MEMORANDUM

To: Board of Directors

Cc: Bill Boyles, Esquire
Mark Storey, M.D.

From: George Mikitarian
President/CEO

Subject: Board/Committee Meetings – March 2, 2020

Date: February 25, 2020

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

The Investment Committee will meet at 11:00 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 Budget and 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 3:00 p.m.

The Planning Committee meeting has been canceled.

Members:
Stan Retz, Chairperson (January 1, 2020 - December 31, 2022)
Michael Allen, Vice-Chairperson (July 1, 2019 – June 30, 2022)
Chris McAlpine (February 4, 2019 – January 31, 2022)
Julia Reyes-Mateo (July 1, 2019 – June 30, 2022)
Dawn Hohnhorst (April 1, 2019 – March 31, 2022)

PARRISH MEDICAL CENTER
PENSION ADMINISTRATIVE COMMITTEE
MARCH 2, 2020 @ 10:30 A.M.
EXECUTIVE CONFERENCE ROOM

CALL TO ORDER

I. Public Comments

II. Applicants for PAC Membership– Mr. McAlpine

III. Adjournment

Members:
Jerry Noffel, Chairperson
Peggy Crooks
Stan Retz

TENTATIVE AGENDA
INVESTMENT COMMITTEE
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, MARCH 02, 2020, 11:00 AM
EXECUTIVE CONFERENCE ROOM

CALL TO ORDER

I. Public Comment

II. Review and approval of minutes December 02, 2019

Motion: To recommend approval of the December 2, 2019 meeting minutes as presented.

III. Quarterly Investment Performance Update – Anderson Financial Partners

IV. Adjournment

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
INVESTMENT COMMITTEE
DECEMBER 02, 2019

The Investment Committee of the North Brevard County Hospital District Board of Directors met on December 02, 2019 in the Executive Conference Room. The following members, representing a quorum, were present:

Jerry Noffel, Chairperson
Stan Retz
Peggy Crooks (absent-excused)

Others present:

Kent Bailey, Vice President-Finance
Pam Perez, Administrative Assistant
Tim Anderson, Anderson Financial Partners

Call to Order

Mr. Noffel called the meeting to order at 11:14 a.m.

Public Comment

No public comments presented.

Review and Approval of Minutes

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

Action Taken: Motion to approve the minutes of the August 05, 2019 and September 09, 2019 meetings as presented.

Operating Funds Performance Summary

Tim Anderson, Anderson Financial Partners, gave an update on the performance of the Operating Funds. The fund managers are performing well with the exception of Hancock Horizon which is on a Watch list as they are not meeting benchmarks.

ROCHE ADR

ROCHE ADR, an Over the Counter investment that is not currently owned, is no longer a target for investment purchase by the investment managers. No further consideration or discussion is warranted at this time.

Adjournment

There being no further business the meeting adjourned at 11:44 a.m.

_____

Jerry Noffel, Chairperson

QUALITY COMMITTEE
Herman A. Cole, Jr. (ex-officio)
Peggy Crooks
Billie Fitzgerald
Elizabeth Galfo, M.D.
Robert L. Jordan, Jr., C.M.
Jerry Noffel
Stan Retz, CPA
Maureen Rupe
Ashok Shah, M.D.
Mark Storey, 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 2, 2020
NOON
EXECUTIVE CONFERENCE ROOM

CALL TO ORDER

I. Election of Chairperson & Vice Chairperson

II. Approval of Minutes

Motion to approve the minutes of the January 6, 2020 meeting.

III. Vision Statement

IV. Public Comment

V. "My Story"

VI. Dashboard Review
  a. Outcomes Review

VII. Joint Commission
  a. National Patient Safety Goals (NPSG)

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 6, 2020 in the Executive Conference Room. The following members were present.

Herman A. Cole, Jr., Chairman (12:08 p.m.)
Peggy Crooks
Billie Fitzgerald
Elizabeth Galfo, M.D.
Robert L. Jordan, Jr., C.M.
Jerry Noffel (12:11 p.m.)
Stan Retz, CPA
Maureen Rupe (12:08)
Ashok Shah, M.D.
Mark Storey, M.D., President/Medical Staff
Christopher Manion, M.D. (12:31 p.m.)
Gregory Cuculino M.D. (12:11 p.m.)
Kiran Modi, M.D. (12:18 p.m.)
George Mikitarian (non-voting)

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

CALL TO ORDER

Mr. Jordan called the meeting to order at 12:04 p.m.

VISION STATEMENT

Mr. Loftin summarized the committee's vision statement.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Dr. Galfo, seconded by Ms. Cooks and approved (7 ayes, 0 nays, 0 abstentions). Mr. Cole, Mr. Noffel, Ms. Rupe, Dr. Manion, Dr. Cuculino and Dr. Modi were not present at the time the vote was taken.

ACTION TAKEN: **APPROVE THE NOVEMBER 4, 2019 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 a mothers experience with the delivery of her third child here at PMC. He shared the heartfelt comments of appreciation from the family to the staff that cared for and went above and beyond for them.

QUALITY DASHBOARD REVIEW

Mr. Loftin reviewed the January 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.

MOTHER BABY FOCUS

Mr. Loftin shared with the committee the focus on critical congenital heart defects in infants and the protocols already in place at PMC for screenings. Mr. Loftin also shared the new standards from the Joint Commission relating to mother and baby care, adding that PMC already has practices in place to be successful.

PEER TO PEER UPDATE

Mr. Loftin updated the committee on the current status of the Peer Recovery Supports Specialist program in the Emergency Department, noting that the program has been successful to date.

OTHER

There was no other business brought before the committee.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 12:33 p.m.

Herman A. Cole, Jr.
Chairman

PARRISH®
MEDICAL CENTER

PARRISH HEALTHCARE

BOARD OF DIRECTORS
QUALITY COMMITTEE PRESENTATION

Healing Families – Healing Communities®

parrishmed.com

March 2020 Quality Agenda

1. Vision Statement
2. My Story
3. Quality Dashboard
   -- Outcomes Review
4. Joint Commission-
   -- National Patient Safety Goals
5. Executive Session

Quality Committee
Vision Statement

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

“My Story”

Board Quality & Safety Committee

Value Dashboard

March

2020

PARRISH MEDICAL CENTER

PARRISH HEALTHCARE

Healing Families – Healing Communities®

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Performance Dashboard

Description	Jan	Jan-Mar	Actual YTD (CY)	Opportunity
Zero Harm	50%	50%	50%	*January* 2 out of – 50% Stroke Goal: 100% Actual 69% Sepsis Goal: 76% Actual 76% Imm Goal 100% Actual 98% EED Goal 0% Actual 0%
HAI	1.5	1.5	1.5	
Readmission	11.29%	11.29%	11.29%	
Person Centered Flow	242	242	242	
Person Experience	68.1/66.7	68.1/71.2	71/68	Overall/Recommend

Outcomes Review

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PARRISH HEALTHCARE

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30 Day Mortality

FY2021 Final

Safety

1. **CAUTI**: Catheter-Associated Urinary Tract Infection
2. **CDI**: *Clostridium difficile* Infection
3. **CLABSI**: Central Line-Associated Bloodstream Infection
4. **MRSA**: Methicillin-resistant *Staphylococcus aureus* Bacteremia
5. **SSI**: Surgical Site Infection Colon Surgery and Abdominal Hysterectomy

Person and Community Engagement

1. **HCAHPS Survey Dimensions**
   - Communication with Nurses
   - Communication with Doctors
   - Responsiveness of Hospital Staff
   - Communication about Medicines
   - Cleanliness and Quietness of Hospital Environment
   - Discharge Information
   - Care Transition
   - Overall Rating of Hospital

Domain Weights

An asterisk (*) indicates the measure is new, beginning this fiscal year.

A double asterisk (**) indicates a cohort expansion for the measure, beginning this fiscal year.

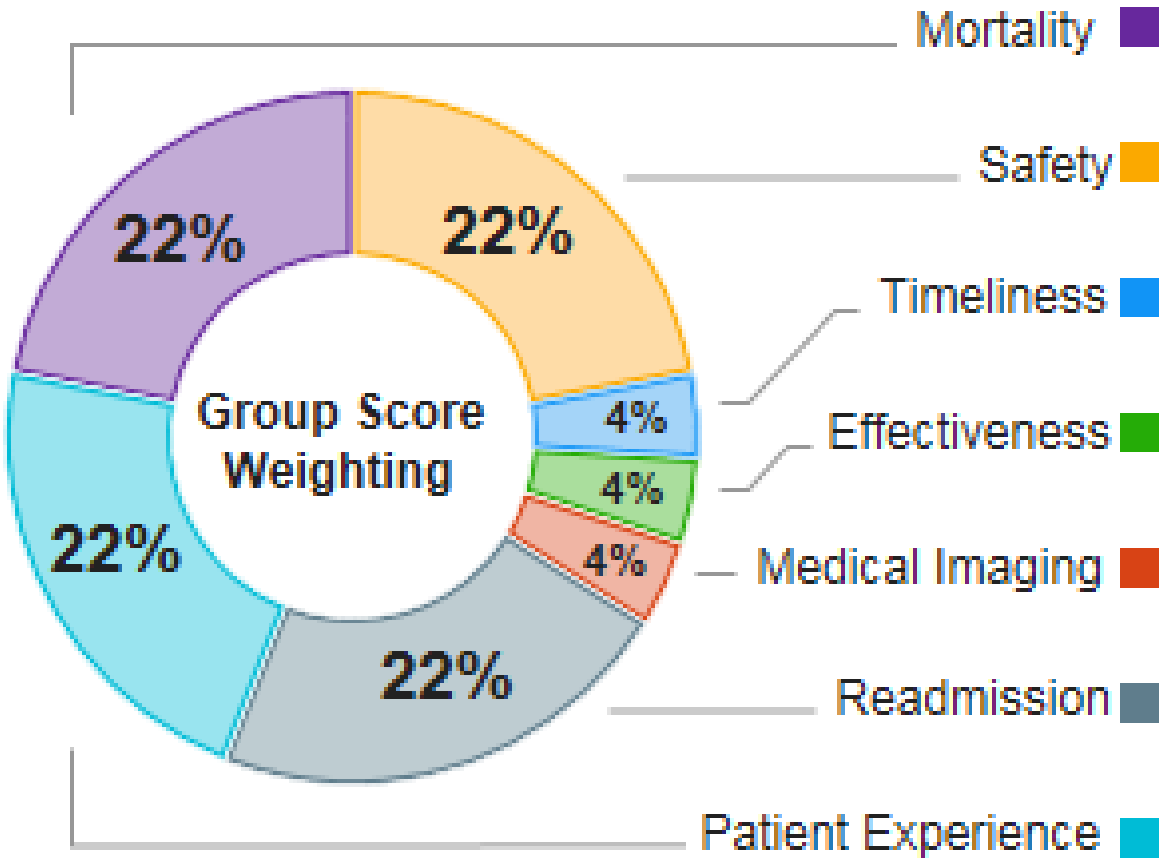
Clinical Outcomes

1. **MORT-30-AMI**: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization
2. **MORT-30-COPD***: Hospital 30-Day, All-Cause, RSMR Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization
3. **MORT-30-HF**: Hospital 30-Day, All-Cause, RSMR Following Heart Failure (HF) Hospitalization
4. **MORT-30-PN****: Hospital 30-Day, All-Cause, RSMR Following Pneumonia (PN) Hospitalization (old cohort)
5. **THA/TKA**: Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Efficiency and Cost Reduction

1. **MSPB**: Medicare Spending per Beneficiary

CY2020 Star Ratings



Mortality Measure Facts

- Inclusions: Medicare FFS and VA for 12 months; age 65 or older; discharged with a qualifying condition; not an AMA discharge.
- Death occurs within 30 days from the start of a qualifying index admission from ANY cause.
- When interpreting the risk-standardized mortality rate (RSRM), the mortality rate has been adjusted for differences in case-mix across hospitals. Lower score is the goal.

Performance Information	AMI 30-Day Mortality	COPD 30-Day Mortality	HF 30-Day Mortality	Pneumonia 30-Day Mortality	Stroke 30-Day Mortality
Your Hospital's Comparative Performance	No different than the national rate	Worse than the national rate	No different than the national rate	Worse than the national rate	No different than the national rate
RSMR at Your Hospital	13.9%	11.0%	14.4%	19.1%	16.2%

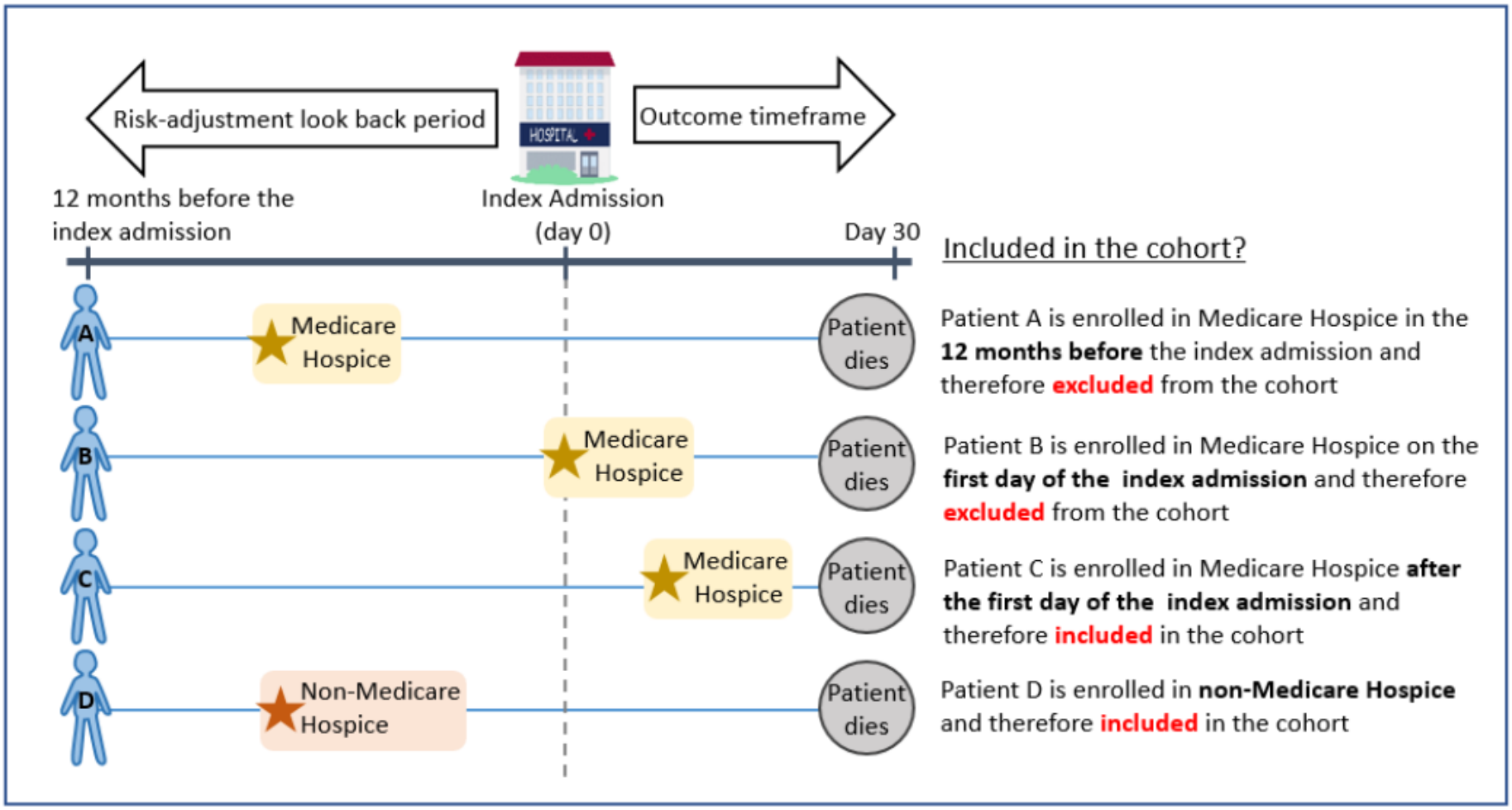
Mortality Measure Facts: Exclusions

The mortality measures exclude index admissions for patients:

- With inconsistent or unknown vital status or other unreliable demographic (age and gender) data;
- Enrolled in the Medicare hospice program or used VA hospice services any time in the 12 months prior to the index admission, including the first day of the index admission; or,
- Discharged against medical advice.

An additional exclusion criterion for the AMI, HF, and pneumonia cohorts is that patients discharged alive on the day of admission or the following calendar day who were not transferred to another acute care facility are excluded as index admissions.

