021
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)

V. Review and Approval of Minutes (January 4, 2021 Regular Meeting)

VI. Open Forum for PMC Physicians

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

VIII. Unfinished Business***

IX. New Business***

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

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

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

C. **Motion to Recommend the Board of Directors approve the Provision of Non-Audit Services Provided by District's Audit Firm policy, as presented.**

X. Medical Staff Report Recommendations/Announcements

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

XII. Consent Agenda***

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

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

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

XIII. Committee Reports

A. Quality Committee

B. Finance Committee

C. Executive Committee

D. Educational, Governmental and Community Relations Committee

E. Planning, Physical Facilities & Properties Committee

XIV. Process and Quality Report – Mr. Mikitarian

A. Other Related Management Issues/Information

B. Hospital Attorney - Mr. Boyles

XVI. Other

XVII. Closing Remarks – Chairman

XVIII. Executive Session (if necessary)

ADJOURNMENT

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

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

A regular meeting of the Board of Directors of the North Brevard County Hospital District operating Parrish Medical Center was held at 3:01 p.m. on January 4, 2021 in Conference Room 2/3/4/5, First Floor. The following members were present:

Herman A. Cole, Jr., Chairman (remote)
Robert L. Jordan, Jr., C.M.
Stan Retz (Remote)
Billie Fitzgerald
Peggy Crooks
Elizabeth Galfo, M.D.
Ashok Shah, M.D.
Maureen Rupe
Jerry Noffel

Member(s) Absent:

None

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

CALL TO ORDER

Mr. Cole called the meeting to order at 3:04 p.m.
At this time Mr. Cole assigned the duty of Chairman to Robert Jordan since he was participating remotely. Mr. Jordan accepted.

REMOTE PARTICIPATION

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

ACTION TAKEN: **MOTION THAT THE BOARD OF DIRECTORS ALLOW, DUE TO EXTRAORDINARY CIRCUMSTANCES RELATED TO COVID-19, HERMAN COLE AND STAN RETZ TO PARTICIPATE REMOTELY IN THE REGULAR MEETING OF THE BOARD OF DIRECTORS AND VOTE ON MATTERS COMING BEFORE THE BOARD OF DIRECTORS IN THE JANUARY 4, 2021 REGULAR MEETING OF THE BOARD OF DIRECTORS.**

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®.*

AGENDA AMENDMENT

Mr. Jordan requested the Public Comments portion of the agenda be moved up to item IV.

APPROVAL OF AGENDA

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

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

PUBLIC COMMENTS

Members of the public spoke at this time. A copy of the public appearance requests are appended to the file copy of these minutes.

RECOGNITIONS

Mr. Jordan recognized and thanked Dr. Storey for his service as Medical Staff President during this exceptionally challenging past year. Mr. Jordan presented Dr. Storey with a plaque in recognition for his service. Dr. Storey thanked Mr. Jordan and the Board of Directors, sharing that is has been his pleasure to serve the Board and the Medical Staff.

SECRETARY'S REPORT & ELECTION OF OFFICERS

Ms. Crooks, Secretary of the North Brevard County Hospital District Board of Directors reviewed the process for the election of officers.

Immediately after nominations are closed for each office, the election for that officer will be held. Ballots will then be distributed, dated and signed by each Board Member. The tellers will count the ballots and provide the results to the Chairperson. The ballots are public records and will continue to be available.

Mr. Jordan then nominated Mr. Boyles and Mr. Kancilia as tellers to distribute, collect and count the ballots.

Election of Chairperson

Ms. Crooks indicated that Mr. Cole, Mr. Jordan and Mr. Retz had been nominated as Chairperson. Mr. Boyles distributed the ballots for Chairperson, which were marked signed by each Board member and collected. Mr. Boyles and Mr. Kancilia counted the ballots and recorded the results.

Mr. Boyles announced the results, stating that there was a three-way tie. Ballots were again distributed, collected and counted. Mr. Boyles announced the second round of voting results which again resulted in a three-way tie.

At this time, Mr. Cole, Mr. Jordan and Mr. Retz each gave a 3 minute speech regarding why he was running for Chairperson of the Board of Directors. Ballots were again distributed, collected and counted. Mr. Boyles announced the third round of voting again resulted in a three-way tie. At this time, Mr. Cole withdrew his name from the election and Mr. Retz stated he would put his support behind Mr. Jordan.

At this time, a verbal vote was taken by roll call; Ms. Rupe, Dr. Galfo, Ms. Fitzgerald, Mr. Jordan, Dr. Shah, Mr. Cole and Mr. Retz voted for Mr. Jordan. Mr. Noffel and Ms. Crooks voted for Mr. Retz. The results were seven votes for Mr. Jordan, two votes for Mr. Retz. Ms. Crooks announced the results, stating that Mr. Jordan was elected as Chairperson.

Election of Vice-Chairperson

Ms. Crooks indicated that there was no nomination for Vice-Chairperson. Dr. Galfo nominated Mr. Retz as Vice Chairperson, and his name was added to the ballot. Mr. Jordan moved to close the nomination, seconded by Mr. Cole. Mr. Boyles distributed the ballots for Vice Chairperson, which were marked signed by each Board member and collected. Mr. Boyles and Mr. Kancilia counted the ballots and recorded the results. Ms. Crooks announced the results, stating that Mr. Retz was elected as Vice Chairperson.

Election of Secretary

Ms. Crooks indicated that there was no nomination for Secretary. Mr. Jordan nominated Dr. Galfo as Secretary, and her name was added to the ballot. Mr. Jordan moved to close the nominations, seconded by Mr. Cole. Mr. Boyles distributed the ballots for Secretary, which were marked signed by each Board member and collected. Mr. Boyles and Mr. Kancilia counted the ballots and recorded the results. Ms. Crooks announced the results, stating that Dr. Galfo was elected as Secretary.

