MEMORANDUM

To: Board of Directors

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

From: George Mikitarian
President/CEO

Subject: Board/Committee Meetings – March 6, 2023

Date: March 1, 2023

The Audit Committee will meet at 10:30 a.m. in the first-floor conference room.

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

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

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

The Planning Committee meeting has been canceled.

Members:
Stan Retz, Chairperson
Robert L. Jordan, Jr., C.M. (ex-officio)
Herman Cole, Jr.
Elizabeth Galfo, M.D.

TENTATIVE AGENDA
AUDIT COMMITTEE
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MARCH 06, 2023 10:30 A.M.
FIRST FLOOR CONFERENCE ROOM 2/3/4/5

Call to Order

I. Public Comments

II. Review and approval of minutes (November 7, 2022)

Motion: To recommend approval of the November 7, 2022 minutes as presented.

III. FY2022 Final Audit Report- MSL

Motion: To recommend to the Board of Directors to accept the Fiscal Year 2022 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***

IV. Adjournment

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
AUDIT COMMITTEE

A regular meeting of the Audit Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on November 7, 2022 at 11:03 a.m. in the Executive Conference Room. The following members were present:

Stan Retz, Chairperson
Robert Jordan, Jr., C.M.
Herman Cole
Elizabeth Galfo, M.D.
Billy Specht

Other Attendees:
Anual Jackson, Corporate Compliance, Chief Compliance and Audit Officer
Marty Penick, Director of Accounting
Tommi Middleton, Manager, Financial Planning
Stephanie Parham, Executive Assistant

Call to Order

Mr. Retz called the meeting to order at 11:03 a.m.

Review and Approval of Minutes

The following motion was made by Mr. Cole, seconded by Dr. Galfo, and approved without objection.

Action Taken: Motion to approve the minutes of the June 6, 2022 meeting as presented.

Public Comments

None.

FY22 Audit Plan

Jeff Goolsby, MSL, gave an overview of the areas of the audit, timeline for the audit and scope of work. Mr. Goolsby reviewed new lease standards released by GASB, noting that management is tracking both old and new methods.

Corporate Compliance Update

Mr. Jackson updated the committee of the recent base line coding audit on PMG practices, noting that 14 providers were reviewed. Providers will be reeducated and a reaudit performed in three months. There will be new changes to coding in January 2023, education will be provided.

In regards to the Compliance Hot Line, there were 20 reported compliance concerns related to HIPAA Privacy. Five calls and 15 reported in office. Four of the cases were reportable.

Adjournment

There being no further business, the meeting adjourned at 11:50 a.m.

____

Stan Retz, Chairperson

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE
MONDAY, MARCH 6, 2023
12:00 P.M.
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Election of Chairperson & Vice Chairperson

II. Approval of Minutes

Motion to approve the minutes of the January 9, 2023 meeting.

III. Vision Statement

IV. My Story

V. Dashboard

VI. Pandemic PI

VII. Other

VIII. Executive Session (if necessary)

ADJOURNMENT

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

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
QUALITY COMMITTEE

A regular meeting of the Quality Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on January 9, 2023 in Conference Room 2/3/4/5, First Floor. The following members were present.

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

Members absent:
Maureen Rupe (excused)
Billie Fitzgerald (excused)
Jerry Noffel (excused)
Kiran Modi, M.D. (excused)
Francisco Garcia, M.D. (excused)

CALL TO ORDER

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

REVIEW AND APPROVAL OF MINUTES

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

ACTION TAKEN: **MOVED TO APPROVE THE NOVEMBER 7, 2022 MINUTES OF THE QUALITY COMMITTEE, AS PRESENTED.**

VISION STATEMENT

Mr. Loftin summarized the committee's vision statement.

MY STORY

Mr. Loftin shared the story of Susan and the kindness and compassion she received from PAT Nurse, Kerri.

QUALITY DASHBOARD REVIEW

Mr. Loftin reviewed the Quality Dashboard discussing 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.