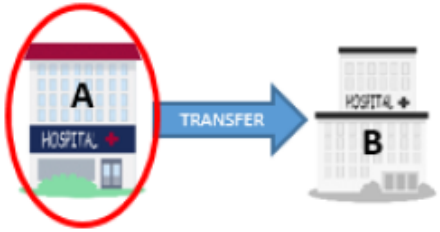
Hospice Inclusion / Exclusion Criteria



Transfer Patients

When patients are transferred between acute care hospitals, the outcome is attributed to the hospital that:

ADMITTED the patient for the index hospitalization



For the following measures:

- AMI mortality
- AMI payment
- COPD mortality
- HF mortality
- HF payment
- Pneumonia mortality
- Pneumonia payment
- Stroke mortality

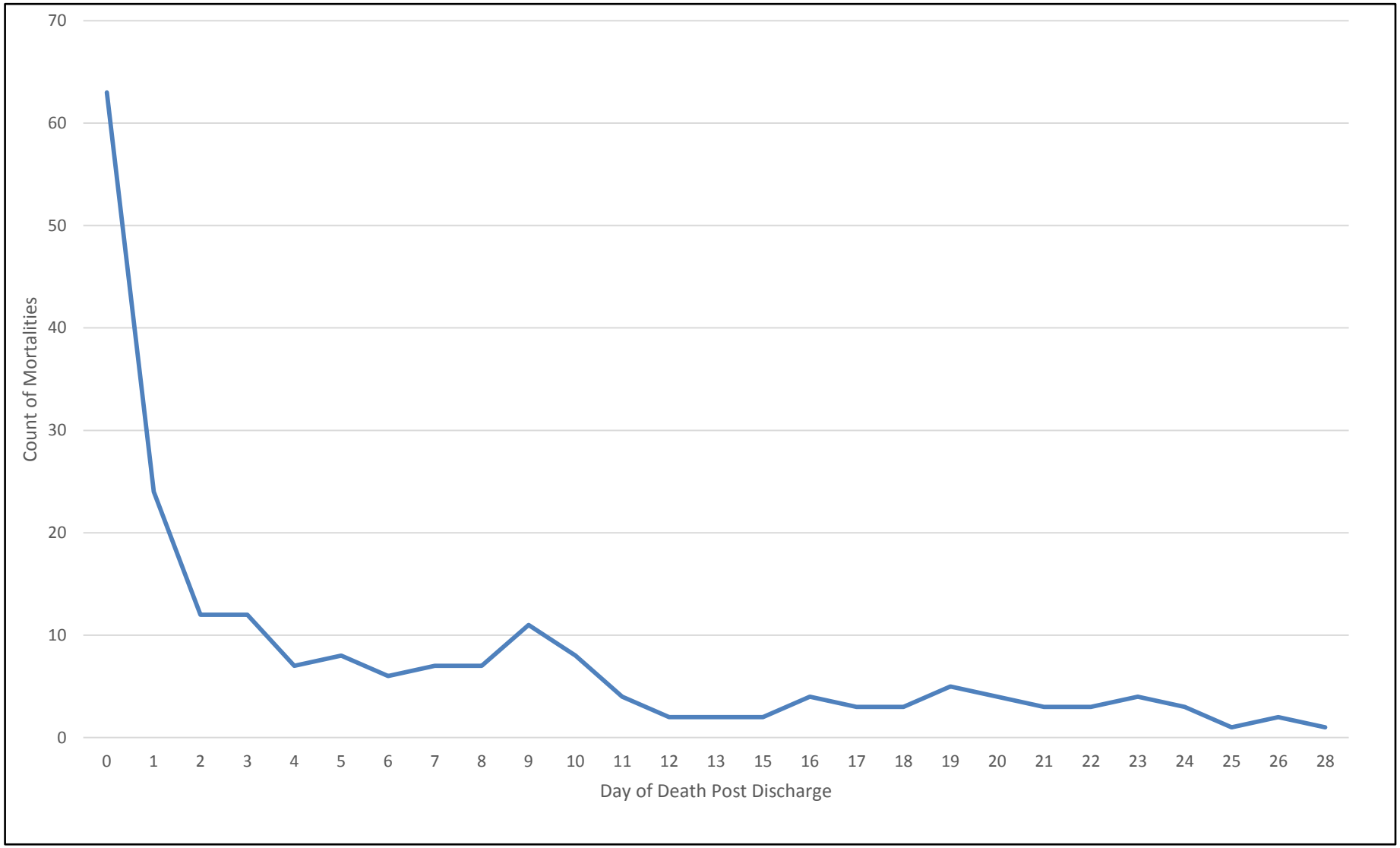
DISCHARGED the patient to the non-acute care setting

For the following measures:

- AMI EDAC
- AMI readmission
- COPD readmission
- HF EDAC
- HF readmission
- Hospital-wide readmission
- Pneumonia readmission
- Stroke readmission

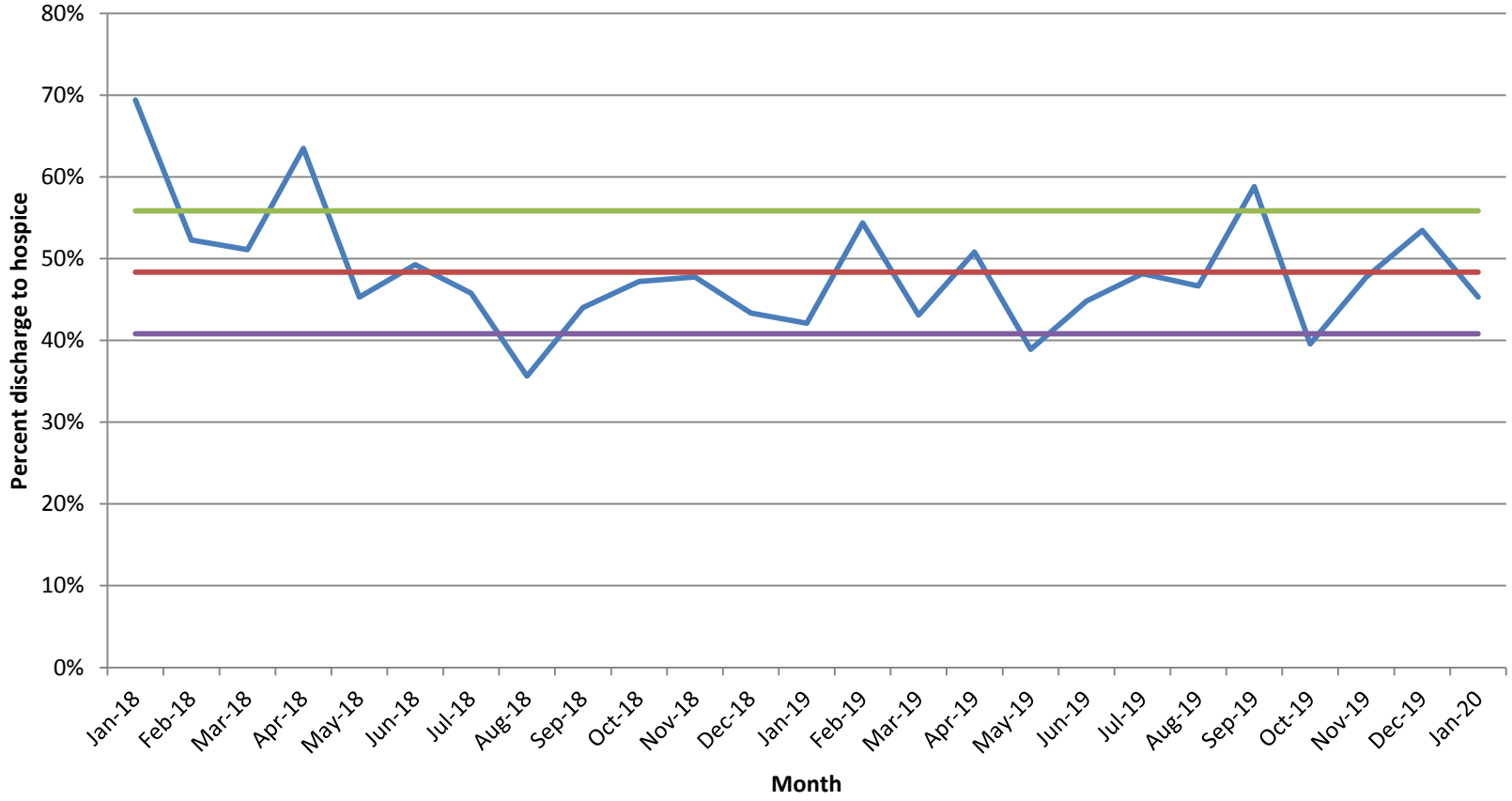
How does PMC transfer agreements impact our scores?

30 Day Mortality



Hospital Discharge Period: July 1, 2015 through June 30, 2018 AMI/COPD/HF/PN/CABG/STR

Hospice Discharge Control Chart 2019-2020



Questions?

The Joint Commission National Patient Safety Goals (NPSG)

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NPSG.01.03.01

Eliminate transfusion errors related to patient misidentification.

NPSG.02.03.01

Report critical results of tests and diagnostic procedures on a timely basis.

NPSG.03.04.01

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

- Note: Medication containers include syringes, medicine cups, and basins.

NPSG.03.05.01

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

- Note: This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (for example, related to procedures or hospitalization).

NPSG.03.06.01

Maintain and communicate accurate patient medication information.

NPSG.06.01.01

Improve the safety of clinical alarm systems.

NPSG.07.01.01

Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

NPSG.07.03.01

Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.

- Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), carbapenem-resistant enterobacteriaceae (CRE), and other multidrug-resistant gram-negative bacteria.

NPSG.07.04.01

Implement evidence-based practices to prevent central line–associated bloodstream infections.

- Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

NPSG.07.05.01

Implement evidence-based practices for preventing surgical site infections.

NPSG.07.06.01

Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

Note: Evidence-based guidelines for CAUTI are located at:

- Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, 2014 at https://doi.org/10.1017/S0899823X00193845
- APIC Implementation Guide: Guide to Preventing Catheter-Associated Urinary Tract Infections, 2014 at https://apic.org/resources/topic-specific-infection-prevention/catheter-associated-urinary-tract-infection/
- Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009 at https://www.cdc.gov/infectioncontrol/guidelines/cauti/index.html

NPSG.15.01.01

Reduce the risk for suicide.

- Note: EPs 2–7 apply only to patients in psychiatric hospitals and patients being evaluated or treated for behavioral health conditions as their primary reason for care in general hospitals.

UP.01.01.01

Conduct a preprocedure verification process.

UP.01.02.01

Mark the procedure site.

UP.01.03.01

A time-out is performed before the procedure.

Questions?

FINANCE COMMITTEE MEMBERS:
Stan Retz, Chairperson
Peggy Crooks, Vice Chairperson
Jerry Noffel
Elizabeth Galfo, M.D.
Robert Jordan
Billie Fitzgerald
Herman Cole (ex-officio)
Christopher Manion, MD.
George Mikitarian, President/CEO (non-voting)
Mark Storey, M.D., President/Medical Staff

TENTATIVE AGENDA
BUDGET & FINANCE COMMITTEE MEETING - REGULAR
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, MARCH 02, 2020
EXECUTIVE CONFERENCE ROOM
(IMMEDIATELY FOLLOWING QUALITY COMMITTEE)
SECOND FLOOR, ADMINISTRATION

CALL TO ORDER

I. Election of Vice Chairperson

II. Review and approve of minutes (January 6, 2020)

Motion: To recommend approval of the January 6, 2020 minutes as presented.

III. Public Comments

IV. Financial Review – Mr. Bailey

V. Out of State Medicaid – Mr. Bailey

Motion: To approve the Resolution of the Board of Directors of the North Brevard County Hospital District Regarding the Out of State Medicaid Form for the State of Mississippi, Division of Medicaid.

VI. Appointment of New Pension Committee Member- Mr. Bailey

VII. 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.

VIII. Executive Session (if necessary)

ADJOURNMENT

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

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

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
BUDGET AND 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 6, 2020 in the Executive Conference Room. The following members, representing a quorum, were present:

Stan Retz, Chairperson
Peggy Crooks, Vice Chairperson
Jerry Noffel
Elizabeth Galfo, M.D.
Robert Jordan, Jr., C.M.
Billie Fitzgerald
Herman A. Cole, Jr.
Christopher Manion, M.D.
Mark Storey, 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 12:56 p.m.

REVIEW AND APPROVAL OF MINUTES

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

ACTION TAKEN: **APPROVE THE NOVEMBER 4, 2019 MEETING MINUTES, AS PRESENTED.**

PUBLIC COMMENTS

There were no public comments.

FINANCIAL REVIEW

Mr. Bailey summarized the November 2019 financial statements.

OTHER

Mr. Retz took this opportunity to thank Mr. Bailey, noting it was extremely hard work done by the Finance team and the Auditors preparing the audit.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 1:17 p.m.

Stan Retz
Chairperson

Board of Directors Resolution Form
Section C - 2

Required for non-individual applicants only and must be an original, notarized form.

MEDICAID

For non-individual applicants, this form must only be filled out once and submitted with the application for the group/payee number.

State of _____

County of _____

On the _____ day of _____ , _____ at a meeting of the Board

of Directors of North Brevard County Hospital District , held in the City of _____ ,

in _____ County, with a quorum of the directors present, the following business was conducted:

It was duly moved and seconded that the following resolution be adopted:
Be it resolved that the Board of Directors does hereby authorize

Arvin Lewis

and his/her successors in office to negotiate, on terms and conditions that he/she may deem advisable, a contract or contracts with the Mississippi Medicaid agency and to execute said contract or contracts, and further we do hereby give him/her the power and authority to do all things necessary to implement, maintain, amend, or renew said contract.

The above resolution was passed by a majority of those present and voting in accordance with the bylaws.

I certify that the above constitutes a true and correct copy of a part of the minutes of a meeting of the

Board of Directors of North Brevard County Hospital District

Held on the _____ day of _____ , _____

X _____
Signature of Board Member

Subscribed and sworn before me, _____, a Notary Public for the

County of _____, on the _____ day of _____

Notary Stamp/Seal	*Notary County Of*
	State Of

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. #
Monitor, Fluid	KN018133	6/28/04	958.25	02244	Equipment is no longer supported and cannot be repaired. Please see attached documentation from manufacturer	-0-	1.342

Requesting Department: ICU _____ Department Director Michelle Tackley

Net Book Value (Finance) R. Murray 2/7/20 EMC Member _____ 2.6.20

Sr. VP Finance/CFO Kurt Bailey 2/11/20 President/CEO _____

Board Approval: (Date) _____ CFO Signature _____ 2/21/2020

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

Biomed Fact Sheet

CritiCore® Monitor Obsolescence & Discontinuation History

Since 1995, BARD® Medical Division (BMD) has offered several versions of CRITICORE® MONITOR in addition to accessories. The following document details the monitors, parts and support status for each. If you require assistance, please contact your local Territory Manager or Customer Service at: (800) 526-4455

Part Number	Description	Status	Support	Notes
000002N (2010-2015)	CRITICORE® MONITOR	Discontinued	Through May 2018	8 digit serial number; No Comm Module avail
000002N (2006 -2010)	CRITICORE® MONITOR	Obsolete	Not Supported	8 digit serial number; Comm Module Optional
000926	CRITICORE® MONITOR COM MODULE KIT	Obsolete	Not Supported	
CCP01100	CRITICORE® MONITOR MAIN PCB KIT	Obsolete	Not Supported	
CCP01106	MAIN PRINTED CIRCUIT BOARD	Obsolete	Not Supported	
CCP03000	DISPLAY ASSEMBLY	Obsolete	Not Supported	
CCP03006	DISPLAY ASSEMBLY	Obsolete	Not Supported	
MR008245	CALIBRATION PLUG	Obsolete	Not Supported	

BMD will continue to support the current version of CRITICORE® MONITORS which can be identified with a 9-digit serial number and are manufactured after December of 2015.

All CRITICORE® MONITORS require depot repair and are not serviceable outside a Bard service center. An extended warranty is available at time of purchase. Please consult with your local Territory Manager for details.

Identify date of manufacture and serial number for CRITICORE® MONITOR Model 000002N on Rear Label (Date of Manufacture and Serial Number circled)

Definitions

Discontinued: BMD no longer manufactures the version of the monitor or part(s) and will continue to support until the date indicated.

Obsolete: BMD no longer supports the version of the monitor or part(s) indicated.

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. #
Pump, Heat Therapy Hypo/Hyperthermia Unit	—	12/02/13	—	06728	Unit is obsolete and cannot be repaired per the manufacturer	-0-	1.375

Requesting Department: Cardiovascular 1.312 Department Director

Net Book Value (Finance) A. Franks EMC Member 1.31.20

Sr. VP Finance/CFO Kurt Zeiler 2/11/20 President/CEO 2/21/2020

Board Approval: (Date) CFO Signature

Requestor Notified Finance

Asset Disposed of or Donated

Removed from Asset List (Finance)

Requested Public Entity for Donation

Entity Contact

Telephone

Singer, Serena

From: Return Repair <Return.Repair@stryker.com>
Sent: Tuesday, January 28, 2020 9:18 AM
To: Singer, Serena
Subject: [EXTERNAL Sender] RE: New submission: Repair Exchange Return
Attachments: TPump 2 year repair policy.pdf

This message came from an external source. Please do not click links or open attachments if unexpected or unusual.

Begin Original Message:

TP700H31461 shipped 11.20.2013.

This device has exceeded the 2yr operational life and cannot be repaired or replaced through my services. You can purchase parts to repair the device locally, but it is recommended to retire the device and purchase a new pump.

The most likely failed part is the PCB and that is around $145. The 2nd reason for the failure is the membrane keyboard and that is around $127. A new pump is around $400 or less with discount. Customer Service can place your order. 800.327.0770

100269001	MEMBRANE PANEL	TP700
100898000	Kit, PC Board/Sensor Assembly	TP700

Thank you

Download Product Information > techweb.stryker.com

Bob Vick
ProCare Operations Representative
Depot Repair
Stryker Medical
3800 East Centre Avenue
Portage, MI 49002
P 269 389 8107
Customer Service 800 327 0770
Option 2 for Technical Support

From: Parrish Medical Center <noreply@jotform.com>
Sent: Tuesday, January 28, 2020 9:00 AM
To: Return Repair <Return.Repair@stryker.com>
Subject: New submission: Repair Exchange Return

EXTERNAL EMAIL

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. #
Defibrillator Analyzer				00968	Unit is obsolete and cannot be repaired.		
Defibrillator Analyzer	KN017427	8/2/10	2129.11	05511		-0-	1.684

Requesting Department: Clinical Equipment _____ Department Director _____

Net Book Value (Finance) _____ -0- EMC Member _____ 1.31.20

Sr. VP Finance/CFO _____ 2/11/20 President/CEO _____

Board Approval: (Date) _____ CFO Signature _____ 2/21/2020

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

Singer, Serena

From: Shady Albasyouny (Fluke Biomedical Support) <techservices@flukebiomedical.com>
Sent: Tuesday, January 28, 2020 4:16 AM
To: Singer, Serena
Subject: [EXTERNAL Sender] Re: QED 6 Defib Analyzer Needs Repair

This message came from an external source. Please do not click links or open attachments if unexpected or unusual.