Election of Treasurer

Ms. Crooks indicated that she had been nominated as Treasurer, and no other names were presented. Dr. Galfo moved to close the nominations, seconded by Mr. Cole. Mr. Boyles distributed the ballots for Treasurer, which were marked signed by each Board member and

collected. Mr. Boyles and Mr. Kancilia counted the ballots and recorded the results. Ms. Crooks announced the results, stating that she has been elected as Treasurer.

Election of Member-at-Large

Ms. Crooks indicated that there was no nomination for Member-at-Large. Ms. Crooks moved to nominate Mr. Cole for Member-at-Large, and his name was added to the ballot. Mr. Boyles distributed the ballots for Member-at-Large, which were marked signed by each Board member and collected. Mr. Boyles and Mr. Kancilia counted the ballots and recorded the results. Ms. Crooks announced the results, stating that Mr. Cole was elected as Member-at-Large, and this concluded the election.

REVIEW AND APPROVAL OF MINUTES

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

ACTION TAKEN: **MOTION TO APPROVE THE MINUTES OF THE NOVEMBER 2, 2020 REGULAR MEETING OF THE BOARD OF DIRECTORS OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT, AS PRESENTED.**

OPEN FORUM FOR PMC PHYSICIANS

There were no physician comments.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

There was no new business.

MEDICAL STAFF REPORT RECOMMENDATIONS/ANNOUNCEMENTS

There were no recommendations or announcements.

CONSENT AGENDA

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

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

A. Audit

1. To recommend to the Board of Directors accept the Fiscal Year 2020 audit results and reports:
    - Audited Financial Statements and Supplementary Information
    - Report on Internal Control and Compliance
    - Communications With the Board of Directors and Audit Committee
    - Management Letter

2. **To recommend the Board of Directors allow, due to an extraordinary circumstance related to Covid-19, Herman Cole and Stan Retz to participate remotely and vote on committee matters in this January 4, 2021 meeting of the Audit Committee.**

B. Quality

1. **To recommend the Board of Directors allow, due to extraordinary circumstances related to Covid-19, Herman Cole and Stan Retz to participate remotely and vote on matters coming before the January 4, 2021 meeting of the Quality Committee.**

C. Finance

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

2. Motion To approve the proposed settlement in the Metrus Energy dispute and authorize the President and Chief Executive Officer to finalize the terms and execute the settlement agreement and all documents necessary to implement the settlement agreement.

3. To recommend to the Board of Directors accept the Fiscal Year 2020 audit results and reports:
    - Audited Financial Statements and Supplementary Information
    - Report on Internal Control and Compliance
    - Communications With the Board of Directors and Audit Committee
    - Management Letter

4. **To recommend the Board of Directors allow, due to an extraordinary circumstance related to Covid-19, Herman Cole and Stan Retz to participate remotely in the Finance Committee Meeting and vote on**

matters coming before the January 4, 2021 meeting of the Finance Committee.

D. Executive

1. Motion to approve the Resolution of the Board of Directors of the North Brevard County Hospital District regarding the updated North Brevard County Hospital District Corporate Compliance Program.

2. **To recommend the Board of Directors allow, due to extraordinary circumstances related to Covid-19, Herman Cole and Stan Retz to participate remotely and vote on matters coming before the January 4, 2021 meeting of the Executive Committee.**

COMMITTEE REPORTS

Quality Committee

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

Finance Committee

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

Executive Committee

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

Educational, Governmental and Community Relations Committee

Mr. Jordan reported the Education Committee did not meet.

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 reminded the Board that we are expecting the Joint Commission survey this week, noting that the Chairman will be notified when the survey begins.

Mr. Mikitarian added that PMC continues to comply with CDC guidelines on vaccine distribution.

Hospital Attorney

Legal counsel had no report.

OTHER

Ms. Crooks took this time to congratulate Mr. Loftin on his 14 years with Parrish Medical Center.

Dr. Galfo expressed her thanks to Mr. Cole for his eight years as Chairman of the Board. Ms. Fitzgerald, Dr. Shah ad Mr. Jordan also expressed their appreciation to Mr. Cole for his years of Service to the Board of Directors.

CLOSING REMARKS

Mr. Jordan expressed his appreciation to the Board for electing him as Chairman, noting that he is grateful for the opportunity to serve.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 4:08 p.m.

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

Parrish Health Care

Environment of Care (EOC) Committee Report:
Annual Report for Calendar Year 2020
Executive Summary

During the first quarter of each year the Environment of Care Committee (EOCC) Chair, along with the Environment of Care Plan Owners, review each of the plans in terms of the objectives, scope, performance and effectiveness. Should any plan need its objectives or scope modified, the changes are made and these changes are taken to the EOCC for review and approval. The effectiveness of each plan is reviewed in terms of care partner feedback, care partner knowledge, and regulatory/accrediting body reviews. If there have been any regulatory or accrediting body changes to the requirements during the prior year, the plans are updated to reflect such changes.

In December of 2020 and January of 2021, the EOCC reviewed an evaluation of each of the Environment of Care Plans which contain the objectives, scope and effectiveness of each plan; the committee approved this document as presented. The Environment of Care was an effective program for 2020. Goals for 2021 are set based on prior incidences and risk assessments. The 2021 goals are listed below and the results of the 2020 goals are highlighted.

Outcome of a goal as specified with a color coded RESULT: MET / NOT MET

Safety and Security

2020Goal(s)

A. One Hundred Percent (100%) of active Security Officers will complete training in management of aggressive behavior (MOAB) by March 31, 2020. MET
B. Track Security Officer rounds to assure 80% of all areas are patrolled daily. NOT MET

2021 Goal(s):

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

Hazardous Materials

2020 Goal(s)

A. Education, Training, and Action for Code Orange NOT MET
B. Reduction of Biohazardous Waste NOT MET

Neither goal was met as no baseline was established for a threshold to be determined; nor was there a methodology in how to gather the appropriate data established. The up side of these goals is that even though there was an increase in the amount of biohazardous waste due to COVID-19, the weight of hazardous waste removed from the facility in 2020 was essentially the same as in 2019.