STROKE MANAGEMENT

Mr. Loftin presented current information related to stroke performance measures.

OTHER

Mr. Jordan inquired on the status of the Emergency Medical Services (EMS) resolution. Mr. Mikitarian noted that Dr. Cuculino has been named as the Associate Medical Director for Brevard County EMS. The issues seem to be being addressed so there appears no need to initiate the conflict to accomplish the resolution.

ADJOURNMENT

There being no further business to be brought before the Committee, the Quality Committee meeting adjourned at 12:55 p.m.

Elizabeth Galfo, M.D.
Chairperson

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

FINANCE COMMITTEE MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT OPERATING
PARRISH MEDICAL CENTER
MONDAY, MARCH 6, 2023
FIRST FLOOR CONFERENCE ROOMS 2/3/4/5
(IMMEDIATELY FOLLOWING QUALITY COMMITTEE)

CALL TO ORDER

I. Election of Vice Chairperson

II. Approval of minutes.

Motion: To recommend approval of the January 9, 2023 meeting.

III. Emergency Purchase of Capital Equipment | Da Vinci Robot – Mr. Loftin

IV. Financial Review – Mr. Eljaiek

V. Disposal

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

VI. Executive Session (if necessary)

ADJOURNMENT

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

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

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
FINANCE COMMITTEE

A regular meeting of the Finance Committee of the North Brevard County Hospital District operating Parrish Medical Center was held on January 9, 2023 in Conference Room 2/3/4/5, First Floor. The following members, representing a quorum, were present:

Herman A. Cole, Jr., Chairperson
Stan Retz, Vice Chairperson
Robert Jordan, Jr., C.M.
Elizabeth Galfo, M.D.
Billy Specht
Ashok Shah, M.D.
Aluino Ochoa, M.D.
Christopher Manion, M.D.
George Mikitarian (non-voting)

Member(s) Absent:
Jerry Noffel (excused)
Maureen Rupe (excused)
Billie Fitzgerald (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. 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 Dr. Galfo seconded by Dr. Shah and approved (8 ayes, 0 nays, 0 abstentions).

***ACTION TAKEN:* MOVED THAT THE FINANCE COMMITTEE OF THE BOARD OF DIRECTORS APPROVE THE NOVEMBER 7, 2022 MEETING MINUTES OF THE FINANCE COMMITTEE, AS PRESENTED.**

PUBLIC COMMENTS

There were no public comments.

FINANCIAL REVIEW

Mr. Eljaiek summarized the November financial statements of the North Brevard County Hospital District and the year to date financial performance of the Health System.

DISPOSALS

Discussion ensued regarding the surplus property and the following motion was made by Mr. Jordan, seconded by Dr. Galfo and approved (8 ayes, 0 nays, 0 abstentions).

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

OTHER

There was no other business to come before the committee.

ADJOURNMENT

There being no further business to come before the committee, the Finance Committee meeting adjourned at 1:28 p.m.

Herman A. Cole, Jr.,
Chairman

MEMORANDUM

To: Finance Committee

From: Matthew F. Graybill, Executive Director of Surgical, Emergency and Critical Care Services

Subject: Budget Request – Da Vinci Robot-Assisted Surgery System

Date: January 12, 2023

This request is for the funding and acquisition of the Da Vinci Robot-Assisted Surgery System at Parrish Medical Center.

The Da Vinci Surgical System is a robot with four arms. It's controlled by a surgeon and allows surgeons to operate in confined spaces with smaller incisions, advancing minimally invasive surgery (MIS) across a wide spectrum of surgical procedures. A full assessment of this equipment was recently performed with considerations given to the equipment quality, service and cost. Representatives from the Surgical Services, Clinical Engineering, Finance, Facilities, Project Management, Medical Staff Services and Administration have been involved in the analysis, evaluation, and the decision.

Based on these considerations, at this time, we are requesting your approval to fund and acquire the Da Vinci Robot-Assisted Surgery System.