Begin Original Message:

##- please reply above this line -##

Hi, we have an update to your request (#341317). To respond, please reply to this email or click the ticket number link.

Shady Albasyouny (Fluke Biomedical / RaySafe / LANDAUER)

Jan 28, 01:15 PST

Dear Serena,

Thank you for contacting us.
Unfortunately that product was discontinued ailable due to lack of parts. but calibration is available.
We would recommend you the Impulse 7000I

Please let me know if you have further questic

Best regards.

Shady Albasyouny | Tech Support Engineer |

CTM/CE # 05311
Analyzer, Defibrillator
Model QED-6H
Serial # 91064
1.684
KN017427
8/22/2010
00079 Bio-Tek Instruments

Serena Singer

Jan 27, 08:28 PST

We have a Fluke QED 6 Analyzer that performs a ion does not work properly. We would like to get the equipm with how we proceed in this process.

Best Regards,

CTM/CE # 00967
Warmer, Blanket Active
KN020954 Purchased 6/28/99
$4683.98
1,381 Net Book Value *C
Warming Cabinet, Electric
Blickman
Model 7924SSD
Serial 87150-26

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. #
Regulator, Suction	KN019909			00958	Unit broken and unable to be repaired, no longer supported by manufacturer	-0-	ICU (2nd flr)

Requesting Department ICU

Department ~~Director~~ Clin. Coord.

Net Book Value (Finance) -0- A. Finney 1/28/20

EMC Member 1/31.20

Sr. VP Finance/CFO 1-31-20

President/CEO 2/6/20

Board Approval: (Date) _____

CFO Signature _____

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

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. #
ESTIM Electrotherapy	KN027691	11/20/02	1275.00	0071-01422	obsolete	-0-	1.481

Requesting Department Rehab 1.481 Department Director Marsha L Quinn _____

Net Book Value (Finance) [signature] EMC Member Drew Waterman [signature] 1-29-2020

Sr. VP Finance/CFO [signature] 1-31-20 President/CEO _____ 2/6/20

Board Approval: (Date) _____ CFO Signature _____

Requestor Notified Finance _____

Asset Disposed of or Donated _____

Removed from Asset List (Finance) _____

Requested Public Entity for Donation _____

Entity Contact _____

Telephone _____

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. #
GE Vital signs monitor	021995	09/28/2002	2,995	00416	Blood pressure not working, unit obsolete and not repairable.	-0-	1314
GE Vital signs monitor	028800	12/27/2006	2,684	03763		-0-	1312

Requesting Department 4th Floor Telemetry Department Director

Net Book Value (Finance) -0- 1/28/20 EMC Member

Sr. VP Finance/CFO 1-31-20 President/CEO 2/6/20

Board Approval: (Date) CFO Signature

Requestor Notified Finance

Asset Disposed of or Donated

Removed from Asset List (Finance)

Requested Public Entity for Donation

Entity Contact

Telephone

PARRISH®

MEDICAL CENTER

PARRISH HEALTHCARE

Healing Families – Healing Communities®

parrishmed.com

Finance Committee

FYTD January 31, 2020 – Performance Dashboard

Indicator	FYTD 2020 Actual	FYTD 20 Budget	FYTD 19 Actual
IP Admissions	1,872	2,070	2,079
LOS	4.7	4.0	4.6
Surgical Procedures	2,205	2,282	2,259
ED Visits	12,982	12,212	12,935
OP Volumes	61,488	62,773	58,961
Hospital Margin %	6.43%	5.72%	4.78%
Investment Income $	$3.4 million	$1.2 million	-$2.2 million
EBIDA Margin %	7.85%	5.77%	-4.92%
EBIDA Margin %- Excluding Invest Income	1.33%	3.56%	-0.30%

Board of Directors Resolution Form
Section C - 2

Required for non-individual applicants only and must be an original, notarized form.

MEDICAID

For non-individual applicants, this form must only be filled out once and submitted with the application for the group/payee number.

State of Florida

County of Brevard

On the 2 day of March, 2020 at a meeting of the Board of Directors of North Brevard County Hospital District, held in the City of Titusville, in Brevard County, with a quorum of the directors present, the following business was conducted:

It was duly moved and seconded that the following resolution be adopted:
Be it resolved that the Board of Directors does hereby authorize

Arvin Lewis

and his/her successors in office to negotiate, on terms and conditions that he/she may deem advisable, a contract or contracts with the Mississippi Medicaid agency and to execute said contract or contracts, and further we do hereby give him/her the power and authority to do all things necessary to implement, maintain, amend, or renew said contract.

The above resolution was passed by a majority of those present and voting in accordance with the bylaws.

I certify that the above constitutes a true and correct copy of a part of the minutes of a meeting of the Board of Directors of North Brevard County Hospital District

Held on the 2 day of March 2020

X _____
Signature of Board Member

Subscribed and sworn before me, Stephanie Parham, a Notary Public for the County of Brevard, on the 2 day of March 2020

Notary Stamp/Seal	*Notary County Of*
STEPHANIE PARHAM Notary Public - State of Florida Commission # GG 206767 My Comm. Expires Apr 12, 2022 Bonded through National Notary Assn.	Brevard
	State Of
	Florida

EXECUTIVE COMMITTEE
Robert L. Jordan, Jr., C.M., Chairman
Herman A. Cole, Jr.
Peggy Crooks
Stan Retz, CPA
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 2, 2020
2nd FLOOR, EXECUTIVE CONFERENCE ROOM
IMMEDIATELY FOLLOWING FINANCE COMMITTEE

CALL TO ORDER

I. Approval of Minutes

Motion to approve the minutes of the January 6, 2020 meeting.

II. Reading of the Huddle

III. Public Comment

IV. Attorney Report – Mr. Boyles

V. Other

VI. Executive Session (if necessary)

ADJOURNMENT

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

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

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EXECUTIVE COMMITTEE

A regular meeting of the Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on January 6, 2020 in the Executive Conference Room. The following members were present:

Robert L. Jordan, Jr., C.M., Chairman
Herman A. Cole, Jr.
Peggy Crooks
Stan Retz
Elizabeth Galfo, M.D. (1:23 p.m.)
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 1:18 p.m.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Ms. Crooks, seconded by Mr. Retz and approved (4 ayes, 0 nays, 0 abstentions). Dr. Galfo was not present at the time the vote was taken.

ACTION TAKEN: APPROVED THE MINUTES OF THE NOVEMBER 4, 2019 MEETING AS PRESENTED.

READING OF THE HUDDLE

Ms. Crooks read the Weekly Huddle.

PUBLIC COMMENT

There were no public comments.

ATTORNEY REPORT

Mr. Boyles updated the committee on the ongoing audit and investigation regarding the use of Parrish Medical Center property and resources in connection with the false unauthorized practice of law complaint to the Florida Bar concerning Dr. Deligdish. He also updated the committee concerning the false August 19, 2019 Lo Tignov, Inc. letter to City and County Officials. Mr. Boyles noted that at this time, the results have been inconclusive; the search has not revealed whether either letter originated within Parrish Medical Center or as a result of the use of its property or resources. A full report should be forthcoming at the February 3, 2020 meeting.

OTHER

There was no other business to discuss.

ADJOURNMENT

There being no further business to discuss, the committee adjourned at 1:23 p.m.

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

Chairperson

EDUCATION COMMITTEE
Billie Fitzgerald, Chairperson
Herman A. Cole, Jr. (ex-officio)
Elizabeth T. Galfo, M.D.
Maureen Rupe
Ashok Shah, M.D.
Robert L. Jordan, Jr., C.M.
Mark Storey, 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 2, 2020
IMMEDIATELY FOLLOWING EXECUTIVE SESSION
FIRST FLOOR CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Election of Chairperson & Vice Chairperson

II. Review and Approval of Minutes

Motion to approve the minutes of the January 6, 2020 meeting.

III. Coronavirus – Ms. Leathers

IV. 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.

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
EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE

A regular meeting of the Educational, Governmental and Community Relations Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on January 6, 2020, at 12:34 p.m. in the Executive Conference Room. The following members were present:

Billie Fitzgerald, Chairperson
Herman A. Cole, Jr.
Maureen Rupe
Ashok Shah, M.D.
Mark Storey, M.D.
Elizabeth T. Galfo, 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

Ms. Fitzgerald called the meeting to order at 12:34 p.m.

REVIEW AND APPROVAL OF MINUTES

The following motion was made by Mr. Retz, seconded by Mr. Cole, and approved (6 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO APPROVE THE MINUTES OF NOVEMBER 4, 2019 MEETING, AS PRESENTED.**

DO NO HARM

Ms. Sellers presented to the committee on the Do No Harm campaign, a program that brings awareness to violence against healthcare and Social Service professionals. Ms. Sellers shared the steps Parrish Medical Center has taken, such as posting notices publically of zero tolerance as well as policy enhancements. Copies of the Power Point slides presented are appended to the file copy of these minutes.

OTHER

No other items were presented.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 12:55 p.m.

Billie Fitzgerald
Chairperson

Healing Families – Healing Communities®

parrishmed.com

COVID-19

What we know

Coronavirus disease 2019 (COVID-19)

- Respiratory illness
- Person-to-person transmission
- Novel
- First identified in Wuhan, China

Risk of infection

Coronavirus disease 2019 (COVID-19)

- Depends on exposure
- Close contacts of people who are infected are at greater risk of exposure

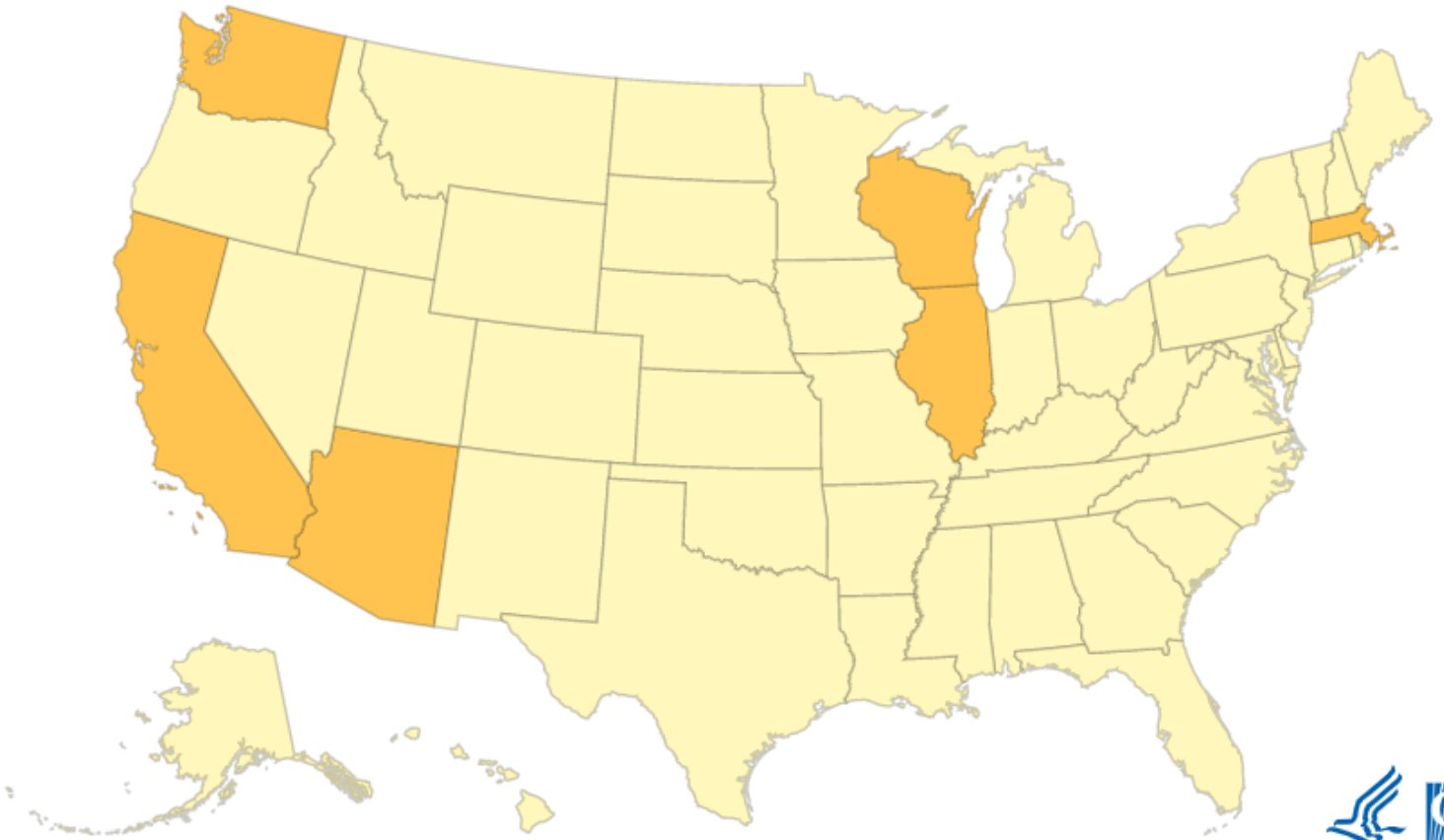
Affected Geographic Areas

Coronavirus disease 2019 (COVID-19)

Widespread or sustained community transmission:

- China
- Iran
- Italy
- Japan
- South Korea

States with Confirmed Cases of COVID-19*



Symptoms

Coronavirus disease 2019 (COVID-19)

- Fever
- Cough
- Shortness of breath

- Severe complications can include pneumonia in both lungs

Preventive actions

Coronavirus disease 2019 (COVID-19)

- Avoid being exposed to the virus that causes COVID-19
- Avoid close contact with people who are sick
- Avoid touching your eyes, nose, and mouth with unwashed hands
- Wash hands often with soap and water for at least 20 seconds. Use an alcohol based hand sanitizer that contains at least 60% alcohol if soap and water are not available

Preventive actions

Coronavirus disease 2019 (COVID-19)

- Stay home when you are sick
- Cover your cough or sneeze with a tissue
- Clean and disinfect frequently touched objecs and surfaces

Preparation

Coronavirus disease 2019 (COVID-19)

- Planning sessions
- Developed/posted entrance signage
- Secured Personal Protective Equipment
- Developed new isolation sign
- Updated travel questionnaire for rapid detection
- Education for Care Partners

Mikitarian, George

From: Mikitarian, George
Sent: Monday, March 02, 2020 8:54 AM
To: Mikitarian, George
Subject: CDC Updates Coronavirus Guidance

American Hospital Association™
Advancing Health in America

AHA TODAY
Your source of news and insight.

February 28, 2020 | www.aha.org/news

Perspective: Meeting the Coronavirus Challenge

As I write, the U.S. has fewer than 100 cases so far, but we need to be prepared to handle whatever may come our way.

Ensuring safe care for patients, protecting health care professionals providing patient care, and supporting the health and safety of communities requires every part of the health sector to work together ... from front line health care providers to federal, state and local governments.

The AHA has been working closely with the Centers for Disease Control and Prevention, the Department of Health and Human Services and our allied hospital association partners who are in touch with their state and local government officials. Meanwhile, Congress is moving quickly to put together a supplemental funding package. That's why we've also joined with the American Nurses Association to make sure providers have the resources they need to take care of patients, communities and our staffs if the virus

spreads. And we've partnered with other health groups to call on legislators to ensure patients and providers can access critical prescription drugs in light of ongoing shortages that could be exacerbated by the COVID-19 outbreak.

Of course, we're very much focused on making sure you have the latest information. We've assembled key resources for you and your teams — updated regularly — to help you address the situation from a variety of perspectives. This includes the latest updates on the spread of the virus, guidance on stewardship of personal protective equipment and recorded discussions with government officials and experts.

We're also sharing CDC's information on how to protect your teams from exposure, what to do if health care personnel have been exposed to the coronavirus, clinical criteria for evaluating patients ... and more.

Two new resources in particular to highlight: First, last Friday's webinar with Rebecca Bartles, the executive director of system infection prevention at Providence St. Joseph Health, who shares the health system's lessons learned during treating the first coronavirus case in the U.S. Second: this week's podcast with Colleen Kraft, M.D., of Emory University, who was a physician leader during the West African Ebola outbreak. She shares her experience with Ebola, what this new outbreak could look like and how hospitals can prepare. Both are worth a listen.

With every continent except Antarctica reporting cases, this issue will continue to be a serious worldwide concern. America's hospitals and health systems know how to prepare for situations like this. We are always there, ready to care ... and our communities are counting on us to be there for them now, just as we were for SARS, H1N1, Ebola and Zika. AHA will keep updating our coronavirus page with new resources to help you respond to this virus, so stay tuned.

American Hospital Association™

(/)

Updates and Resources on Novel Coronavirus (COVID-19)

AHA continues to report on the novel coronavirus (COVID-19) and monitor updates from the Centers for Disease Control and Prevention and World Health Organization. First identified in Wuhan, China, in December 2019, the virus has spread to thousands in China, with over 2,000 associated deaths. Cases in several other countries continue to grow, and WHO and CDC expect more confirmed cases globally, including the U.S.