2021 Goal(s)

A. 75% of care partners questioned during environmental rounds will be able to speak correctly concerning actions to take when a Code Orange (hazardous spill/event) occurs.
B. Reduce the number of hazardous waste disposal deficiencies by 10 percent from 2020 as reported through the monthly audit of same.

Emergency Management

2020 Goal(s)

A. Two tests of the Comprehensive Emergency Management Plan will take place in 2020. MET
   1. An internal event: Code Pink (Drill) February 2020
   2. An external event: Code Green (Real Event) COVID-19 Response - ongoing

2021 Goal(s)

A. In spite of the ongoing Code Green, PHC will conduct several tests of the Comprehensive Emergency Management Plan:
   1. Internal Event: Code Black at the hospital
   2. Internal Event: Code Black at the Port St. John Building
   3. Internal Event: Code Black at the Titus Landing Building
   4. Internal Event: Code Pink
   5. External Event: Code Green – Covid-19 continues currently at a level 3
   6. Any other test that may appear on the Hazard Vulnerability Analysis which will be completed not later than May 31, 2021
   7. Participation in any Brevard County Emergency Management Drill, if available.

Life Safety

2020 Goal(s)

A. Life Safety PM completion rate will be at 100% MET
B. Conduct one Fire Drill in an Operating Room Suite with a physician involved in the drill NOT MET
C. Annual life safety inspection of 100% in all facilities MET

While there was a fire drill conducted in an Operating Room Suite, there was no physician involved.

2021 Goal(s)

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

Medical Equipment

2020 Goal(s)

A. Track medical equipment user error NOT MET
B. Track damage and abuse of medical equipment NOT MET
C. Track valid work order requests (not user error) NOT MET

2021 Goal(s)

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

Utilities Management

2020 Goal(s)

A. Critical utilities testing completed at 100% of required MET
B. Annual Medical Gas component testing at 100% of required MET
C. Environmental Rounds conducted at 100% of required MET
D. Non-Critical utility PM completion at 100% of required MET

2021 Goals

A. Improvement of room pressure compliance in all designated high risk areas and in licensed off-site locations to 90%
B. A adopt a standardized flushing program to include chlorine content and water temperature monitoring not later than April 30, 2021

Worker Safety

2020 Goal(s)

A. Monitor and track employee lost time and restrictive days due to any work related incident or injury. NOT MET
B. The threshold for lost time days will remain the same as we strive for zero lost time days. NOT MET

2021 Goal(s)

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

ENVIRONMENT OF CARE

2020

ANNUAL REPORT

By

Environment of Care Committee

March 1, 2021

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I. ENIRONMENT OF CARE SCOPE:

EOCC scope includes all PHC inpatient and ambulatory clinical sites. The EOCC through the seven (7) management plans ensure areas are monitored and evaluated for hazards and address issues related to patient, visitor, care partner and medical staff safety. EOC plans as measured through annual evaluation of the 7 Management Plans are approved by the EOCC, PHC Administration, and the hospital Board.

PHC departments responsible for the EOC are:

A. Plant Services (Maintenance)
B. Environmental Services (Housekeeping, Hazardous Waste Pickup)
C. Security
D. Clinical Equipment
E. Food and Nutrition
F. Human Resources and Employee Health
G. Risk Management

The EOCC Chair leads the EOCC who, based on the implementation and evaluation of the 7 Plans, perform an annual evaluation assuring that any needed changes are noted in the 2020 Plans Evaluation, and incorporate such changes into the 2021 Management Plans.

The 7 Plans and additional activities of the EOCC are:

A. Worker Safety Plan
B. Safety & Security Management
C. Life Safety/Fire Safety (Protection of PHC assets from fire and products of combustion)
D. Emergency Management
E. Waste Management and Hazard Surveillance
F. Clinical Equipment
G. Utility Management
H. Review of FDA Equipment Failures, Recalls, and Reporting of same
I. Assuring orientation & education for newly hired employees as well as annual education for current care partners

II. STATEMENT OF CONDITIONS

PHC prepares a Statement of Conditions (SOC) to determine PHC facility status in regards to all regulatory requirements, assuring all buildings are appropriately maintained, regularly reviewed and evaluated with revision as needed through the EOCC. All defects identified are specifically required to be corrected within sixty (60) days of identification per The Joint Commission (TJC) standards.

Florida's Agency for Health Care Administration (AHCA) conducts bi-annual surveys to assure that State requirements are met. The last bi-annual survey was in August 2019. All deficiencies found in that survey were corrected in appropriate time frames. As of the end of 2020 the next TJC triennial survey is expected to take place in January 2021.

III. MANAGEMENT PLAN OBJECTIVES

The primary objective of the PHC EOCC is to maintain a safe and reliable facility, and an appropriate healing environment. EOC Plan objectives are designed to minimize adverse occurrences through recognition, evaluation, and elimination of workplace safety hazards. The EOCC strives to be proactive in addressing any safety hazards, and meeting or exceeding compliance with all laws, regulations and rules concerning healthcare environment. Each of the 7 plans addresses their respective requirements, identifies objectives for maintaining and improving the area(s) addressed, and measuring identified goals to meet the objectives.