Motion: To recommend to the Board of Directors to approve the funding and acquisition for the Da Vinci Robot-Assisted Surgery System at a total cost not to exceed the amount of $2,237,549.

2/13 R. Jordan approved
H. Cole approved GC

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 ID# / KN#	Purchase Date	Purchase Amount	CE #	Reason for Disposal	Net Book Value (Provided by Finance)	Dept. #
WEIGHT MACHINES							
Body Master Back Machine - Qty 1	PMC03039/023927	10/1/1997	$2,595.00		Ceased to serve	$0.00	1.482
Body Master Super Leg Curl - Qty 1	PMC03038/023923	10/1/1997	$2,135.00		Ceased to serve	$0.00	1.482
Technogym Upper Back - Qty 1	PMC02980/029840	10/3/2012			Ceased to serve	$0.00	1.482
Technogym Vertical Trac - Qty 1	PMC02993/029840	10/3/2012			Ceased to serve	$0.00	1.482
Tricep Bar Dips - Qty 1	KN021444	2/8/2005	$3,754.00		Ceased to serve	$0.00	1.482
Paramount Cable Pull - Qty 1	PMC03004/023004	1/18/1995	$2,268.00		Ceased to serve	$0.00	1.482
Matrix Neck - Qty 1	N/A	N/A	N/A		Ceased to serve	$0.00	1.482
Matrix Neck - Qty 1	N/A	N/A	N/A		Ceased to serve	$0.00	1.482
Matrix Neck - Qty 1	N/A	N/A	N/A		Ceased to serve	$0.00	1.482
MedX Chest Press - Qty 1	PMC02949/021446	2/8/2005	$4,254.00		Ceased to serve	$0.00	1.482
MedX Lateral Raise - Qty 1	PMC02948/021448	2/8/2005	$3,754.00		Ceased to serve	$0.00	1.482
MedX Triceps - Qty 1	PMC02947/021444	2/8/2005	$3,754.00		Ceased to serve	$0.00	1.482
MedX Biceps - Qty 1	PMC02946/021442	2/8/2005	$3,254.00		Ceased to serve	$0.00	1.482
MedX Adductor - Qty 1	PMC02944/021443	2/8/2005	$3,754.00		Ceased to serve	$0.00	1.482
MedX Abductor - Qty 1	PMC04159/021441	2/8/2005	$3,754.00		Ceased to serve	$0.00	1.482
MedX Core Ab Isolator - Qty 1	PMC02898/028452	4/20/2005	$3,820.00		Ceased to serve	$0.00	1.482
Decline Bench w/bar weights - Qty 1	KN023036	1/18/1995	$ 451.00		Ceased to serve	$0.00	1.482
Decline Bench - Qty 1	KN023043	1/6/1995	$ 780.00		Ceased to serve	$0.00	1.482
HS High Row - Qty 1	PMC03008/023121	3/24/1999	$1,799.00		Ceased to serve	$0.00	1.482
Hammer Strength Shoulder Press - Qty 1	PMC03000/023120	3/24/1999	$1,699.00		Ceased to serve	$0.00	1.482