AHA Resources and Special Communications

- AHA podcast: Emory Doctor Discusses Coronavirus Outbreak (https://www.aha.org/advancing-health-podcast/2020-02-26-emory-doctor-discusses-coronavirus-outbreak) (Feb. 26, 2020)
- AHA Webinar: Learnings from Providence St. Joseph Health, the first health care organization to care for a patient in the U.S. with coronavirus (https://www.aha.org/webinar-recordings/2020-02-21-aha-members-only-coronavirus-webinar-replay-february-21-2020) (Feb. 21, 2020)
- AHE: Coronavirus Advisory for Environmental Services Professionals (https://www.ahe.org/novel-coronavirus-evs-advisory) (Feb. 20, 2020)
- AHA Coronavirus Advisory: Updated Resources for U.S. Hospitals and Health Systems on Preparing for COVID-19 and Stewardship of Personal Protective Equipment (https://www.aha.org/advisory/2020-02-18-coronavirus-update-updated-resources-preparing-covid-19-and-stewardship) (Feb. 18, 2020)
- AHA Special Bulletin: AHA Members-only Call on Feb. 3 with CDC Official on Novel Coronavirus (2019-nCoV) (https://www.aha.org/special-bulletin/2020-01-30-special-bulletin-aha-members-only-call-feb-3-cdc-official-novel) (Jan. 30, 2020)

- AHA Quality Advisory: Update and Resources on Novel Coronavirus (2019-nCoV) for U.S. Hospitals (https://www.aha.org/advisory/2020-01-23-quality-advisory-update-and-resources-novel-coronavirus-2019-ncov-us-hospitals) (Jan. 23, 2020)

AHA News

- CDC updates coronavirus guidance; FDA reports a related drug shortage (https://www.aha.org/news/headline/2020-02-28-cdc-updates-coronavirus-guidance-fda-reports-related-drug-shortage) (Feb. 28, 2020)
- HHS tracking drugs made in China; global coronavirus cases increase (https://www.aha.org/news/headline/2020-02-26-hhs-tracking-drugs-made-china-global-coronavirus-cases-increase) (Feb. 26, 2020)
- Coronavirus spread in U.S. is inevitable, CDC official says (https://www.aha.org/news/headline/2020-02-25-coronavirus-spread-us-inevitable-cdc-official-says)(Feb. 25, 2020)
- WHO: Novel coronavirus not yet a pandemic, but preparing for it (https://www.aha.org/news/headline/2020-02-24-who-novel-coronavirus-not-yet-pandemic-preparing-it) (Feb. 24, 2020)
- CDC confirms new U.S. coronavirus patient, changes how it reports cases (https://www.aha.org/news/headline/2020-02-21-cdc-confirms-new-us-coronavirus-patient-changes-how-it-reports-cases)(Feb. 21, 2020)
- CMS develops new code for coronavirus lab test (https://www.aha.org/news/headline/2020-02-20-cms-develops-new-code-coronavirus-lab-test) (Feb. 20, 2020)
- Cruise ship passengers under travel restrictions due to coronavirus (https://www.aha.org/news/headline/2020-02-19-cruise-ship-passengers-under-travel-restrictions-due-coronavirus) (Feb. 19, 2020)
- Americans repatriated from coronavirus-quarantined cruise ship (https://www.aha.org/news/headline/2020-02-18-americans-repatriated-coronavirus-quarantined-cruise-ship) (Feb. 18, 2020)
- CDC to use local flu surveillance for wider coronavirus testing (/news/headline/2020-02-14-cdc-use-local-flu-surveillance-wider-coronavirus-testing) (Feb. 14, 2020)
- 2 U.S. Evacuees Test Positive for Coronavirus, Global Case Total Spikes (/news/headline/2020-02-13-2-us-evacuees-test-positive-coronavirus-global-case-total-spikes) (Feb. 13, 2020)
- State labs report issues with coronavirus test kit, CDC to send new reagents (/news/headline/2020-02-12-state-labs-report-issues-coronavirus-test-kit-cdc-send-new-reagents) (Feb. 12, 2020)
- CDC offers strategies for conserving PPE supplies, confirms 13th coronavirus case in U.S. (/news/headline/2020-02-11-cdc-offers-strategies-conserving-ppe-supplies-confirms-13th-coronavirus) (Feb. 11, 2020)
- CDC updates coronavirus guidance for health care personnel (https://www.aha.org/news/headline/2020-02-10-cdc-updates-coronavirus-guidance-health-care-personnel) (Feb. 10, 2020)
- Concerns rise for PPE shortages with coronavirus (https://www.aha.org/news/headline/2020-02-07-concerns-rise-ppe-shortages-coronavirus) (Feb. 7, 2020)
- CDC confirms 12th U.S. novel coronavirus case (/news/headline/2020-02-06-cdc-confirms-12th-us-novel-coronavirus-case) (Feb. 6, 2020)

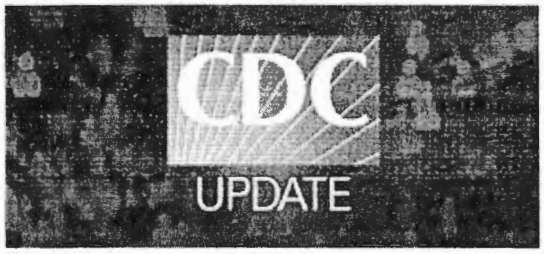
- FDA issues emergency authorization for CDC novel coronavirus test kits (/news/headline/2020-02-05-fda-issues-emergency-authorization-cdc-novel-coronavirus-test-kits) (Feb. 5, 2020)
- CDC updates coronavirus guidance; HHS pursues treatment (/news/headline/2020-02-04-cdc-updates-coronavirus-guidance-hhs-pursues-treatment) (Feb. 4, 2020)
- CDC: 11 people in the U.S. have tested positive for coronavirus (/news/headline/2020-02-03-cdc-11-people-us-have-tested-positive-coronavirus) (Feb. 4, 2020)
- U.S. declares coronavirus a public health emergency, CDC updates guidance (https://www.aha.org/news/headline/2020-01-31-us-declares-coronavirus-public-health-emergency-cdc-updates-guidance) (Jan. 31, 2020)
- CDC confirms first U.S. person-to-person coronavirus case (https://www.aha.org/news/headline/2020-01-30-cdc-confirms-first-us-person-person-coronavirus-case)(Jan. 30, 2020)
- State Department relocates U.S. citizens out of Wuhan, China (https://www.aha.org/news/headline/2020-01-29-state-department-relocates-us-citizens-out-wuhan-china) (Jan. 29, 2020)
- CDC increases coronavirus screenings to 20 airports (https://www.aha.org/news/headline/2020-01-28-cdc-increases-coronavirus-screenings-20-airports) (Jan. 28, 2020)
- Second U.S. patient tests positive for coronavirus, 63 under investigation (/news/headline/2020-01-24-second-us-patient-tests-positive-coronavirus-63-under-investigation) (Jan. 24, 2020)
- WHO meets on coronavirus, decision delayed on whether to declare emergenc (/news/headline/2020-01-22-who-meets-coronavirus-decision-delayed-whether-declare-emergency)y (Jan. 22, 2020)
- CDC reports first U.S. case of coronavirus from China (/news/headline/2020-01-21-cdc-reports-first-us-case-coronavirus-china) (Jan. 21, 2020)
- 3 U.S. airports begin screening for virus in response to outbreak in China (/news/headline/2020-01-17-3-us-airports-begin-screening-virus-response-outbreak-china) (Jan. 17, 2020)
- CDC issues guidance for U.S. providers on pneumonia outbreak in China (/news/headline/2020-01-09-cdc-issues-guidance-us-providers-pneumonia-outbreak-china) (Jan. 9, 2020)

Other Resources

- CDC: Evaluating and Reporting Persons Under Investigation (PUI) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html)
- CDC: Interim Guidance for Businesses and Employers to Plan and Respond to COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-business-response.html)
- CDC: ICD-10-CM Code information for 2019 Novel Coronavirus (https://www.cdc.gov/nchs/icd/icd10cm.htm)
- CDC: Coronavirus Health Care Leadership Listening Session Presentation (/presentation-resource/2020-02-21-cdc-coronavirus-health-care-leadership-listening-session)
- WHO: Coronavirus disease (COVID-19) advice for the public: Myth busters (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/myth-busters)
- ASPR TRACIE: Highly Pathogenic Infectious Disease Training and Exercise Resources Webinar (https://files.asprtracie.hhs.gov/documents/aspr-tracie-netec-exercise-and-training-tools-webinar-flyer.pdf) March 5 at 1:30 p.m. ET (registration required (https://register.gotowebinar.com/register/6044772285384190475))

- OSHA: Protecting workers from potential exposure to COVID-19 (https://www.osha.gov/SLTC/novel_coronavirus/index.html)
- CDC: Healthcare Supply of Personal Protective Equipment (https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe.html)
- CDC: What Healthcare Personnel Should Know about Caring for Patients with Confirmed or Possible 2019-nCoV Infection (https://www.cdc.gov/coronavirus/2019-ncov/hcp/caring-for-patients.html)
- CDC: Interim Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019-nCoV (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)
- CDC: Persons Evaluated for 2019 Novel Coronavirus - United States, January 2020 (https://www.cdc.gov/mmwr/volumes/69/wr/mm6906e1.htm?s_cid=mm6906e1_w)
- HHS Seeks Abstract Submissions for 2019-nCoV Diagnostics Development (https://www.hhs.gov/about/news/2020/02/05/hhs-seeks-abstract-submissions-for-2019-ncov-diagnostics-development.html)
- ECRI Institute's Coronavirus Outbreak Preparedness Center (https://www.ecri.org/coronavirus-outbreak-preparedness-center)
- Presidential proclamation on travel entry ban for those posing a risk of transmitting 2019-nCoV (https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-02424.pdf)
- CDC: Risk Assessment & Public Health Management of Persons with Potential 2019-nCoV Exposure (https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html)
- CDC checklists for hospitals and health care professionals (https://www.cdc.gov/coronavirus/2019-ncov/hcp/preparedness-checklists.html)
- CDC information for laboratories (https://www.cdc.gov/coronavirus/2019-ncov/lab/index.html)
- CDC Resources (https://www.cdc.gov/coronavirus/2019-ncov/index.html)
- World Health Organization Resources (https://www.who.int/emergencies/diseases/novel-coronavirus-2019)

For More Resources Visit



(https://www.cdc.gov/coronavirus/2019-ncov/index.html)

(https://www.who.int/emergencies/diseases/novel-coronavirus-2019)

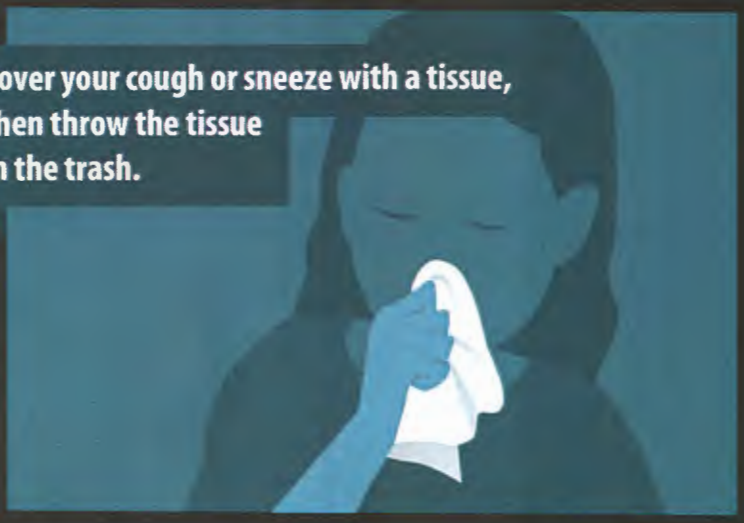
COVID 19 CORONAVIRUS DISEASE

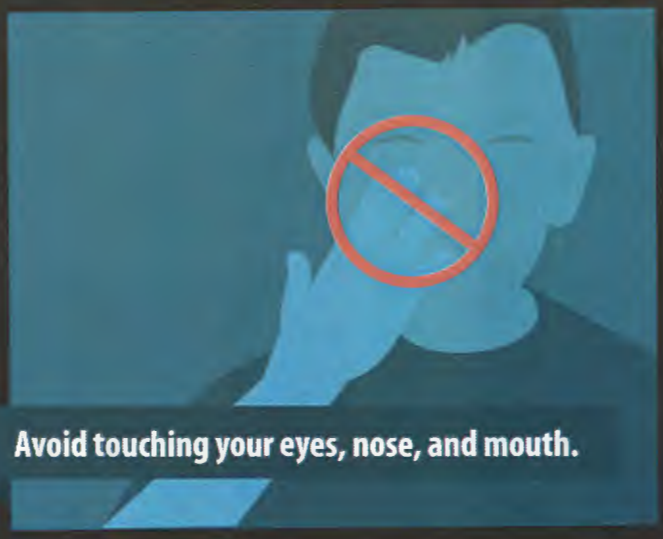
STOP THE SPREAD OF GERMS

Help prevent the spread of respiratory diseases like COVID-19.

Avoid close contact with people who are sick.

Cover your cough or sneeze with a tissue, then throw the tissue in the trash.





Avoid touching your eyes, nose, and mouth.

Clean and disinfect frequently touched objects and surfaces.

Stay home when you are sick, except to get medical care.

Wash your hands often with soap and water for at least 20 seconds.

CDC

For more information: www.cdc.gov/COVID19

What you need to know about coronavirus disease 2019 (COVID-19)

What is coronavirus disease 2019 (COVID-19)?

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.

Can people in the U.S. get COVID-19?

COVID-19 is spreading from person to person in China, and limited spread among close contacts has been detected in some countries outside China, including the United States. At this time, however, this virus is NOT currently spreading in communities in the United States. Right now, the greatest risk of infection is for people in China or people who have traveled to China. Risk of infection is dependent on exposure. Close contacts of people who are infected are at greater risk of exposure, for example health care workers and close contacts of people who are infected with the virus that causes COVID-19. CDC continues to closely monitor the situation.

Have there been cases of COVID-19 in the U.S.?

Yes. The first case of COVID-19 in the United States was reported on January 21, 2020. The current count of cases of COVID-19 in the United States is available on CDC's webpage at https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.

How does COVID-19 spread?

The virus that causes COVID-19 probably emerged from an animal source, but now it seems to be spreading from person to person. It's important to note that person-to-person spread can happen on a continuum. Some diseases are highly contagious (like measles), while other diseases are less so. At this time, it's unclear how easily or sustainably the virus that causes COVID-19 is spreading between people. Learn what is known about the spread of newly emerged coronaviruses at https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html.

What are the symptoms of COVID-19?

Patients with COVID-19 have had mild to severe respiratory illness with symptoms of

- fever
- cough
- shortness of breath

What are severe complications from this virus?

Many patients have pneumonia in both lungs.

How can I help protect myself?

The best way to prevent infection is to avoid being exposed to the virus that causes COVID-19.

There are simple everyday preventive actions to help prevent the spread of respiratory viruses. These include

- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Wash your hands often with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.

If you are sick, to keep from spreading respiratory illness to others, you should

- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces.

What should I do if I recently traveled to China and got sick?

If you were in China within the past 14 days and feel sick with fever, cough, or difficulty breathing, you should seek medical care. Call the office of your health care provider before you go, and tell them about your travel and your symptoms. They will give you instructions on how to get care without exposing other people to your illness. While sick, avoid contact with people, don't go out and delay any travel to reduce the possibility of spreading illness to others.

Is there a vaccine?

There is currently no vaccine to protect against COVID-19. The best way to prevent infection is to avoid being exposed to the virus that causes COVID-19.

Is there a treatment?

There is no specific antiviral treatment for COVID-19. People with COVID-19 can seek medical care to help relieve symptoms.

For more information: **www.cdc.gov/COVID19**

DRAFT AGENDA
BOARD OF DIRECTORS MEETING - REGULAR MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MARCH 2, 2020
NO EARLIER THAN 3:00 P.M.,
FOLLOWING THE LAST COMMITTEE MEETING
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Pledge of Allegiance

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

III. Approval of Agenda

IV. Review and Approval of Minutes (January 6, 2020)

V. Recognitions(s)

VI. Open Forum for PMC Physicians

VII. Public Comments

VIII. Unfinished Business

IX. New Business

A. **Environment of Care Annual Approval**

Motion to Recommend the Board of Directors approve the Environment of Care Plans for the year 2020 to include:
The Utility Management Plan
The Emergency Management Plan
The Environment of Care Management Plan
The Hazardous Materials Waste Management Plan
The Life Safety Management Plan
The Medical Equipment Management Plan
The Security Management Plan

X. Medical Staff Report Recommendations/Announcements – Dr. Storey

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

XII. Consent Agenda

A. Finance

1. Recommend to the Board of Directors approve the Resolution of the Board of Directors of the North Brevard County Hospital District Regarding the Out of State Medicaid Form for the State of Mississippi, Division of Medicaid.

2. 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.

XI. Committee Reports

A. Quality Committee – Mr. Cole

B. Budget and Finance Committee – Mr. Retz

C. Executive Committee – Mr. Jordan

D. Educational, Governmental and Community Relations Committee – Ms. Fitzgerald

E. Planning, Physical Facilities & Properties Committee (Did Not Meet)

XII. Process and Quality Report – Mr. Mikitarian

A. Other Related Management Issues/Information

B. Hospital Attorney - Mr. Boyles

XIII. Other

XIV. Closing Remarks – Chairman

XV. Executive Session (if necessary)

XVI. Open Forum for Public

ADJOURNMENT

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

PERSONS WITH A DISABILITY WHO NEED A SPECIAL ACCOMMODATION TO PARTICIPATE IN THIS PROCEEDING SHOULD CONTACTTHE ADMINISTRATIVE OFFICESAT 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. TO THE EXTENT OF SUCH DISCUSSIONS, A JOINT PUBLIC MEETING OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT AND NORTH BREVARD MEDICAL

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 on January 6, 2020 in Conference Room 2/3/4/5, First Floor. The following members were present:

Stan Retz
Jerry Noffel
Billie Fitzgerald
Robert L. Jordan, Jr., C.M.
Maureen Rupe
Peggy Crooks
Elizabeth Galfo, M.D.

Member(s) Absent:
Herman A. Cole, Jr., Chairman (excused)
Ashok Shah, M.D (excused)

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 3:05 p.m.

PLEDGE OF ALLEGIANCE

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

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

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

APPROVAL OF AGENDA

Mr. Jordan asked for approval of the agenda in the packet. Discussion ensued and the following motion was made by Dr. Galfo, seconded by Ms. Fitzgerald and approved (7 ayes, 0 nays, 0 abstentions).