V. MANAGEMENT PLAN STANDARDS

One of the evaluations for EOC Management Plans is the determination of meeting acceptable practice standards and meeting the stated standards, as follows:

A. EMPLOYEE SAFETY MANAGEMENT

1. EOCC met at least quarterly?	Yes
2. EOC Rounds conducted at least semi-annually for all clinical areas?	Yes
3. EOC Rounds conducted annually for all non-clinical areas?	Yes
4. Employee Safety Plan Performance Improvement (PI) reviewed by the EOCC quarterly?	No[1]

B. LIFE SAFETY MANAGEMENT

1. PHC Fire Plan approved during 2020 by City of Titusville Fire Marshal?	No[2]
2. Required fire drills, one per shift per quarter at PMC, and annually at the off-site facilities completed?	Yes
3. Interim Life Safety Measures were implemented as needed?	Yes
4. Life Safety Plan PI was reviewed by EOCC quarterly?	Yes

[1] Due to the COVID-19 emergency, the Employee Health Nurse was unable to attend all meetings. Data to be presented has been modified and will meet this standard in 2021

[2] There was a delay in having the plan approved by the end of 2020 due to the COVID-19 emergency and a revision of the plan to provide more specifics

C. HAZARDOUS MATERIALS AND WASTE MANAGEMENT

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

D. SECURITY MANAGEMENT

1. Safety & Security Management Plans/policies were evaluated and updated?	Yes
2. Care Partners in sensitive areas were educated on the security issues?	Yes
3. Security rounds were conducted at regular intervals?	No[3]
4. The Security Plan PI was reviewed by EOC Task Force quarterly?	Yes

E. EMERGENCY MANAGEMENT

1. Emergency Management Plans were evaluated and updated?	Yes
2. Comprehensive Emergency Management Plan approved by the B.E.O.C.?	No[4]
3. PMC's Emergency Plan was activated at least twice?	Yes
4. Plan activations were critiqued and follow-up actions were addressed?	Yes[5]
5. Management Plan PI's were reviewed by the EOC task force quarterly?	Yes

F. CLINICAL EQUIPMENT MANAGEMENT[6]

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

G. UTILITY MANAGEMENT

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

[3] The goal set to meet this standard could not be met as the system set to gather the metrics failed. This goal has been renewed.
[4] This is an ongoing process to assure the full Comprehensive Emergency Plan meets all standards and is easy for use by those involved
[5] Due to the ongoing Code Green, the critique and changes to be made are an on-going process
[6] Multiple changes in personnel over the last year delayed/prevented effective monitoring. The plan was effective, just not consistent in the ability to measure or assure completely.

V. MANAGEMENT PLAN EFFECTIVENESS

While there were elements of some plans that could not be measured, based on overall outcomes of EOCC reports and findings on EOC rounds, it has been determined that the management plans approved in 2020 ultimately were effective. Each individual responsible for a plan or plans made some edits or revisions to the particular plan(s). Additionally, plan owners worked with the EOCC to determine goals that are "S.M.A.R.T." (simple/specific, measurable, achievable, relevant, and time bound).

Plan	2020 PI Goals	Outcomes/Follow-up
Worker Safety	**A)** Lost Work Day Rate (LWDR)	**A)** While tracked as a number, there were no goals set for improvement/ reduction; therefore the goal was not met. New measurable metric chosen.
Life Safety	**A)** PM completion rate 100% **B)** Conduct one fire drill in an OR suite with physician involvement **C)** Annual life safety inspection in 100% of PHC occupied facilities	**A)** Goal met. New goal set. **B)** Drill held. No physician involved. Repeat goal. **C)** Goal met. No new goal.
Hazardous Materials & Waste Management	**A)** Education, training and action for Code Orange **B)** Reduction of biohazardous waste	**A) & B)** Neither goal met as no baseline was established for a threshold to be determined; nor was there a methodology in how to gather the appropriate data. Empirically, there was some reduction in biohazardous waste as the tonnage of such waste is similar to 2019, and there was an additional element to the waste due to COVID-19.
Safety and Security	**A)** 1000% of active Security Officers complete Management of Aggressive Behavior (MOAB) training **B)** Track Security Officer rounds to assure 80% of all areas are patrolled daily	**A)** Met. New goal set for 2021 **B)** Not Met as tracking of officer capabilities were not maximized to assure correct data. Similar goal set for 2021
Emergency Management	**A)** Two tests of the Comprehensive Emergency Management Plan will take place in 2020: 1. Internal – Code Pink (planned) 2. External – Code Green (unplanned) COVID-19 response	**A)** 1. Learning experience for staff. Issues identified and corrected. Repeat drill planned. **A)** 2. This response began January 29, 2020 and continues. Level of severity has gone for 3 to 1 to 3 again.

Utility Management	**A)** Critical utilities testing completed at 100% of required **B)** Annual Medical Gas component testing at 100% of required **C)** Environmental rounds conducted at 100% of required **D)** Non-critical utility PM completion at 100% of required	**A), B), C), D):** All goals were met. New goals selected
Medical Equipment	A) Track medical equipment user error B) Track damage and abuse of medical equipment C) Track valid work order requests (not user error)	**A), B), & C):** None were met as there was no base information or a process to appropriately do the tracking for each goal. New goals set for 2021.

VII. EOC 2021 MANAGEMENT PLAN INDICATORS

A. WORKER SAFETY MANAGEMENT PLAN GOALS 2021

1. **Plan Owner: Jean Halett, COHN, Employee Health**
2. **Goals for 2021:**
   - **a.** One Hundred percent (100%) of employees with musculoskeletal injuries during 2021 will be referred to Rehab ("back school") for education and training in proper movement and lifting skills.
   - **b.** Reduce the number of injuries to care partners by ten percent (10%) based on 2020 totals.

B. LIFE SAFETY/Fire Safety MANAGEMENT PLAN GOALS 2021

1. **Plan Owners: Jeff Riley, Facilities Director and David Marquez, Security Manager**
2. **Goals for 2021:**
   - **a.** Portable fire extinguisher inventory with all proper documentation will be completed by April 30, 2021
   - **b,** Compliance with the hospital's fire response plan will be 100% as measured after online training and evaluated by onsite questions/education to three (3) care partners during each EOC rounds.

C. HAZARDOUS MATERIALS & WASTE MANAGEMENT PLAN GOALS 2021

1. **Plan Owner: Taylor Ray**
2. **Goals for 2021:**
   - **a.** Seventy five percent **(**75%) of care partners questioned during environmental rounds will be able to speak correctly concerning actions to take when a Code Orange (hazardous spill/event) occurs.
   - **b.** Reduce the number of hazardous waste disposal deficiencies by 10 percent from 2020 as reported through the monthly audit of same.

D. SECURITY MANAGEMENT PLAN GOALS 2021

1. **Plan Owner: David Marquez, Security Manager**
2. **Goals for 2021:**
   - **a.** Ninety percent (90%) of all bags, purses, suitcases, duffels, etc. entering through the Main and ER entrances will have thorough bag checks done prior to entry into the building. This is accomplished through review of cameras at each location for a minimum of 4 bags/persons by each officer.
   - **b,** Loading dock rounds will be completed every two (2) hours at a minimum of 90% (11 every 24 hours).
   - **c.** Ninety percent (90%) of active care partners will receive education on de-escalation techniques by December 31, 2021.

E. EMERGENCY MANAGEMENT PLAN GOALS 2021

1. **Plan Owner: Lori Thompson**
2. **Goals for 2021:**
   - **a.** In spite of the ongoing Code Green, PHC will conduct several tests of the Comprehensive Emergency Management Plan:
     1. Internal Event: Code Black at the hospital
     2. Internal Event: Code Black at the Port St. John Building
     3. Internal Event: Code Black at the Titus Landing Building
     4. Internal Event: Code Pink
     5. External Event: Code Green – Covid-19 continues currently at a level 3
     6. Any other test that may appear on the Hazard Vulnerability Analysis which will be completed not later than May 31, 2021
     7. Participation in any Brevard County Emergency Management County-wide Drill, if available.

F. UTILITY MANAGEMENT PLAN GOALS 2021

1. **Plan Owner: Jeff Riley**
2. **Goals for 2021:**
   - **a.** Improvement of room pressure compliance in all designated high risk areas and in licensed off-site locations to 90%
   - **b.** A adopt a standardized flushing program to include chlorine content and water temperature monitoring not later than April 30, 2021

G. MEDICAL EQUIPMENT MANAGEMENT PLAN GOALS 2021

1. **Plan Owners: Herb Whitman**
2. **Goals for 2021:**
   - **a.** Determine the cause of medical equipment repair. If due to user error, trend for one rolling quarter. If repeated as to a person or a particular device, training will be requested – then track for repeat errors
   - **b.** Determine the cause of medical equipment repair. If due to damage or abuse, determine the cause of such damage or abuse and trend for the year by damage

EMERGENCY MANAGEMENT PLAN 2021

By
Lori Thompson, Interim EOC Chair

I. MISSION

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

II. PURPOSE

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

III. SCOPE

Applies to all types of emergency situations whether an act of nature or humans that occurs within or outside the organization and which affects the safety and security of PHC property and/or care partners.

IV. RESPONSIBILITIES AND REPORTING STRUCTURE

- The PHC Hospital Board approves all elements of the Comprehensive Management Plan (CEMP) based on regular reporting of emergency management activities by the Environment of Care Committee (EOCC).
- Medical Staff Leadership provides a physician leader as an active member of the Incident Command (IC) team who participates in planning activities as part of development, updating or revision of the Emergency Management Plan, including implementation of the plan and actively participating in drills and actual events as the CEMP requires.
- The PHC CEO receives and reviews reports of the CEMP drills as well as 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 activities pertaining to drills and events relevant to the CEMP to the CEO and hospital board.
- The EOCC, in conjunction with the PHC Safety Officer, develops, revises and maintains the PHC CEMP assuring coordination with Brevard County's CEMP. Additionally, EOCC assures available resources and assets to address needs for the various events that fall under the CEMP.
- The Safety Officer advises the EOCC regarding emergency management issues that affect PHC which may require supplies, personnel, orientation and training as to CEMP procedures; overseeing the implementation of the CEMP in drills and actual events; evaluating the CEMP

before, during and after any implementation of the CEMP; and provides recommendations regarding any and all aspects of the CEMP.

- Department leaders are responsible for assuring departmental staff are educated and oriented to their role during the implementation of the CEMP during any event with such education and orientation provided upon hire and annually.
- All Care Partners participate in education regarding the CEMP and their response to the events contained within it by participating in the educational activities and participating in drills/actual events in accordance with policy and procedure.

V. PHC EMERGENCY MANAGEMENT PROCESSES and Plans

- **Hazard Vulnerability Analysis (HVA)**
  An annual assessment is conducted to assess the impact of likely emergencies to guide the EOCC in updating/revising the CEMP and its associated policies. Based on the HVA, EOCC assures proper mitigation, preparedness, response and recovery plans for each of the identified emergencies (Emergency Response Plans)

- **Notification to Governmental Authorities**
  The CEMP includes a current list of governmental and commercial organizations to be notified of plan implementation along with the identification of any immediate or longer term needs, as known.

- **Alternate Roles for Care Partners during Emergencies**
  In any specific emergency, PHC uses the CEMP as well as the specific emergency plan which together defines the Incident Command Staff who supersede normal PHC management.

  Senior staff, as available, is assigned responsibilities using the EOP and assure that key tasks are staffed. Most care partners perform their usual position as they are hired for, however in context of the emergency at hand, care partners may assume additional duties or assume other duties based on organizational need and care partner competency.

  Incident Command Staff receive one-on-one training and drills about their roles. Other care partners, who are asked to perform alternate tasks are trained for them, or receive just-in-time briefing at the time of the activity.

- **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. Actual events are documented in the same manner as planned drills.

  In accordance with 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.