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

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Ms. Crooks, seconded by Mr. Retz and approved (7 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOTION TO APPROVE THE MINUTES OF THE NOVEMBER 4, 2019 REGUALR MEETING AND NOVEMBER 8, 2019 SPECIAL MEETING, AS PRESENTED.**

RECOGNITIONS

Mr. Jordan took this time to recognize Dr. Rojas. Mr. Jordan presented Dr. Rojas with a plaque in recognition for his service as Medical Staff President. Mr. Jordan shared that a donation in Dr. Rojas' honor has been made to the All Hands and Hearts Puerto Rico Recovery Efforts Program. Mr. Jordan thanked Dr. Rojas for his contributions to both PMC and the Board of Directors, adding it has been a pleasure to serve with him. Dr. Rojas thanked Mr. Jordan and the Board of Directors, sharing that is has been his pleasure to serve the Board and the Medical Staff.

OPEN FORUM FOR PMC PHYSICIANS

There were no physician comments.

PUBLIC COMMENTS

There were no public comments.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

Discussion ensued and the following motion was made by Ms. Crooks, seconded by Ms. Fitzgerald, and approved (7 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: MOTION TO RECOMMEND THE BOARD OF DIRECTORS APPROVE POLICY 9500-5014, FINANCIAL ASSISTANCE, AS PRESENTED.

MEDICAL STAFF REPORT RECOMMENDATIONS/ANNOUNCEMENTS

Discussion ensued and the following motion was made by Ms. Crooks, seconded by Dr. Galfo, and approved (7 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: MOTION TO RECOMMEND THE BOARD OF DIRECTORS APPROVE THE AMENDMENT TO THE RULES AND REGULATIONS, SECTION IV, TO INCLUDE A FINE OF $100.00 PER DOCUMENTATION VARIANCE FOR ANY VARIANCES OCCURRING PAST THE INITIAL NINE (9) VARIANCES AS OUTLINED IN THE MEDICAL RECORDS COMPLETION POLICY. ANY OUTSTANDING BALANCE OF THESE FINES WILL BE CONSIDERED AT THE TIME OF REAPPOINTMENT. THIS PROPOSED RULES AND REGULATIONS

AND POLICY CHANGE WAS SENT TO THE ENTIRE MEDICAL STAFF FOR THE 30 DAY REVIEW AND RESPONSE PERIOD.

Resignations – **For Information Only**

1. Nitin Hate, MD
2. Huijian Wang, MD
3. Cecil Robertson, MD
4. Juan Santiago, MD
5. Rodolfo Torres, MD
6. John Flaherty, MD
7. Katherine Braley, MD
8. Tanmay Patel, MD
9. Simon Symeonides, MD
10. Jyohi Krishnamurthy, MD
11. Madonna Hanna, MD
12. Michael Sorbello, DO

PUBLIC COMMENTS

There were no public comments regarding the revised consent agenda.

CONSENT AGENDA

Discussion ensued regarding the consent agenda, and the following motion was made by Mr. Retz, seconded by Ms. Rupe and approved (7 ayes, 0 nays, 0 abstentions).

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

A. Audit

1. To recommend the Board of Directors to accept the Fiscal Year 2019 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

COMMITTEE REPORTS

Quality Committee

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

Budget and Finance Committee

Mr. Retz 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

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

Planning, Physical Facilities and Properties Committee

Mr. Jordan reported the Planning Committee did not meet.

PROCESS AND QUALITY REPORT

No additional information was presented.

Hospital Attorney

Legal counsel had no report.

OTHER

No other business was discussed.

CLOSING REMARKS

There were no closing remarks.

OPEN FORUM FOR PUBLIC

No members of the public spoke.

ADJOURNMENT

There being no further business to discuss, the meeting adjourned at 3:12 p.m.

Herman A. Cole, Jr.
Chairman

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MEDICAL EXECUTIVE COMMITTEE MEETING – REGULAR

February 18, 2020

Present: D. Barimo, G. Cuculino, A. Hemaidan, R. Henry, C. Manion, A. Ochoa, R. Patel, J. Rojas, M. Storey, V. Williams, J. Zambos, H. Cole, G. Mikitarian
Absent: J. Flynn, P. Carmona, B. Mathews

The regular meeting of the Medical Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was February 18, 2020, at 5:30 PM in the Conference Center. A quorum was determined to be present.

CALL TO ORDER
Dr. Mark Storey called the meeting to order at 5:31 pm.

REVIEW AND APPROVAL OF MINUTES
The following motion was made, seconded, and unanimously approved:
ACTION TAKEN: Motion to approve the previous meeting minutes (Jan 21, 2020) as written and distributed.

UNFINISHED BUSINESS
None

FOLLOW-UP MEC ITEMS
None

NEW BUSINESS
Quality Review – This information is unavailable for review at this time.

INFORMATION/EDUCATION:
Joint Commission Perspectives – February 2020 – Information was emailed for review prior to meeting.
ACTION TAKEN: Noted by Committee
Information /Education items to the Medical Staff to Be Noted in Minutes –
1. ***Meditech Enhancements*** – Information was emailed for review prior to meeting.

ACTION TAKEN: Noted by Committee

REPORT FROM ADMINISTRATION: Nothing to report.

REPORT FROM THE BOARD: Nothing to report.

CONSENT AGENDA: Discussion ensued and a motion was made, seconded, and approved unanimously to approve the following:
a. Our Legacy Transplant Order Set (E3457ab)

COMMITTEE REPORTS:
b. Bylaws 2/5/20
i. Pg 18, line 641: Addition of "electronic signatures acceptable"

ACTION TAKEN: **Motion to approve the recommendation of the addition of "electronic signatures are acceptable" to page 18 of the Medical Staff Bylaws. This revision will be recommended to the medical staff with a vote taking place at the General Medical Staff meeting on March 3, 2020.**

ii. Pg 20, line 708: Add the word "not"

ACTION TAKEN: This has been deemed to be a clerical error that may be corrected without vote.

iii. Pg 28, line 1074: change the word "Champus" to "TRICARE".
ACTION TAKEN: This has been deemed to be a clerical error that may be corrected without vote.
iv. Pg 30, lines 1162-1176: Re-sequence the paragraphs to match the process.
ACTION TAKEN: This has been deemed to be a clerical error that may be corrected without vote.

c. EMR Governance 2/12/20
ACTION TAKEN: Noted by Committee.

CLINICAL DEPARTMENT REPORTS:

a. Medicine 1/21/20
b. Emergency 1/28/20
c. Family Medicine 2/17/20

ACTION TAKEN: Noted by Committee.

OPEN FORUM

Cafeteria – Is the cafeteria no longer stocking the fridge? Need information so we can tell colleagues to plan accordingly. Lunch is not available for physicians after 12:30PM.
ACTION TAKEN: CEO will follow up with cafeteria staff.

Call Schedule – Neurosurgery provider is performing surgeries but is not submitting call days.
ACTION TAKEN: Department Chair and Medical Staff Services will reach out to get call days for this specialty.

TigerConnect Usage - Discussion ensued regarding TigerText being used to communicate at inappropriate hours and sending poor quality photos. TigerText should not be used alone as a means of communication with physicians especially with ICU/ER/OR physicians as they are not always able to access phones.
ACTION TAKEN: Communication policies including Policy 9900-77 and MS Rules and Regulations, section I regarding coverage will be distributed to medical staff and further discussion will take place at the next MEC meeting.

ADJOURNMENT

There being no further business, the meeting adjourned to the executive session at 6:01 PM.

Mark Storey, MD
President/Medical Staff

Christopher Manion, MD
Secretary - Treasurer

2020 UTILITIES MANAGEMENT PLAN

Ted Bryant, Director of Facilities

November 14, 2019

I. PURPOSE

The mission of Parrish Healthcare (PHC) is to improve the health of the people of North Brevard County by providing cost-effective, quality health and hospital services. Consistent with this mission, the Governing Body, the medical staff, and administration have established and provide ongoing support for the Utility Systems program described in this plan.

The purpose of the **Utilities Management Plan** is to support a safe patient care environment at PMC by managing risks associated with the operation and maintenance of utility systems. The plan includes processes for selection, operation and maintenance, and training designed to assure safe, effective performance of utility systems.

II. SCOPE

The Utility Systems Program is designed to assure design and installation of appropriate utility systems equipment to support the medical care processes of PMC. The program is designed to assure effective preparation of staff responsible for the use or maintenance and repair of the equipment. Finally, the program is designed to assure continual availability of a comfortable, safe, and effective patient care environment through a program of planed maintenance, timely repair, and evaluation of all events that could have an adverse impact on the safety of patients or staff. The program applies to all operations owned, leased, or operated by PMC.

III. FUNDAMENTALS

A. The complexity of utility systems required to support patient care continues to increase. Selecting new or upgraded utility system technology requires research and a team approach to assure all functional and medical needs are met.

B. Patient care providers need training to understand how utility systems support patient care, limitations of system performance, safe operating conditions, safe work practices, and emergency clinical interventions during interruptions.

C. Critical components of utility systems require maintenance to minimize potential failures.

D. Emergency response procedures are required to manage utility system disruptions.

IV. OBJECTIVES

A. An assessment of the risks and consequences of utility system failure is conducted annually. Identified risks are addressed in the procedures, training, and/or equipment provided.

B. Maintenance strategy criteria for the Utility Systems inventory are reviewed annually.

C. PMC's preventive maintenance program includes testing and inspections for each item or class of items in the Preventive Maintenance elements of utility systems management program and are reviewed on an ongoing bases. Changes are reported to the Environment of Care (EOC) Committee (EOCC) as appropriate.

D. Medical Gas System components are tested and inspected at least annually and results reported to the EOCC.

E. Testing and certification of Medical Gas System piping and systems is current and verified following invasive maintenance, or construction and reported to the EOCC.

F. Processes to control pathogenic biological organisms in the chilled water, domestic water, and protective water systems are evaluated annually, and reported to the EOCC.

G. Processes used to control infection by maintenance of pressure relationships and maintaining filtration are evaluated annually, and irregularities are reported to the EOCC.

H. Operational plans for normal and urgent operations of utility system elements are evaluated for current accuracy annually, and results reported to the EOCC.

I. Failures and errors that affect operational reliability of the utility systems are reported to the EOCC in a timely fashion, and evaluated as part of annual evaluation, and results reported to the EOCC.

J. Performance is measured using various performance indicators, and is reported to the EOCC quarterly, evaluated annually, and results reported to the EOCC.

K. Emergency procedures for response to failure or malfunction of utility systems are exercised periodically, evaluated annually, and the results reported to the EOCC.

V. GOALS

1. Critical Utility PM's completed at 100%
2. Annual Medical Gas components are tested annually
3. Conduct environmental rounding at 100% (2 times/yr. in patient care areas and 1time/yr. in non-patient care areas)
4. Non-critical Utility PM's completed at 100%

V. ORGANIZATION AND RESPONSIBILITY

A. The Hospital Board receives regular reports on the activities of the Utility Systems program from the EOCC. The Hospital Board reviews reports and, as appropriate, and communicates concerns about identified issues and regulatory compliance. The Hospital Board provides support to facilitate the ongoing activities of the Utility Program.

B. The CEO receives regular reports of the current status of the Utility Program through the EOCC. The CEO reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the Director of Facilities. The CEO collaborates with the Director of Facilities to establish operating and capital budgets for the Utility Systems.

C. The Operations Managers work under the general direction of the Director of Facilities, both of whom are responsible for operation and maintenance of the utility systems and management of contractors working on PMC's utility systems.

D. Department heads are responsible for orienting new staff to the Facilities Department and, as appropriate, to job and task specific uses of utility systems. When requested, the Facilities Department provides assistance.

E. Individual staff members are responsible for learning and following job and task specific procedures for safe utility system operation, maintenance, or use. Individual care partners are responsible for timely reporting of utility problems.

VI. UTILITY SYSTEMS MANAGEMENT PLAN PROCESSES (How PMC manages utility risks):

A. Utility Systems Management Plan

Parrish Healthcare maintains a written management plan describing the processes it implements to manage the effective, safe, and reliable operation of utility systems. This plan is evaluated annually, changed as necessary based on changes in conditions, regulations, standards, and identified needs.

B. Design and Maintenance of Utility Systems

The Director of Facilities is responsible for managing, the planning, design, construction, and commissioning of utility systems to meet the patient care and the operational needs of Parrish Healthcare. The construction and commissioning programs are designed to assure compliance with codes and standards and to meet the specific needs of the occupants throughout the institution. In addition, the design process is intended to assure performance capability in

excess of current needs to help assure that changing demands on utility systems can be managed without major capital investment. The Director of Facilities is responsible for setting maintenance standards and implementing a program of planned maintenance and customer service.

C. Risk Criteria

PMC has established and uses risk criteria for identifying, evaluating, and creating an inventory of operating components of systems to be included in the utility management plan before the equipment is used, which address the following:

1. Life support
2. Infection control
3. Support of the Environment of Care
4. Equipment support
5. Communication

The results of assessment of the various utility systems and components are used to identify the maintenance strategies, and to identify which equipment may be included in preventive maintenance, corrective maintenance and the other types of maintenance used at PMC.

The results of assessing the risks of failures of the utility systems are also used to identify those systems and areas for which emergency plans are needed.

D. Maintenance Strategies

PMC has developed appropriate strategies for all utility systems equipment on the inventory for ensuring effective, safe, and reliable operation of all equipment in the inventory. These strategies include:

1. OEM recommended maintenance
2. Preventive and predictive maintenance based on experience with the specific equipment.
2. Corrective Maintenance
4. Maintenance prior to use

E. Maintenance Intervals

The organization defines the intervals for maintenance, inspection and testing of all equipment under preventive or predictive maintenance. The equipment and the maintenance activity are based upon manufacturers' recommendations, evaluated risk levels, and Parrish Healthcare's experience. Preventative and corrective maintenance activities are managed utilizing a computerized maintenance management system..

The results, including over due work orders, compliance rates, timeliness rates, and outliers (corrective maintenance needed after PM's) are evaluated to determine the effectiveness of the system, the need to replace components, and opportunities to improve by changing intervals and activities. The results of the analysis are reported to the EOCC, and used internally for program improvements.

F. Emergency Procedures

PMC has identified and implemented emergency procedures for responding to utility system disruptions or failures that address the following:

1. What to do if utility systems malfunction (on a departmental and organization wide

basis)
2. Identification of an alternative source of organization defined essential utilities (where alternate sources are appropriate)
3. Shutting off malfunctioning systems and notifying staff in affected areas
4. How and when to perform emergency clinical interventions when utility systems fail (focusing on clinical staff and support staff)
5. Obtaining repair services (both internal and external resources)
6. Emergency responses are integrated into Emergency Operations plans.
7. Plans are developed to include criteria and indications for implementing a utility response plan; staff responsible for making decisions, activities and resources used to mitigate the emergency (such as an emergency power system to mitigate external power failure); preparation for the failure (e. g., flashlights, staff training about how to respond to a power failure). The response plans are also included in a quick reference chart which is widely distributed and posted under or near telephones throughout the facility. The recovery plans focus on return to normal conditions, and the resetting and recovery of emergency equipment and supplies.

G. System Layout and Mapping

The Director of Facilities manages the process for documenting the layout of distributions of utility systems and the locations of critical or emergency controls for a partial or complete shut-down of the system.

H. Labeling of Controls for Emergency Shutdown

Critical or emergency operating components of utility systems are identified on paper documents or computerized drawings. Legends, symbols, labels, numbers, and color-coding are used to identify the location/ type of critical or emergency controls.

I. Management of Waterborne Pathogenic Agents

PMC has identified and implemented processes to minimize pathogenic biological agents in cooling towers, domestic hot/cold water systems, and other aerosolizing water systems.

When the presence of pathogenic biological agents is identified in water systems, the Infection Control Nurse and the Director of Facilities collaborate to identify an effective treatment and future growth prevention program.

Domestic water is watched by the Infection Control Nurse. When an outbreak of an infectious, waterborne disease (such as legionella) is identified, the Parrish Healthcare Facilities Department staff treat the affected domestic water system to eliminate the hazard.

Any ornamental water within PMC is periodically treated, and the potential aerosol is controlled by ventilation, or other methods acceptable to the Infection Control Nurse.

J. Detailed maintenance procedures for Eye Wash Stations, are defined in PMC Policies.

K. Maintenance of Air Pressurization, Filtration, and Filter Efficiency

PMC HVAC systems were designed and installed to provide appropriate pressure relationships, air-exchange rates, and filtration efficiencies for ventilation systems serving areas specially designed to control air-borne contaminants. PMC HVAC systems are maintained by Facilities Department staff, and where appropriate by sub-contractor. The schedule of regular inspection of filter performance monitoring equipment, air pressure

sensing equipment, and air flow rate sensors is managed by the Operations Manager of the Facilities Department.

A qualified service provider is engaged to verify volume flow rates (air exchange rates, and positive or negative pressure rates) and pressure relationships as part of the commissioning of the new PMC and subsequent building projects and major space renovations. In addition, the air volume flow rates and pressure relationships are tested periodically throughout the hospital including investigation of complaints related to indoor air quality. The results of testing are used to adjust the performance of air handling systems by changing control software parameters and mechanical or electrical controls.

If system performance cannot be adjusted to meet code requirements or occupant needs, the Director of Facilities works with appropriate Infection Control and clinical staff to develop temporary management practices. In addition, a recommendation for upgrading or replacing the equipment involved is prepared and submitted to the President/CEO and the Hospital board as part of the budgetary process, or when appropriate, as an emergency request.

L. Emergency Electrical Power Systems

PMC provides reliable emergency power systems, as required by the Life Safety Code. Emergency Life Safety power systems supply sufficient emergency power to allow for normal operations during loss of normal power, including the following systems critical to Life Safety:

1. Alarm systems (e, g, Fire Alarms, and other emergency alarm systems)
2. Exit route illumination (Corridor lighting to illuminate exit paths).
3. Emergency communication systems, the PA system, and emergency phone system, Exit sign illumination.