  When planned, FSE's are tested at least four months apart, to maintain training and readiness and to allow time to integrate the findings and opportunities to improve plans for future plans and emergency responses. At least one FSE is designed to determine PHC's ability to function for 96 hours without outside assistance of any kind.

- **Comprehensive Emergency Management Plan (CEMP)**
  The CEMP contains the PHC overall emergency plan which contains the resources available, as well as the individual emergency response plans. EOCC evaluates the CEMP annually and submits the CEMP to Brevard County Emergency Management for review and approval pursuant to State Statute. The CEMP may be amended as necessary, based on changing conditions, regulations, standards, and identified needs.

LIFE SAFETY/FIRE SAFETY MANAGEMENT PLAN

2021

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

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

Parrish Medical Center, Parrish Healthcare, Parrish Medical Croup

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

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

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

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

GOALS & PERFORMANCE MANAGEMENT:
- The hospital will implement standardized documents to inventory all hospital fire extinguishers, including spares and reconcile the master inventory with the monthly inspection log by 04-30-21, with documented and monthly monitoring through 12-30-2021.
- The hospital will achieve 100% 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, as well weekly Environment of Care rounds and during Fire Drills, with documented and monthly monitoring through 12-30-2021.

Written Management Plan

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

Protecting Individuals and Property

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

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

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

Inspection, Testing, and Maintenance

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

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

Documentation of all maintenance, testing, and inspection includes:

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

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

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

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

Fire Response Plan

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

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

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

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

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

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

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

Review of Acquisitions

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

***Life Safety Code*®**

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

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

Fire Drills

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

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

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

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

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

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

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

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

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

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

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

Staff training records are kept in the Human Resource Department.

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

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

Approval Required by EOC Committee

Date: _____

_____

Signature
EOC Committee Chairperson

UTILITIES MANAGEMENT PLAN

2020

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

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

The utility systems addressed by this plan include:

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

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

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

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

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

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

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

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

GOALS AND PERFORMANCE MANAGEMENT:

- The hospital will improve room pressurization compliance in all designated high-risk areas within the hospital and in licensed off site locations, with a failure rate of 2% or less. The results will be monitored and documented monthly through 12-30-2021.
- The hospital will adopt the standardized flushing program, as well as chlorine and water temperature monitoring, as outlined in the Water Management Plan. This will be achieved by 04-30-2021 with documented and monthly monitoring through 12-30-2021.

ELEMENTS OF THIS PLAN INCLUDE:

Written Management Plan

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

Design and Installation

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

Inventory Inclusion

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

Utility Systems Maintenance

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

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

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

The following equipment is maintained on a predictive maintenance strategy:

- Electrical components – thermal scan

Hospital will achieve 100% completion rate for critical equipment.

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

Emergency Procedures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

These areas include, but are not limited to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical Gas

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<u>USERS</u>

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

<u>MAINTAINERS</u>

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

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

Training records are kept in the Human Resources Department.

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

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

Approval Required by EOC Committee

Date: _____

_____

Signature
EOC Committee Chairperson

SECURITY MANAGEMENT PLAN 2021

David Marquez, Safety and Security Manager

SCOPE

To provide a safe and secure environment for Parrish Healthcare (PHC) care partners, patients, and visitors and a secure yet accessible environment. The overall intent of this plan is to establish an efficient and effective program that incorporates training and development, care partner education, and planning.

PURPOSE

To provide an effective safety and security program through crime prevention and protection, as well as assess aggressive behaviors through ongoing methods in order to promote a safe and secure environment.

OBJECTIVES

- To provide the level of security necessary for the protection and safety of our care partners, patients, and visitors.
- To provide security for PHC properties for the protection and safety of the facilities and equipment
- Prioritize continuous training and development for security staff in the "Use of Force Continuum," hand-cuff, baton, and Taser use.
- Assure officers maintain their certification requirements and have the knowledge and skills required to maintain the safety and integrity of PHC.
- Assess areas of vulnerability within PHC's main campus, property, and facilities. Through various periodic vulnerability audits and assessments, the security department can then review any vulnerable areas that need attention to keep PHC as a hard target for the criminal element.
- Provide safety and security education on how to de-escalate and deal with aggressive behavior for care partners and especially security officers

- Prevent and reduce criminal activity through using "Threat Assessments," and a collaboration between the care partners and security personnel to review incidents of concern.

- Develop a plan for upgrading our Closed-Circuit Television (CCTV) system, Infant Abduction system, two-way radios, and security officer personal equipment. This includes, but is not limited to the updating of the CCTV cameras and recording system and replacing the older analog system to digital for better clarity and video quality. Additionally, upgrade the current two-way radios along with any outdated personal equipment to ensure compliance with known security standards.

ORGANIZATION AND RESPONSIBILITY

PHC Board of Directors (Board)

- receives reports on the activities of Safety Management from the Environment of Care Committee (EOCC).
- authorizes capital budget expenses, as necessary, to meet the needs of PHC safety and security

PHC Executive Management Team

- receives reports on the activities of Safety Management from the EOCC
- reviews reports and as necessary communicates concerns about key issues and regulatory compliance to the EOCC
- collaborates with the EOCC and the Security Manager to establish operating and capital budgets for Safety Management

EOCC & Security Manager

- receives reports from the Security Manager
- manages the Safety and Security Management Plan
- advises the EOCC of safety and security issues

PHC Department leaders

- orient new care partners to department-specific safety and security measures and plans, as well as department specific procedures.

- provide ongoing training/education of their care partners in safety and security measures/procedures.

- Security Manager provides department heads with assistance in developing departmental safety and security procedures and training, as needed.

Individual care partners

- learn and follow PHC organization-wide and departmental safety and security measures.

PERFORMANCE MONITORING

- Performance measurements are designed to monitor the actual and potential risks in relations to the following issues:
    - Care Partner knowledge and skillset when detailing with violent or aggressive encounters with confidence.
    - Monitoring and inspection of sensitive areas and the avoidance of vulnerabilities.
    - Review and evaluate emergency and incident reports to measure the frequency and severity of such events to develop best case.