PMC provides a reliable emergency power system for services provided and patients that supplies electricity to the following areas when normal electricity is interrupted:

1. Blood, bone, and tissue storage units (in laboratory, OR and other areas)
2. Emergency/urgent care areas (Including the ED and selected treatment areas)
3. Elevators (at least one for non-ambulatory patients) (at least one in each bank)
4. Medical air compressors
5. Medical and surgical vacuum systems
6. Areas where electrically powered life-support equipment is used.
7. Operating Suites
8. Postoperative Recovery rooms
9. Obstetrical Delivery rooms
10. Newborn Nurseries

M. Maintenance, Testing and Inspection of Utility Systems

PMC maintains a current inventory of all utility Systems. This inventory includes all equipment maintained by PMC staff, by manufacturers' representatives, and by contractors.

The inventory is maintained in the computerized maintenance management system.

Each component identified in the plan is subject to performance and safety testing before initial use, as part of the acceptance process, and is added to the inventory

Information about significant failures and equipment concerns are reported to the Executive Management Team and the EOCC.

VII. Reporting Environment of Care Issues (Improving conditions in the Environment of

Care):

The Director of Facilities reports problems, failures, and significant repair activities and maintenance activities to the EOCC.

A. Collection, Analysis, and Dissemination of Information

The Facilities Director coordinates the collection and analysis of information about each of the Utility systems. The information is used to evaluate the effectiveness of the program and to improve performance

B. Performance Monitoring

The Director of Facilities establishes performance indicators (PI) to measure the effectiveness of the Utility Management Plan using appropriate data sources, data collection methods, data collection intervals, analysis techniques and report formats.

C. Annual Review of the Utility Management Plan

The EOCC Chairman and managers responsible for the design and implementation of the Utility Management Plan will perform an annual review of the plan and report those results to the PHC Board.

EMERGENCY MANAGEMENT PLAN 2020

By
Lori Thompson, Interim EOC Chair

I. MISSION

To provide safety for all patients, and care partners consistent with Parrish Healthcare's (PHC) mission, vision and values by establishing the organizational response to emergency situations.

II. PURPOSE

To define the organization's response to situations that pose an immediate danger to the health and safety of all who enter PHC doors; return of the organization to normal status; and to comply with regulatory requirements.

III. SCOPE

Applies to all types of emergency situations whether a natural disaster or a human created situation and occurring within or outside the organization which affects the safety and security of PHC.

IV. RESPONSIBILITIES AND REPORTING STRUCTURE

- The PHC Hospital Board:
  - receives regular reports of the activities of the Emergency Management Program from the Environment of Care Committee (EOCC) Chairperson.
  - review the reports and, as appropriate, supports the EOCC activities related to Emergency Management.
- Medical Staff Leadership:
  - participates in planning activities as part of development and revision of the Emergency Management Plan.
  - assists in implementation of the four phases of emergency management (mitigation, preparedness, response, and recovery)
  - assists in the implementation of emergency management as to communication, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities.
  - collaborates across clinical and operational areas in implementing emergency management organization wide
  - helps identify and collaborate with community response partners.
- The PHC CEO:
  - receives regular reports of the current status of the Emergency Management Plan through the EOCC.
  - reviews the reports provided by the EOCC, and communicates to the EOC Chair.
  - Helps determine fiscal needs in support of the Emergency Management Plan.

- The EOCC Chairperson:
  - works under the general direction of the PHC CEO, or designee.
  - Leads the EOCC activities relevant to emergency management
  - Reports activities of the Emergency Management Program to the governing board

- The EOCC:
  - develops, maintains and revises the Emergency Management Plan.
  - reviews the countywide emergency plan(s) to assure consistency
  - in conjunction with such countywide emergency plans, reviews and updates the Emergency Management Plan annually.
  - maintains a documented inventory of the resources and assets that may be needed during an emergency.
  - establishes staff training requirements for the Emergency Management Plan.
  - addresses the implementation of any 1135 waivers

- The Safety Officer
  - Advises the EOCC regarding emergency management issues that necessitate the following:
    - purchase of necessary supplies and equipment for improvement of emergency response
    - management of grant programs
    - changes to policy and procedure
    - orientation, education and training of staff regarding emergency response
    - overall activities of the incident command structure and integration with the Brevard County command structure
    - reporting of disaster activity via drills and interim changes that may be needed to the Emergency Management Plan
    - evaluation of the Emergency Management Plan through the use of drills, exercises in various situations and the evaluation of same.

- Department heads:
  - orientation of new personnel to the department regarding emergency response.
  - provide new care partners with department, job , or task-specific education and training regarding emergency response.
  - provide assistance to the Safety Officer and/or EOCC.

- Individual personnel:
  - Participate in emergency response orientation, education and training activities.
  - Lean and follow appropriate procedures for emergency response.

V. PHC EMERGENCY MANAGEMENT PROCESSES

- **Hazard Vulnerability Analysis (HVA)**
  Assess the impact of likely emergencies to guide the EOCC in updating/revision of the Emergency Management Program. Such analysis is done by the EOCC on an annual basis by:

- review the prior year's HVA on an annual basis
    - Determine any changes in likely emergencies
    - Collaborate with Brevard County Emergency Management in prioritization of emergencies
- Communicate needs and vulnerabilities to Brevard County Emergency Management and identify capabilities of all involved to meet the organization's needs
- Based on the HVA, define mitigation activities and preparedness activities

- **Emergency Response Plans**
    - Emergency Response Plans are developed and maintained for each of the emergencies identified as priorities in the HVA's, and are annually compared to the Brevard County Emergency Management plan(s) to assure consistency and coordination of PHC's role in those plans.
        - PHC uses and "all hazards" methodology in the overall description of emergency response and includes:
            - Emergency preparation activities
            - Criteria to be met to activate the plan
            - Person responsible for authorization to activate the plan
            - Chain of command for duration of the emergency, including succession planning
            - Emergency response processes for leadership, staff, physicians and volunteers
            - Management of patients and patient care during the emergency
            - Alternative sites for care, treatment and services
            - Means to provide shelter of patients, staff and volunteers on site who remain in the facility
            - Criteria to end the emergency response
            - Emergency recovery activities, which include but are not limited to medical record activity, financial information, and restoration of areas modified for emergency use
            - Capabilities and response procedures when the hospital is isolated from normal resources such as communication, resources and assets, security, safety, staff, utilities, or patient care for at least 96 hours
            - Management of security and safety during an emergency including:
                - Internal security and safety
                - Role of law enforcement if requested and available
                - Management of hazardous materials and waste
                - Provision for decontamination
                - Control of organization entrances and exits
                - Control of movement within facilities affected
                - Control of vehicles that access facilities
            - Management of staff during an emergency, including:
                - Assigning staff to essential functions
                - Identification of persons to whom staff report in the incident command structure
                - Staff support, such as housing, transportation, and incident stress debriefing
                - Support needs of staff, i.e. family, pets, elder care

    - system to track location of on-duty staff during emergency
- Management of utilities, including alternate sources to provide:
    - Electricity and lighting
    - Water for consumption, essential care activities, equipment operation and sanitary purposes
    - Fuel for building operations, generators, and essential transport services as may be provided by the hospital
    - Medical gas and vacuum systems
    - HVAC
    - Other utilities deemed essential
- Management of patients
    - Scheduling, triage, assessment, admission, transfer and discharge
    - Evacuation to a safe location within or outside of the hospital
    - Demand for clinical services for vulnerable populations
    - Personal hygiene and sanitary needs
    - Mental heal health service needs
    - Mortuary services
    - Documentation and tracking of patient clinical information
    - Tracking location of patients sheltered on site
- Management of resources and assets, including:
    - Obtaining and replenishing:
        - Medications and related supplies
        - Medical supplies and Personal Protective Equipment
        - Nonmedical supplies
        - Sharing resources with other health care organizations
        - Monitoring quanitites used during an emergency
        - Arranging transportation of patients and necessary supplies to alternative care site(s)
        - Arranging transfer of pertinent clinical and medication related information with patients moving to alternative care sites
- Processes for maintaining continuity of operations during an emergency, particularly as related to patient care, which includes but is not limited to:
    - Succession plan listing key leader replacements if not available to carry out his/her duties
    - Delegation of authority providing succession authority to implement policies and make decisions along with criteria for same
    - Process to request an 1135 waiver for care at an alternative site, i.e. at Eastern Florida State College
    - Criteria to discontinue elective treatment/services
    - Management of information about incoming patients
    - Availability of patient care supplies and equipment during the emergency
    - Evaluation of patients for movement to other units
    - Release of patients to home or transfer to other facilities
    - Communication with patients and families regarding patient status, movement, relocation or transfer
    - Transportation of patients, as needed
    - Criteria for relocating or evacuation of patients, staff and others
    - Identification of alternative locations in order to continue

patient care
    - Assignment of staff in the hospital or at relocation/evacuation sites
    - Description of patient tracking procedures to be used during relocation/evacuation
    - Alternate roles for staff during the emergency

- **Emergency Communications Plan**
  As part of the Emergency Response Plan, PHC includes communications during emergency situations. Elements addressed related to communications when the Emergency Management Plan is implemented include, but are not limited to:
    - Notification to affected staff regarding the initial implementation of the Emergency Management Plan and regular updates via overhead announcements, telephones, cell phones, text, employee hotline, email, and iCare communications board.
    - Notification of Brevard County Emergency Management Office, local law enforcement agencies regarding the situation with regular updates regarding new information and conditions
    - Communication with the media and the community
    - Process to communicate with suppliers and vendors of essential supplies
    - Communication with any alternative care site
    - Informing entities assisting with disaster services regarding general condition and location of patients
    - Process to notify families/patient representatives/health care surrogates in the event of an evacuation of patient(s)
    - Current listing of names and contact information for the following:
        - Employees
        - Physicians
        - Hospital Auxillians
        - Other hospitals
        - Organizations with whom PHC has a Memorandum of Understanding or contract for goods and services
        - Relevant federal, state and local emergency preparedness staff
        - Other sources of assistance

    - The Safety Officer with the assistance of the EOCC assures the following is up to date
        - Contact lists as identified above
        - Criteria for calling staff to assist with any emergency response
        - Assures up to date contact list for all known emergency response organizations

C. Emergency Management Plan

PHC has developed, maintains, and evaluates annually a set of emergency management plans describing processes PHC implements to effectively manage emergencies affecting the facility, patients, staff, and to respond to emergencies in the community that cause an influx of patients. These emergency plans are amended as necessary, based on changing

conditions, regulations, standards, and identified needs.

D. Leadership and Medical Staff Involvement

Emergency Management Plans are developed, maintained, and reviewed with PHC leadership, and medical staff. PHC leadership reviews and approves all management plans, and both leadership and medical staff are involved in plan development, and in critique of plan activation for exercises or for real events.

E. Processes for Mitigation, Preparedness, Response, and Recovery

Emergency Response Plans include activities designed to mitigate the impact of the emergency, such as building elements, specialized equipment, staff preparation, staff Training, adequate supplies, equipment for responding to potential emergency, plans to handle the space and facilities during emergency situations. The Emergency Response Plans include the specifics of the response, including job assignments, staffing strategies, and the management of both victims of the emergency and existing patients. Recovery plans include the immediate cessation of the emergency plans, return to normal operations, critique and evaluation of the plan response, and changes to the plans to improve them. Recovery plans for incidents that directly affect the PHC facility are accomplished as quickly as practical after the event, and include interim measures to provide for ongoing patient care.

F. Processes for Implementing Emergency Plans and Recovery Processes

The EOP clearly states the criteria and the processes to initiate an implement the plan. Criteria include examples of conditions that indicate the plan should be activated, individual(s) responsible for plan initiation, and the use of PHC's Incident Command System to manage the emergency. The emergency plan also includes staff response elements, and facility use. The emergency plans define when the plan should be terminated, the transition back to normal, recovery elements such as medical record information capture, financial information, restoration of areas modified for emergency use, and return to normal management.

G. Processes to Notify Staff of Emergency Implementations

When emergency plans are activated, several methods are used to notify affected staff. Primary method of staff notification is the overhead page system, also used to announce codes to alert the staff. In addition, communications tools such as telephones and cell phones are used to assure key staff are aware of the situation. For notifying care partners away from the facility, telephones, and cell phones are used. For staff call back to PHC when needed, telephone callback trees are maintained by departments and updated on a regular basis.

H. Notifying Governmental Authorities

The EOP includes a current list of governmental and commercial organizations that should be notified of plan implementation which includes the agency or organization name, basic organization function, telephone and other contact numbers, and a list of contact personnel. When an emergency event requires contact with a governmental agency or authority, the Incident Commander authorizes the contact and forwards the information to the Incident Command Liaison Officer for dissemination.

Specific plans in the PHC's Emergency Department help to identify bioterrorist agents, support the early identification of a bioterrorist event, and include automatic lockdown (Code Yellow) during mass casualty (Code Green) events.

I. Assignment of Staff

The EOP is used to assure that each plan implementation includes sufficient care partners to effectively activate the plan. The IC system is based on the use of position descriptions and an organization chart to assure each task is considered, and staff is made available to

complete those tasks. The IC organization chart assists the Incident Commander in allocating available staff to fill critical tasks. In many cases individuals may be able to accomplish tasks from several position descriptions. The incident command system is designed to be scalable. The EOP process also allows for planning staff to plan ahead to determine when more staff should be called in, and when staff on duty should be relieved with rest and breaks.

J. Management of Patient Care Activity

The EOP addresses the management of patient care activities. Plans include procedures for discontinuation of elective treatment, for evaluation of patients for movement to other units, release to home or transfer to other facilities as space is needed. The plan also includes procedures for the management of information about incoming patients and about current patients for planning, patient management, and informing relatives and other; and for transport of patients.

Procedures also address the transportation and housing of staff that may not be able to get to or from the facility during an emergency or who may need housing and other services for their families. A procedure is in place for incident stress debriefing. Care partners involved in emergency operations are offered an opportunity to address incident related issues with qualified behavioral health professionals.

Arrangements have been made with vendors and other services to assure availability of supplies and materials in a timely fashion. Additionally, the Brevard County Emergency Operations Center plans provide for mission critical supplies.

Release of information to the news media would follow the procedures developed by the Communications and Community Services Department who will act as spokespersons for PHC. The Incident Commander will release information as appropriate to the situation. In larger incidents, the Brevard County Emergency Operation Center may act as spokesperson for the overall emergency and PHC information.

K. Staff Identification

PHC uses identification badges to identify Care Partners during mass casualty or major environmental disasters. Individuals entering the facility must have a visible PHC ID in order to enter. Staff or civil authorities without ID's must be approved by Security, positively identified, and receive a temporary badge or other approved alternate method of identification. Key members of the Incident Command team are issued a colored vest with the ICS command title across the back and front to identify their role. Emergency vests move with the job as more senior staff become available, and during longer incidents, as jobs are handed from staff to staff. The Liaison Officer from the Incident Command team is assigned to work with law enforcement, fire services, emergency management agencies, contractors, and volunteer responders to issue PHC emergency identification, or to determine what form of identification each responding group will display. Media representatives are handled by the PHC Public Information Officer (PIO).

L. Backup Systems for Failures In Communications

Alternate communication systems are available for use during emergency responses including the PHC phone system, an emergency backup phone system (black telephones), 800 MHz radios, cellular phones, and portable and hard-wired satellite phones. The implementation of the emergency plan focuses on maintaining vital patient care communications. Once the initial level of the plan is in place, the Incident Command Communications Leader will work with the telephone company and wireless provider representatives to determine the scope, likely

duration of any outage, and to identify additional communication strategies and alternatives.

M. Alternate Roles for Care Partners during Emergencies

During emergencies PHC implements the EOP, which defines the Incident Command Staff that supersedes normal PHC management. Senior staff, as available, is assigned responsibilities using the EOP. They assure that key tasks are staffed. Most care partners perform their usual tasks as they are trained for, however in context of the emergency at hand. Incident Command Staff receive one-on-one training and drills about their roles. Other care partners, who will be asked to perform alternate tasks are trained for them, or receive just-in-time briefing at the time of the activity.

N. Alternate Sources of Utility Systems

Alternate plans to provide utilities for patient care are maintained, and include restoration of normal operations using the emergency power system, backup systems for water, fuel stored for heating and power, and critical HVAC. Managers and care partners in all departments affected by the plans are trained as part their organization wide and department specific roles. Plans are tested as part of the regularly scheduled drills of the EOP, and when actual outages of utility systems occur.

O. Chemical and Radioactive Isolation and Decontamination

The management of nuclear, biological, or chemical contamination situations is a joint effort between national, state, local officials, and the healthcare community. PHC is prepared to manage a limited number of individuals contaminated with hazardous materials and to meet the care needs of others who have been decontaminated by other agencies.

The staff of the Emergency Department has training and equipment for handling decontamination of affected individuals, depending on the severity of the event. Once that capability is exhausted, contaminated victims will be isolated and managed by local agencies with specific appropriate expertise.

If a facility is contaminated, a contractor experienced in the isolation and decontamination process will be contacted by the Incident Command staff. The Safety Officer, with Infection Control assistance will assure isolation of affected areas until they are declared safe by appropriate experts.

P. 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. Drills are planned to test various elements of the EOP and to test the various Emergency Response Plans for specific priority emergencies. When practical, full scale exercises (FSE) are planned in conjunction with other PHC's, local Emergency Management agencies, and healthcare coalitions.

FSE's are planned 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 will determine our ability to function for 96 hours.

PHC offers emergency services as a community-designated disaster-receiving station, and conducts at least one FSE each year that includes an influx of actual or simulated patients. When practical, actual simulated patients are used. When live patients are not available "paper patients" are used with their characteristics and injuries noted on cards. care partners indicates with note what to would do and what supplies would be "expended" to better evaluate the logistics of handling a large influx of patients.