PERFORMANCE INDICATORS FOR 2020

- Complete training in management of aggressive behavior for 100% of Security staff by the end of March 2020.
- Track the rounds of officers to assure that rounds are made in a minimum of 80% of all areas to be patrolled on a daily basis.
- Review and evaluate emergency and incident reports to measure the frequency and severity of such events to develop best practice for two types of events.

PERFORMANCE INDICATORS FOR 2021

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

WORKER SAFETY MANAGEMENT PLAN 2021

Jean Hallett, COHN, Employee Health

I PURPOSE

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

II SCOPE

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

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

III FUNDAMENTALS

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

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

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

IV OBJECTIVES

A. Minimize safety hazards by conducting Safety Surveillance Inspections.

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

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

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

V ORGANIZATION AND RESPONSIBILITY

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

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

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

VI PERFORMANCE MEASURE/MONITORING

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

1. In 2020, the following performance measures were conducted:
    a. Monitor and track employee lost time and restrictive days due to any work related incident or injury. This measure was not met as actual metrics were not established.
    b. The threshold for lost time days will remain the same as we strive for zero lost time days. This measure was not met as actual metrics were not established.
2. For 2021, the following performance measures will be undertaken:
    a. One Hundred percent (100%) of employees with musculoskeletal injuries during 2021 will be referred to Rehab ("back school") for education and training in proper movement and lifting skills.
    b. Reduce the number of injuries to care partners by ten percent (10%).

VII PROCESSES OF THE WORKER SAFETY MANANGMENT PLAN

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

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

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

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

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

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

2021 Hazardous Materials Waste Management Plan

By

Taylor Ray, Director of EVS

December 16, 2020

I. SCOPE

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

II. MISSION

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

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

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

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

III. PLAN FUNDAMENTALS

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

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

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

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

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

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

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

IV. PLAN OBJECTIVES

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

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

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

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

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

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

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

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

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

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

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

V. GOALS

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

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

VI. ORGANIZATION

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

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

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

the Hazardous Materials Waste Management and the Hazardous Communication Plans.

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

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

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

VII. RISK MANAGEMENT PROCESSES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IX. REFERENCES

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MEDICAL EQUIPMENT MANAGEMENT PLAN

2021

MISSION STATEMENT

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

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

PURPOSE

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

SCOPE

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

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

OBJECTIVE

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

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

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

ORGANIZATION & RESPONSIBILITY

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

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

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

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

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

PERFORMANCE ACTIVITIES

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

The performance measures for the Medical Equipment Program are:

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

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

MANAGEMENT PLAN

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

PROCESSES FOR MANAGING MEDICAL EQUIPMENT RISKS

Selection & Acquisition

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

Medical Equipment Inventory

PHC maintains a written inventory of all medical equipment.

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

Identify High Risk Equipment

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

Maintenance strategies

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

Maintaining, Inspecting, & Testing Frequencies

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

- Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining must be in accordance with the

manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements - Medical laser devices
- Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes) - New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies

Qualified persons
A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following:
- How the equipment is used, including the seriousness and prevalence of harm during normal use.
- Likely consequences of equipment failure or malfunction.
- Maintenance requirements of the equipment.

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

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

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

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

The Risk Manager uses the Incident Reporting Forms to investigate and document reportable incidents and reports quarterly to the Safety Committee on those incidents

determined to be reportable. The Risk Manager is also responsible for completing all reports and handling other communications with medical equipment manufacturers and the FDA required by the Safe Medical Devices Act. Each potentially reportable SMDA event is also processed through the Sentinel Event analysis and reporting process.

Emergency Procedures

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

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

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

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

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

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

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

Contacts for spare equipment or repair services.

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

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

The Medical Physicist has identified the method for the quality control and maintenance activities for maintaining the quality of the diagnostic computed tomography (CT), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. They are performed annually.

Hazard Notices and Recalls

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

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

PROCESS FOR INSPECTING, TESTING, AND MAINTAINING MEDICAL EQUIPMENT

Testing medical equipment prior to initial use

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

Testing of High-Risk Equipment

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

Testing of non-High-Risk Medical Equipment

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

Testing of Sterilizers

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

Testing of Dialysis Equipment

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

Electrical Equipment in Patient Care Vicinity

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

Inspect, test and calibrate Nuclear Medicine Equipment Annually-

All Equipment used in Nuclear Medicine will be inspected, tested, and calibrated at the intervals recommended by both the United States Nuclear Regulatory Commission and

the Department of Environmental Protection, this is coordinated by the Radiation Safety Officer and Clinical Engineering.

Quality Control of CT, MRI, and Nuclear Medicine

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

CT Radiation Dose Measurement

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

Performance Evaluation of CT

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

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

Performance Evaluation of MRI

Annually, the Medical Physicist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any

problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics

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

Performance Evaluation of Nuclear Medicine

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

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

Testing of Image Acquisition Monitors

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

Defibrillators

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

Annual Evaluation

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

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Applicability:	*Parrish Medical Center*

Provision of Non-Audit Services Provided by District's Audit Firm

~~**Policy Type: ADMINISTRATIVE**~~

POLICY STATEMENT

To establish guidelines for determining ~~if~~whether non-audit services provided by the District's independent audit firm can be provided, without potential impairment of ~~their~~the independence of the independent audit firm arising from the ~~nonaudit~~non-audit services, and that the factors for that determination will be based on business judgments.

PURPOSE

The Audit Committee should pre-approve all non-audit service performed by the District's independent audit firm on behalf of the District.