PHC participates in at least one community-wide full scale exercise (FSE) a year relevant to high priority emergencies identified in PHC's HVA. During each FSE communication, logistics, and functionality of PHC's and the local community's incident command structures are accessed, looking for methods to improve communications, and overall facility effectiveness.

FSE's and plan implementations are documented, observed as practical, and critiqued to identify deficiencies and opportunities for improvement. Identified problems and opportunities are resolved to improve overall emergency response processes.

VII. Monitoring and improving conditions in the Environment of Care®

A. Reporting of Environment of Care Issues

Quarterly reports of problems, failures, and user errors are made to the EOCC by those responsible who summarize findings of incident reports, maintenance and repair activities, hazard notices, equipment recalls, and other relevant information.

B. Collection, Analysis, and Dissemination of Information

The EOC Chairman coordinates the collection and analysis of information about each EOC management program. The information is used to evaluate the effectiveness of these programs and to improve performance. The information collected includes deficiencies in the environment, staff knowledge, performance deficiencies, actions taken to address identified issues, and evidence of successful improvement activities.

C. Performance Monitoring

The EOC Chairman coordinates the performance indicator measurement and improvement process for each of the functions associated with management of the EOC, and is responsible for preparing quarterly reports of those performance indicators for the EOCC which includes ongoing measurement of performance, effectiveness, a summary of identified problems, and potential improvements. A summary of Emergency Management and Emergency Operation Plan improvements identified during FSE and plan implementations debriefs is presented to the EOCC. Root Cause Analysis (RCA) of Sentinel Events is presented by the Risk manager if necessary.

The EOC Chairman determines appropriate data sources, data collection methods, data collection intervals, analysis techniques and report formats for the performance improvement standards. Human, equipment, and management performance are evaluated to identify opportunities to improve the Emergency Management Plan.

Performance Indicator is one part of the evaluation of the effectiveness of the Emergency Management Plan. A performance indicator has been established to measure an important aspect of the Emergency Management Plan, as well as the other areas of the Environment of Care, and are evaluated by the EOCC each quarter for performance and effectiveness.

D. Annual Review of Management Plans

The EOC Chairman and managers responsible for the design and implementation of the EOC programs perform an annual review of each EOC Plan. The review evaluates the content of the plan to determine if changes in organization structure, scope of services, or other changes or needed to update the EOP.

E. Annual Program Evaluation

The EOCC Chairman is responsible for coordinating the annual evaluation of the management plans associated with management of the EOC, and performs the

annual evaluation of the Emergency Management Plan, the Life Safety Plan, and the Utilities Plan. Other management plan annual evaluations are performed by their respective authors.

Annual evaluations examine the scope, objectives, performance, and effectiveness of each plan using a variety of sources including internal policies, procedural reviews, incident report summaries, EOCC meeting minutes and/or reports, white papers, and summaries of other activities. Findings by accrediting agencies, licensing bodies, or qualified consultants may be used. The findings of each annual evaluation are presented in a narrative report supported by a balanced summary of relevant data from the preceding 12 months. Strengths as well deficiencies are evaluated to set goals.

Completed annual evaluations are presented to the EOCC for review, comment, and approval, and are documented in Task Force minutes. Annual evaluations are distributed to the CEO, PHC board, and department heads as part of *the EOCC Annual Report*. Once evaluations are finalized, respective authors of each plan are responsible for implementing report recommendations as part of the normal PHC management process

F. Patient Care Improvement

The Chairman of the EOC is responsible for working with individual(s) responsible for PHC's Patient Care Improvement program, performs risk assessments to identify Patient Care environmental threats, conducts EOC Rounding on a regular basis, evaluates Patient Care concerns as required, participates in the analysis of Patient Care incidents as requested, in the development of material for general and job-related orientation and on-going education, such as migrating from MSDS to GHS hazardous communication programs, and attends Patient Care Improvement meetings as necessary.

G. PHC identifies EOC issues and actions necessary to resolve them.

The EOCC considers reports of EOC issues at six regularly scheduled meetings, evaluating submitted reports, and approving actions to address issues.

The EOCC meets at least six times per year to address EOC, Risk Management, Patient Care Improvement, quality, and other PHC business.

Managers of each EOC function and members of the EOCC collaborate to analyze EOC issues, including ongoing performance analysis and aggregate analysis of environmental rounds, incident reports, maintenance activities, and other such issues.

The EOCC analysis is used to manage the stability of current programs, assess new program needs, and to identify opportunities for improvement.

The EOCC publishes minutes of each meeting which summarize materials presented, issues identified, actions to be taken, including timelines to complete. The EOC minutes are designed to assure activity resolution.

Managers of each EOC function are responsible for identifying important measures of environmental, Patient Care Improvement, or of program management. Performance and effectiveness measures are used to evaluate performance on an ongoing basis, measure the success of implementation of performance improvement activities, and to develop an understanding of processes that are not meeting expectations.

Minutes and relevant supporting materials are communicated to all EOC and organization leaders. All managers are required to respond as appropriate.

When EOC managers and the EOCC identify performance improvement opportunities, a proposal for improvement is prepared and sent to leadership.
PHC Leadership reviews all improvement proposals, and determines the priority and need for the proposed improvement.

When leadership approves a proposal for improvement, appropriate staff is appointed to address the identified issues and to design a process improvement. The staff or team appointed make regular reports to the EOCC and PHC leadership addressing progress toward improvement, including measurement of changes to assure they are effective, and sustainable.

EOCC minutes are presented to the Patient Care Improvement Task Force when appropriate. Issues of interest to the Patient Care Improvement Task Force are presented for discussion and action as appropriate. The minutes and issues identified by the Patient Care Improvement Task Force are handled in the same manner as the EOCC.

H. Orientation, Training, and Education

All PHC staff & contract employees must attend new employee orientation within thirty (30) days of their initial hire date. New employee orientation addresses key issues and objectives of all areas of the EOC, including the role each area and care partners play in overall Patient Care.

The EOCC supports a safe and secure environment for patients, visitors, physicians, and care partners at PHC by identification and analysis of potential hazards/emergencies and their effects on operations and services including procedures for the Mitigation, Preparedness, Response, and Recovery phases of an emergency.

Annually, the PHC Environment of Care (EOC) Task Force reviews an evaluation of the Emergency Management Plan for performance and effectiveness. Emergency Management reports are presented to the EOCC on a regular basis. The EOCC meets at least four (4)) times a year, annually reviewing EOC goals, performance and effectiveness.

Emergency Management procedures are found in the following PHC emergency response policies and procedural documents which are integral to success of the Emergency Management plan:

Incident Command System
Emergency Operations Plan
Bioterrorism Response Procedures
Main Campus & Ambulatory Site Hazard Vulnerability Analysis
Departmental Emergency Response Plans
Loss of Pressurized Potable Water Procedure

II. SCOPE

PHC's Emergency Management Plan is prepared by the PHC Safety Officer, and is monitored by EOCC, whose members include representatives of Administration, Medical Staff, Nursing, Risk Management, Infection Control, Facilities, Security, and Clinical Equipment

departments. The EOCC's responsibility is to develop effective processes to ensure that Environment of Care issues are identified, analyzed, and resolved in a timely manner.

The EOCC is responsible for the coordination of an effective Emergency Management Plan based on organizational experience, applicable laws, regulations, and accepted local practice which includes identifying specific procedures in response to a variety of situations such as:

A. Plan activation; integrating the organization's role with community wide emergency response agencies to promote interoperability between PHC and the local community.
B. Notifying external authorities of emergencies.
C. Notifying PHC staff when emergency response measures are initiated.
D. Identifying and assigning available personnel in emergencies to cover staff positions.
E. Patient activities including scheduling, modifying, or discontinuing service.
F. Control of patient information and patient transportation;
G. Staff activities such as housing, transportation, and incident debriefing.
H. care partners-family support activities and logistics of critical supplies.
I. Security including access, crowd and traffic control.
J. Interaction with news media**.**
K. Partial or whole building evacuation when PHC cannot provide adequate patient care.
L. Establishing alternate care site(s) to meet the clinical needs of patients when PHC can no longer support adequate patient care and processes for:

1. Management of patient medications, medical records, transportation, and patient tracking to and from alternative care sites.
2. Inter-facility communication between PHC and alternative care sites;
3. Continuity of PHC operations following a disaster.

The PHC Emergency Operations Plan (EOP) is meant to be used in conjunction with other Emergency Management and Preparedness documents.

III. FUNDAMENTALS

Emergencies always occur. No two emergencies are alike. Effective planning and plan changes reduce the impact of emergencies on the quality of patient care.

Some emergencies are best managed by developing redundant sets of resources to mitigate anticipated impacts.

Many types of emergencies can be identified from past organizational and community experience.

Collaborative planning by healthcare organizations and local, state, and federal emergency response agencies can help identify the types of emergencies most likely to affect an area through use of a Hazard Vulnerability Analysis (HVA). In addition, collaborative planning helps communities maximize the effectiveness of available resources.

An EOP describing the management processes for emergency situations must also describe specific responses to emergencies which were identified by the annual HVA's.

Emergencies impact space, personnel, supplies, communications, and other resources.

Care partners on duty may be unable to maintain essential services without additional assistance.

Emergency conditions may require modification of normal patient care routines and require discontinuation of some services, patient transfers, establishment of alternative care sites, partial or whole facility evacuation, and discharge of patients, when possible.

Full scale exercises are staged at regular intervals and are essential for maintaining care partners awareness of emergency procedures and for evaluating plan performance and effectiveness.

Scheduled plan activations provide an opportunity to observe and evaluate care partners performance and effectiveness, and to identify future opportunities for improvement.

A return to normal operations after an emergency may take days, or weeks. Business and clinical recovery plans are essential to the mitigation of disaster events effects.

IV. OBJECTIVES

A. Annual HVA's are used to assess the likely impact of emergencies, and to guide the development of PHC's EOP. HVA's are reviewed annually to determine if circumstances of likely emergencies have changed.

B. PHC's EOP clearly defines the process for initiation and activation of Emergency plans, including the Incident Command structure, conditions requiring activation of the plan, and the individual(s) responsible for plan activation.

C. PHC's EOP includes a current Incident Command chart illustrating how PHC's incident command staff is organized, and will work with the Brevard Emergency Operations Center (BEOC) and other community agency Incident Command structures.

D. PHC's EOP includes a current list of governmental and commercial organizations that must be notified to effectively implement the emergency plan, and includes the agency or organization name, the basic organization function, the telephone or other contact numbers, and a list of contact personnel.

E. PHC's EOP includes a list of key care partners needed for scalable plan implementation, and procedures for contacting them. Contact procedure includes on-site and remote contact processes

F. PHC's EOP includes a description of the methods of identification of Care Partners, facility staff, and community responders. Community responders may include law enforcement, fire service personnel, media, and volunteer organizations.

G. PHC's EOP includes a list of critical response requirements. A list of on-duty staff that will be assigned (i. e., Job Action Sheets) to critical response positions is included in the Incident Command System.

H. PHC's EOP Plan includes processes that address support of staff and staff family members, identifying critical supplies, monitoring consumption, metering supplies to maximize response effectiveness, and a process for re-supply. Processes are incorporated into individual department plans as appropriate.

I. Plans for horizontal, vertical, partial, and full evacuation of the facility are maintained, and incorporated into the EOP Plan.

J. PHC's EOP includes a list of organizations that can be used as alternate care sites, with current contact information.

K. Utility failure response plans are current.

L. Backup systems for internal and external communications systems are in place.

M. Appropriate facilities for managing biological, chemical, radioactive isolation, and decontamination are in place, and tested as necessary.

N. Staff's knowledge of their role in the EOP is evaluated annually. Changes in EOPs are incorporated into the annual mandatory net learning education curriculum.

ENVIRONMENT OF CARE MANAGEMENT PLAN 2020
BY BEN MENDEZ

PLAN MISSION STATEMENT
Consistent with the mission, vision, and values of Parrish Healthcare (PHC) to provide safe care, this plan establishes the parameters of a safe physical environment. It addresses both specific responsibilities and general safety.

PURPOSE
To reduce risk of injury or harm related to the environment of care (EOC).

SCOPE
Applies to all buildings and outdoor areas owned by PHC.

Applies to all six functional areas of the environment of care: safety, security, hazardous materials and waste, fire safety, medical equipment, and utilities.

Applies to EOC-related risks to patients, staff, visitors, volunteers, and everyone else who uses the organization's facilities.

RESPONSIBILITIES AND REPORTING STRUCTURE

The Vice President for Acute Care Services appoints the EOC Committee (EOCC), EOCC chairperson, and the Safety Officer.

The EOCC, EOCC chairperson, and Safety Officer develop, implement, and monitor the Safety Management Plan.

EOCC members include, at a minimum, the safety officer, facilities manager, security manager, and representatives from leadership, administration, infection control, security, risk management, information technology, and clinical departments within the organization.

The EOCC does the following:
- Meets at least quarterly.
- Reports significant findings and recommends actions to the governing body, medical staff, hospital administration, and, when deemed necessary, all departments.

The safety officer does the following:
- Directs the safety program.
- Directs ongoing, organization wide performance improvement activities related to the EOC management programs.
- Intervenes whenever conditions exist that pose a threat of damage to equipment or property.
- Evaluates information submitted to the EOCC.

Department directors and/or managers do the following:
- Implement and enforce employee workplace safety.
- Use appropriate safety program guidelines provided by the EOCC and the Safety Committee to ensure staff awareness and effective implementation.
- Follow up with employees who miss safety education program sessions.

Each employee does the following:

- Attends safety education programs.
- Understands how the material relates to his or her specific job requirements.
- Follows the safety guidelines established in the Safety Management Plan.

OBJECTIVES

1. Develop and implement department-specific safety policies and education.
2. Monitor, track, and trend employee injuries throughout the organization.
3. Use environmental tour data effectively.
4. Develop and implement employee and contractor knowledge of the Safety Management Plan.

PROCESSES

Risk Assessments

Risk assessments proactively evaluate the impact of proposed changes to new or existing areas of the organization. The purpose is to reduce the likelihood of future incidents that have the potential to result in harm, injury, or other loss to patients, employees, or hospital assets.

Incident Reporting and Investigation

The Safety Management Plan documents patient and visitor incidents, employee incidents, and property damage. The purpose is to identify trends or patterns in incidents to develop changes that control or prevent future occurrences.

The Security Department performs the following activities:

- Documents patient and visitor incidents on the Occurrence Report.
- Completes Public Safety Incident Reports.
- Directs reports of patient and visitor incidents to the Risk Management Department.
- Directs reports of employee injuries and incidents to the Workers' Compensation Department.
- Directs reports of property damage to the manager of public safety.

The Risk Management and Security departments perform the following activities:

- Analyze incident reports.
- Report findings of that analysis to the Safety Committee.

Environmental Rounds

The safety officer participates in the management of environmental tours. The purpose of environmental rounds is to observe and evaluate the current conditions in the EOC.

Those who participate in the environmental rounds perform the following activities:

- Evaluate employee knowledge and skills.
- Observe current practices.
- Evaluate environmental conditions.
- Report results of the tour to the EOCC.

The EOCC performs the following activities:

- Reviews results of environmental rounds.

- Provides an overview of environmental round findings to leadership and others, including but not limited to the leaders of the units where environmental rounds were conducted, risk management, and the EOCC as a whole.

Safety Recalls

Information about recalled products, blood, food, supplies, medications, and equipment is collected and distributed by the Safety Management Alert System. The purpose is to minimize the risk of a recalled item causing harm to an individual.

The Medical Equipment Management Committee and Safety Committee perform the following activities:

- Review recall and alert compliance.

Designated departments perform the following activities:

- Develop approved implantable device tracking methods to include all information required by the Food and Drug Administration.

Policies and Procedures

Safety-related policies and procedures provide guidance on both system wide and department-level safety issues. These are reviewed at least every three years or more often if required by regulatory standards. The purpose is to establish standardized expectations to decrease the variations in processes that can cause risk.

The safety officer performs the following activities:

- Coordinates the development of system wide safety policies and procedures.
- Assists department managers in the development of new department-level safety policies and procedures.
- Distributes system wide safety policies and procedures to all departments.
- Ensures enforcement of all safety policies and procedures.

Department directors and/or managers perform the following activities:

- Manage the development of safety policies and procedures specific to their departments. These include but are not limited to safe operations, use of hazardous equipment, and use of personal protective equipment.

- Distribute department-level safety policies and procedures to their employees.
- Ensure enforcement of all safety policies and procedures.

Each employee performs the following activities:

- Follows all safety policies and procedures, both system wide and at the department level.

Grounds and Equipment

The Facilities Department schedules and performs maintenance of hospital grounds and external equipment. Policies and procedures for this function are located in the Facilities Department.

ORIENTATION AND EDUCATION

New Employee Orientation

All new employees participate in the Safety Education/Orientation and Training Program. This includes the following components:

- General safety information and training provided as part of the New Employee Orientation Program
- Department-specific safety training
- Job-specific safety training
- Ongoing safety education programs required for all employees on an annual basis

Annual Continuing Education

Parrish Healthcare uses self-directed, computer-based learning modules to provide its Annual Continuing Education Program. Modules are reviewed regularly and revised as necessary, and new modules are developed when the need is identified.

Department directors or managers determine whether modules are used by individual employees or as a guide for group instruction.

All employees are required to participate in annual safety training education.

Department-Specific Training

Department directors and/or managers ensure that new employees are oriented to department-specific safety policies and procedures and specific job-related hazards.

Contract Employees

Department directors and/or managers perform safety management assessment and education for contract employees at the time of assignment.

PERFORMANCE MONITORING

The Safety Committee chairperson oversees development of performance monitors for this committee. These performance monitors are used to measure the following:

- Compliance identified during environmental tours
- Compliance for system wide product/medication/equipment recall activity
- Compliance with annual safety education requirements

ANNUAL EVALUATION

The EOCC does the following:

- Coordinates an annual evaluation for each of the six functions associated with managing the EOC (safety, security, hazardous materials and waste, fire safety, medical equipment, and utilities). The evaluation examines the following aspects of the Safety Management Plan:
    - Objectives
    - Scope
    - Performance
    - Effectiveness
- Reports results of the annual evaluation to the following groups:
    - Board of Directors
    - Executive Staff
    - Appropriate Department Managers
- Documents its discussions, actions, and recommendations in its minutes.