The guiding factors that ~~should~~will be considered by the Audit Committee in making business judgments ~~about~~concerning particular non-audit services to be provided by the independent audit firm to limit potential independence issues that may arise are:

A. **Whether the service is being performed principally for the Audit Committee.**

B. **The effects of the service, if any, on audit effectiveness or on the quality and timeliness of the ~~entity~~District's financial reporting process.**

C. **Whether the service would be performed by specialists (e.g., technology specialists) who ordinarily also provide recurring audit support.**

D. **Whether the service would be performed by audit personnel and, if so, whether it will enhance their knowledge of the ~~entity~~District's business and operations.**

E. **Whether the role of those performing the service (e.g., a role where neutrality, impartiality and auditor skepticism are likely to be subverted) would be inconsistent with the auditor's role.**

F. **Whether the audit firm's personnel would be assuming a management role or creating a mutuality of interest with management.**

G. **Whether the auditors, in effect, would be auditing their own ~~numbers~~statements and calculations.**

H. **Whether the project ~~must~~is required to be started and completed ~~very~~ quickly.**

I. **Whether the audit firm has unique expertise in the particular non-audit service.**

J. **The ~~size of the~~amount of the projected professional fee(s) for the non-audit services(s).**

K. **Whether the service facilitates the performance of the audit, improves the ~~client~~District's financial reporting process, or is otherwise in the public interest and benefit.**

In considering the above, the Audit Committee ~~looks~~considers in the first instance ~~to~~ whether a relationship or the provision of a service:

A. creates a mutual or conflicting interest between the independent audit firm and the District;

B. places the independent audit firm in the position of auditing his ~~or~~, her or its own work;

C. results in the independent audit firm acting as management or an employee of the District; or

D. ~~places~~results in the independent audit firm ~~in a~~appearing to be in the position of ~~being~~ an advocate for the District.

By following the above, the Audit Committee will help to ensure that the District's independent audit firm is qualified and independent of the District in fact and appearance.

Therefore, the District's independent audit firm may not perform the following nine non-audit services, as it is believed that if it did so the audit firm would not be independent:

A. **Bookkeeping or other services related to the ~~audit client~~District's accounting records or financial statements.**

1. Any service involving:
    a. Maintaining or preparing the District's accounting records;
    b. Preparing the District's financial statements that are filed with any outside third party; or
    c. Preparing or originating source data underlying the District's financial statements.
2. However, the audit firm's independence will not be impaired, and thus may perform these services in the following circumstances:
    a. In emergency or other unusual situations, provided the independent audit firm does not undertake ~~any~~ managerial actions or make ~~any~~ managerial decisions.

B. **Financial information systems design and implementation.**

1. Directly or indirectly operating, or supervising the operation of the District's information system or managing the District's local area network.
2. Designing or implementing a hardware or software system that aggregates source data underlying the financial statements or generates information that is significant to the District's financial statements taken as a whole.
3. Nothing in the above shall limit services the independent audit firm performs in connection with the assessment, design, and implementation of internal accounting controls and risk management controls, provided the auditor does not act as an employee or perform management functions.

C. **Appraisal or valuation services or fairness opinions.**

1. Any appraisal service, valuation service, or any services involving a fairness opinion for the District where it is reasonably likely that the results of these services, individually or in the aggregate, would be material to the financial statements, or where the results of these services will be audited by the

audit firm during an audit of the District's financial statements.

2. However, the audit firm's independence will not be impaired, and thus may perform these services in the following circumstances:
    a. The audit firm's valuation expert reviews the work of the District or a specialist employed by the District, and the District or the specialist provides the primary support for the balances recorded in the District's financial statements;
    b. The audit firm's actuaries value the District's pension, other post-employment benefit, or similar liabilities, provided that the District has determined and taken responsibility for all significant assumptions and data;
    c. The valuation is performed in the context of the planning and implementation of a tax-planning strategy or for tax compliance services; or
    d. The valuation is for non-financial purposes where the results of the valuation do not affect the financial statements.

D. **Actuarial Services**

E. **Internal audit services**

F. **Management functions**. Acting, temporarily or permanently as a director, officer, or employee of the District, or performing any decision-making, supervisory, or ongoing monitoring function for the District.

G. **Human resources**
    1. Searching for or seeking out prospective candidates for managerial, executive, or director positions;
    2. Engaging in psychological testing, or other formal testing or evaluation programs;
    3. Undertaking reference checks of prospective candidates for an executive or director position;
    4. Acting as a negotiator on the District's behalf, such as determining position, status or title, compensation, fringe benefits, or other conditions of employment; or
    5. Recommending, or advising the District to hire, a specific candidate for a specific job (except that the audit firm may, upon request by the District, interview candidates and advise the District ~~on~~concerning the candidate's competence for financial accounting, administrative, or control positions).

H. **Broker-dealer services**. Acting as a broker-dealer, promoter, or underwriter, on behalf of the District, making investment decisions on behalf of the District or otherwise having discretionary authority over the District's investments, executing a transaction to buy or sell the District's investment, or having custody of assets of the District, such as taking temporary possession of securities purchased by the District.

I. **Legal services.** Providing any service to the District under circumstances in which the person providing the service must be admitted to practice before the courts of a United States jurisdiction.

In addition, the District's audit firm is not independent if, at any point during the audit and professional engagement period, the audit firm provides any service or product to the District for a contingent fee or a commission, or receives a contingent fee or commission from the District. Therefore, if it is determined that the independent audit firm can provide non-audit or audit services, the fee arrangement cannot be on a contingent or commission basis.

All revision dates: 01/2021, 04/2005

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board of Directors	Robert Jordan: Board Member	pending
President/CEO	George Mikitarian: President/CEO [AJ]	02/2021
Executive Management Committee	Executive Management Committee [AJ]	02/2021
Compliance	Corporate Compliance [NV]	01/2021
Executive Management	Kent Bailey: Vice President - Finance	09/2020
	Charlena Kowatch: Director of Accounting	08/2020

Applicability

Parrish Medical Center