Joint Commission Standard EC.01.01.01. The hospital plans activities to minimize risks in the environment of care.

2020 Hazardous Materials Waste Management Plan

By

Taylor Ray, Director of EVS

January 3, 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 cover 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. 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.

VI. 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.

VII. 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.

X. REFERENCES

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2020 LIFE SAFETY MANAGEMENT PLAN

Ted Bryant, Director of Facilities
January 14, 2020

I. MISSION & PURPOSE

The Parrish Healthcare (PHC) mission is to improve the health and well-being of North Brevard County residents by providing high-performance, cost-effective quality health care and medical services. Consistent with our mission, the PHC Hospital Board, and care partners support the Life Safety Management Plan described on the following pages.

The purpose of the Life Safety Management Plan is to define and maintain a life-safety program to protect PHC building occupants from fire, and the products of combustion.

II. SCOPE

The Life Safety Management Plan assures effective response to emergency situations that could adversely affect the Environment of Care (EOC) of patients, care partners, and visitors. The Life Safety Management Plan strives to assure compliance with applicable healthcare codes and regulations and applies to all PHC care partners, visitors, vendors, contractors, at all PHC healthcare locations.

III. FUNDAMENTALS

A. In accordance with TJC standards, and to maintain compliance with current Life Safety Code (LSC), the PHC Life Safety plan is as follows:

PHC was constructed using NFPA 1997 LSC 101, and is maintained as required by the Life Safety Code.

B. Deficiencies with NFPA codes are corrected as quickly as practicable When deficiencies are identified Interim Life Safety Measures (ILSM) are evaluated and implemented, as appropriate.

C. PHC's fire alarm, detection and suppression systems are maintained to ensure reliable performance as follows:

PHC's main hospital is AHCA certified for Healthcare occupancy and protected by a fire alarm system that is regularly tested and maintained by state of Florida certified Life Safety contractors.

PHC fire alarm systems, fire suppression systems and fire prevention systems are maintained by State licensed vendors and PHC staff to ensure sensors, alarms lights and horns, flow valves, fire pumps, fire suppression systems and portable fire bottles are tested and maintained as required by code.

IV. OBJECTIVES

A. PHC's fire plan defines methods for protecting patients, visitors, and care partners from the hazards of fire, smoke and the products of combustion. PHC's fire plan is reviewed, evaluated annually, changed as needed, and approved by the Titusville Fire Department.

B. PHC's fire detection and response systems are tested as required by code, and the results shared with the EOC Committee (EOCC).

C. Summaries of identified problems of fire detection response systems, NFPA® code

compliance, fire response plans, drills, and operations are reported to the EOCC.

D. The procedures used to review furnishings, draperies, bedding, and other new materials for conformance with applicable flammability standards, and the procedures are evaluated every three years.

E. The scope, objectives, program performance and effectiveness, of the PHC's Life Safety Management plan is evaluated annually and approved by the EOCC.

F. Fire prevention and response training includes response at the scene of a fire, use of the fire alarm system, processes for relocation or evacuation of patients if necessary, and building functions in protection of care partners and patients. Care partners knowledge of these issues is evaluated quarterly.

G. Performance Indicators (PI) for this Life Safety Management Plan are reported to the EOCC quarterly.

H. PHC's Life Safety Management Plan defines response to fire emergencies as well as the specific roles and actions care partners should take if patient relocation or evacuation becomes necessary. Unit-specific fire plans are evaluated quarterly, or as significant changes take place.

I. The specific roles of physicians, other licensed independent practitioners, volunteers, students, care partners, and others are defined in the policy containing the fire plan.

J. The role and use of a fire alarm system is included in training, and care partners knowledge is evaluated as part of fire drills. Results of such education and training are reported to the EOCC.

K. Care partner knowledge of patient relocation, compartmentation, and equipment needed in case of relocation or evacuation are included in drills. Care partners knowledge is evaluated and reported to the EOCC annually.

L. Fire extinguishers are visually inspected monthly, maintained annually, and positioned in visible locations, which were selected based on the hazards in the installed area.

M. Automatic fire extinguishing systems, sprinkler systems, and packaged systems are tested annually according to applicable NFPA standards.

N. Life Safety Preventive Maintenance (PM) is expected to be completed 100% each month.

V. Goals

1. Life Safety PM's are to be completed at 100%

2. Conduct at least one Fire Drill in Operating Suite with Physician involvement

3. Conduct annual Life Safety inspection of 100% of the organization

VI. ORGANIZATION AND RESPONSIBILITY

A. PHC's Hospital Board receives reports on the activities of the Fire Safety Program from the EOCC. They review reports and as appropriate communicate concerns about identified issues and regulatory compliance. They also authorize capital budget expenses, as necessary, to correct Life Safety Code deficiencies and to provide support to facilitate the ongoing

activities of the Life Safety Program.

B. PHC's Executive Management Team receives reports on the activities of the Fire Safety Program from the EOCC. The Executive Management Team reviews reports and as necessary communicates concerns about key issues and regulatory compliance to the Director of Facilities. The Executive Management Team collaborates with the Director of Facilities to establish operating and capital budgets for the Fire Prevention Program.

C. The Director of Facilities and the Safety Officer manage the Fire Safety and Response Program. They identify Fire Safety Code deficiencies, develop corrective actions, manage the maintenance of fire systems, the fire plan, fire drills, and fire response. The Human Resources department facilitates training of care partners, volunteers, and physicians. The Director of Facilities and Safety Officer advise the EOCC of fire safety issues.

D. PHC Department leaders orient new care partners to department-specific fire plans, and to job-specific fire safety procedures. Department heads are responsible for ongoing training of their care partners in fire safety procedures. When necessary, the Director of Facilities and/or Safety Officer provides department heads with assistance in developing department fire safety procedures.

E. Individual care partners are responsible for learning and following PHC's hospital-wide and departmental fire plans. Individual care partners are responsible for learning and using emergency reporting procedures for fires and fire hazards.

VII. THE LIFE SAFETY MANAGEMENT PLAN PROCESSES

A. Life Safety Management

PHC has developed and maintains a written management plan describing the processes it implements to effectively manage the Life Safety environment of patients, care partners, and others. The management plan is evaluated annually, and modified as necessary, based on changes in conditions, regulations and standards.

B. Protecting Patients, Care Partners, and Others

The Director of Facilities is responsibility for managing the Life Safety program. The Life Safety protection program includes three phases:

1. **Phase One**-design of buildings and spaces to assure compliance with current local, state, and national building and fire codes. PHC employs qualified architects and engineers to develop building and fire protections system designs. All designs are approved by local or state agencies as a part of the construction and permitting process. A vigorous construction monitoring and building commissioning program are used to validate compliance.
2. **Phase Two**- building maintenance. The Director of Facilities is responsible for setting maintenance standards based on applicable codes. The standards are applied through a process of planned maintenance and management of the work done by PHC care partners and vendors to ensure the end product of all work maintains or improves the level of Life Safety compliance.
3. **Phase Three**-an active program of fire prevention, Life Safety, and fire response training.

C. Fire Detection, Response System Tests, and Inspections

The Director of Facilities maintains the Fire Detection and Response Systems as

required by code:

D. Fire Response Plan

The Fire Response Plan provides clear, specific instructions for care partners responding to an emergency. The procedures provide information about notifying appropriate administrative care partners of the emergency and actions to take to protect patient safety. Department heads are responsible for maintaining copies of emergency procedures in accessible locations.

Heads of each department serving patients are responsible for developing and training care partners about department specific emergency fire response procedures. Each department head is responsible for providing department and area personnel with an orientation to emergency procedures related to their job. Additional department level training is provided on an annual basis as part of the Net-Learning education program, or on an as-needed basis. Each department head is responsible for reviewing departmental Fire Safety Program emergency procedures annually.

E. Fire Plan Elements

1. The roles of all care partners, volunteers and students at or near the point of Fire origin are defined using the acronym “RACE”:

    a. **R**escue anyone directly affected by the Fire
    b. **A**larm by pulling Fire alarm pull stations and calling 6565.
    c. **C**ontain or close doors to contain smoke and the products of combustion
    d. **E**xtinguish or evacuate as needed including patient evacuation

2. The roles of all physicians, care partners, volunteers, and students away from the point of Fire origin are to close doors, and evaluate the situation. If a Fire is in a horizontally adjacent area that would be used for relocation re-evaluate the area with a focus on where transferred patients should be placed.

    a. In other zones, plans should be reviewed, Fire response equipment discussed and checked, oxygen valves checked for access and responsibility for valve shut off discussed.

    b. The roles of others such as students, physicians and volunteers vary depending on the situation.

    c. Long term students (90+ days) are trained as PHC care partners, and monitored in their performance by unit or area care partners.

    d. Short term students, most volunteers, and other visitors are requested to go into rooms and stay until the drill or emergency is over.

    e. Physicians, and volunteers, are directed, as follows:
        [1] If with patients continue to work with the patient. Care partners will close the doors.
        [2] In other areas such as an office, cafeteria, etc., stay there until the emergency is over and ‘All Clear’ is announced.

        [3] If in a hall or corridor, go to the nearest patient unit without going through Smoke or Fire doors if possible to help when medical emergencies occurs. If a relocation or evacuation is authorized, care partners should:
            [a] Assure patients in the most affected areas are moved first, to

adjacent zones.

[b] Patients are moved using the equipment and techniques usually used. Where practical, ambulatory patients walk, or are move in wheel chairs. Non- ambulatory patients are moved in wheelchairs or gurneys as appropriate. Movement on beds is generally the last alternative, because of the additional care partners necessary to move beds.

[c] Patients are moved into rooms in adjacent zones to protect them from the smoke and combustion products that may be in the corridor.

[d] If patients must be moved vertically, elevators provided with emergency power,and with the permission of the Fire Department, are used to move patients to lower floors.

[e] If an evacuation is deemed necessary, the Incident Command System will be activated, and the Emergency Evacuation plans will commence.

F. Processes to Control Flammability of New Acquisitions

The Director of Facilities and the Director of Materials Management are responsible for managing the program to define code requirements for furniture and furnishings, including bedding, window draperies, and other curtains, furnishings and decorations must meet prior to purchase.

The Director of Facilities is responsible for assuring fire rated products installed during construction projects meet PHC standards. fire-rated products are identified for each project using standard specifications. The Director of Facilities maintains documentation on products installed during each project.

The Director of Materials Management is responsible for purchasing only fire / flammability-rated replacement products meeting defined standards. Department heads that need to purchase products must coordinate product evaluations with the Director of Materials Management and the Director of Facilities.

G. Life Safety Code® NFPA 101, 2012 edition

The Director of Facilities is responsible for complying with codes and standards.

PHC was constructed and approved according to Fire Safety Code-NFPA 101, 1997 edition. PHC is maintained in compliance with the Fire Safety Code- by ongoing inspection and maintenance.

When code violations are identified they are corrected promptly.

The Director of Facilities is responsible for the Statement of Conditions document.

H. Fire drills

Fire drills are a critical tool to maintain the readiness of care partners to respond to a fire emergency and to minimize the likelihood of injury to patients, visitors and care partners. Care partner participation is necessary to maintain a level of readiness, and care partner knowledge of the equipment and procedures that must be followed to protect themselves and their patients. To evaluate care partners knowledge, drill activities are observed, and care partners are questioned about their role and activities during a fire emergency nearby and elsewhere in the building.

Fire drills are conducted in all hospital and ambulatory healthcare facilities on each occupied shift each quarter and evaluated on a randomly selected basis to assure

that all elements of the drill activity are exercised in all occupied areas during each alarm activation not announced as a bell test.

Fire drills are conducted in other areas in which patient care takes place at least once a year, with evacuation of the affected area when practical during the drill. These drills are witnessed, documented and evaluated to identify improvement opportunities. Additional fire drills are held as deemed appropriate, or required by ILSM.

All care partners in the affected areas are required to participate in the drills to the extent the fire plan describes. This includes all hospital care partners and all PHC care partners in buildings where space is shared with others.

Fire drills are observed, documented, critiqued to identify opportunities to improve and areas where additional training would be appropriate. In addition, fire response knowledge is evaluated by ongoing questioning during environmental tours.

The results of the critique and evaluation of drills and evaluation of care partner's knowledge are used to identify improvements needed in training programs, equipment and administrative compliance issues. Such improvements are included in monitoring activities and the results used to identify the effectiveness of the activities to improve fire safety.

Care partners knowledge & response to drills is evaluated and corrective action taken when appropriate.

I. Maintaining Fire-safety equipment and building features

Fire Alarm and Related Systems

The Director of Facilities is responsible for maintenance of the fire alarm and related systems. The Facilities Department and a licensed vendor are responsible for troubleshooting, preventative maintenance, testing and corrective actions to maintain the systems in compliance with NFPA codes. Documentation of these activities are maintained by the Facilities Department.

J. Interim Life Safety Measures (ILSM)

The Director of Facilities manages the ILSM program.

An assessment is used to evaluate each situation to determine the ILSM required and what specific measures are required to mitigate the effects of the situation. This mitigation is a required part of the preconstruction risk assessment process.

The assessment evaluates the risk of non-compliance with each of the elements of the Unit Concept of the Fire Safety Code (i. e., smoke and fire walls, floor separation, exiting, building construction, fire alarm system activity). Where any construction or identified deficiency is identified, the key elements of the ILSM are evaluated, and applied as applicable.

The Director of Facilities communicates the findings to appropriate managers, care partners, contractors, and senior leaders. In addition, the Director is responsible for monitoring implementation of the ILSM and taking action if ILSM is not being observed.

The schedule of monitoring and documentation is determined on a per project basis. The Director of Facilities maintains all ILSM documentation from the onset through elimination of the deficiencies. Regular reports of ILSM programs will be made to the Risk Manager and EOCC.

K. Improving conditions in the EOC & Reporting EOC Issues.

The Director of Facilities makes quarterly reports of problems and failures to the EOCC. The reports summarize findings of incident reports, maintenance and repair activities, hazard notices, recalls and other information of interest.

PARRISH HEALTH CARE

MEDICAL EQUIPMENT MANAGEMENT PLAN 2020

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 my 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
- Medical Equipment user abuse

- Work order requests with proper problem description

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 non-high 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.

SECURITY MANAGEMENT PLAN 2020

David Marquez, Safety and Security Manager

SCOPE

The scope of the Security Management Plan is the continuance in providing a safe and secure environment for Parrish Healthcare (PHC) care partners, patients, and visitors a secure and accessible environment. The overall intent of this plan is to establish an efficient and effective program that incorporated training and development, care partner education, and planning. To accomplish our strategy, we will organize a combination of security officers, electron security, closed-circuit television, Security and Human Resource policies and procedures, and the care partner education training. This plan would apply to the main campus hospital and all facilities associated with PHC.

PURPOSE

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

OBJECTIVES

- The objectives of this plan would be to continue and maintain the level of security necessary for the protection and safety of our staff, patients, and visitors.
- 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 patient care staff and security officers. Having such education empowers care partners to manage such events and helps reduce the risk of harm and injuries.

- Prevent and reduce criminal activity through the use of "Threat Assessments," and collaboration between the patient care staff and security personnel to review incidents of concern and creating an individual safety and security plan based on the event. The security department collaborates with the patient care partners when dealing with patients and visitors who pose a "Possible Threat." Security actively investigates reports of threats and communicates with the Titusville Police Department (TPD) to determine if there are any immediate concerns with the patient or visitor, then to determine the next course of action to ensure the safety of all who may have contact with such activity.

- 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 to the current two-way radios along with any outdated personal equipment to ensure compliance with known security standards.

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 dealing 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.

ORGANIZATION AND RESPONSIBILITY

PHC's Hospital Board (Board) receives reports on the activities of Safety Management from the Environment of Care (EOC) Committee (EOCC). The Board reviews reports and as appropriate communicates concerns about identified issues and regulatory compliance. The Board also authorizes capital budget expenses, as necessary, to meet the needs of PHC in providing a safe environment for care partners, patients, and visitors.

PHC's Executive Management Team receives reports on the activities of the Safety Management Plan EOCC. The Executive Management Team reviews reports and as necessary communicates concerns about key issues and regulatory compliance to the Security Manager. The Executive Management Team collaborates with the Security Manager to establish operating and capital budgets for the Safety Management Plan.

The Security Manager/Safety Officer manages Safety Management Plan by identifying security deficiencies, developing corrective actions, managing the maintenance of CCTV and emergency communication systems, fire

drills, and fire response. The Human Resources department facilitates training of care partners, volunteers, and physicians. The Security Manager/Safety Officer advises the EOCC of fire safety issues.

PHC Department leaders orient new care partners to department-specific security measures and plans, as well as job-specific procedures. Department heads are responsible for ongoing training of their care partners in security measures/procedures. When necessary, the Security Manager/Safety Officer provides department heads with assistance in developing departmental security procedures.

Individual care partners are responsible for learning and following PHC's hospital-wide and departmental security measures. Individual care partners are responsible for learning and using reporting procedures for security issues.

BOARD OF DIRECTORS MEETING – REGULAR MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, MARCH 2, 2020

I. Consent Agenda

A. Finance

1. Recommend to the Board of Directors approve the Resolution of the Board of Directors of the North Brevard County Hospital District Regarding the Out of State Medicaid Form for the State of Mississippi, Division of Medicaid.

2. 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.

3. **Recommend to the Board of Directors to approve the appointment of Leigh Spradling to the Pension Committee for a two year term beginning March 2, 2020 through March 1, 2022.**

4. **Recommend to the Board of Directors to approve the appointment of Sylvia Simpson to the Pension Committee for a three year term beginning March 2, 2020 through March 1, 2023.**