Hammer Strength Front Military Press - Qty 1	PMC03009/023119	3/24/1999	$1,699.00		Ceased to serve	$0.00	1.482
Hammer Strength Incline Press - Qty 1	PMC 03007/023118	3/24/1999	$1,699.00		Ceased to serve	$0.00	1.482
Hammer Strength Bench Press - Qty 1	PMC03006/023117	3/24/1999	$1,699.00		Ceased to serve	$0.00	1.482
Paramount Pullover - Qty	PMC02990/023004	1/18/1995	$2,268.00		Ceased to serve	$0.00	1.482
Incline Bench Press - Qty 1	KN023117	3/24/1999	$1,699.00		Ceased to serve	$0.00	1.482
Shoulder Trap Pull (plate machine) - Qty	KN023120	3/24/1999	$1,699.00		Ceased to serve	$0.00	1.482
Calf Raise (plate machine) - Qty	KN023032	1/6/1995	$ 620.00		Ceased to serve	$0.00	1.482
Hamstring (plate machine) - Qty	KN028086	1/21/2004	$2,514.00		Ceased to serve	$0.00	1.482
Quad Extension (plate machine) - Qty	KN023139	5/10/1999	$1,620.00		Ceased to serve	$0.00	1.482
Standing Squat (plate macine) - Qty	KN023141	5/10/1999	$2,520.00		Ceased to serve	$0.00	1.482
FREE WEIGHTS							
All of the below items are assumed to fall into the KN assignments shown to the right and itemsbelow in "Free Weights"	KN020055	6/29/1995	$4,165.00		Ceased to serve	$0.00	1.482
	KN020088	9/1/1995	$3,499.85		Ceased to serve	$0.00	1.482
	KN023679	4/1/1997	$1,904.82		Ceased to serve	$0.00	1.482
	KN023684	1/13/1997	$ 686.09		Ceased to serve	$0.00	1.482
	KN023928	10/1/1997	$ 150.00		Ceased to serve	$0.00	1.482
	KN023929	10/1/1997	$ 145.00		Ceased to serve	$0.00	1.482
	KN020241	1/6/1995	$ 235.00		Ceased to serve	$0.00	1.482
	KN020242	1/6/1995	$ 235.00		Ceased to serve	$0.00	1.482
	KN020243	1/6/1995	$ 235.00		Ceased to serve	$0.00	1.482
	KN023677	4/25/1997	$1,664.15		Ceased to serve	$0.00	1.482
	KN021885	3/1/2001	$2,683.00		Ceased to serve	$0.00	1.482
	KN023034	1/6/1995	$ 875.00		Ceased to serve	$0.00	1.482
Bars - Qty several						$0.00	1.482
Plates 5 lb - Qty 6						$0.00	1.482
10 lb - Qty 12						$0.00	1.482
25 lb - Qty 15						$0.00	1.482
35 lb - Qty 13						$0.00	1.482
45 lb - Qty 50						$0.00	1.482
Dumbells (heavy) 35 lb - Qty 1						$0.00	1.482

65 lb - Qty 2						$0.00	1.482
70 lb - Qty 4						$0.00	1.482
75 lb - Qty 2						$0.00	1.482
80 lb - Qty 4						$0.00	1.482
85 lb - Qty 2						$0.00	1.482
90 lb - Qty 4						$0.00	1.482
95 lb - Qty 4						$0.00	1.482
100 lb - Qty 2						$0.00	1.482
105 lb - Qty 2						$0.00	1.482
130 lb - Qty 2						$0.00	1.482
Dumbell racks - Qty various						$0.00	1.482
Black floor mats - Qty 10-12						$0.00	1.482
CARDIO EQUIPMENT							
Technogym Bike - Qty 1	PMC03064/029840	10/3/2012			Ceased to serve	$0.00	1.482
Technogym Recumbant Bikes - Qty 1	PMC03052/029840	10/3/2012			Ceased to serve	$0.00	1.482
- Qty 1	PMC03050/029840	10/3/2012			Ceased to serve	$0.00	1.482
- Qty 1	PMC03051/029840	10/3/2012			Ceased to serve	$0.00	1.482
Precor Treadmill - Qty 1	PMC03046/	3/5/2003	$4,319.26		Ceased to serve	$0.00	1.482
- Qty 1	PMC02968/024823	3/5/2003	$4,319.26		Ceased to serve	$0.00	1.482
- Qty 1	PMC02959/024824	3/5/2003	$4,319.26		Ceased to serve	$0.00	1.482
- Qty 1	PMC04156/024825	3/5/2003	$4,319.26		Ceased to serve	$0.00	1.482
- Qty 1	PMC03048/024826	3/5/2003	$4,319.26		Ceased to serve	$0.00	1.482
- Qty 1	PMC04164/024827	3/5/2003	$4,319.26		Ceased to serve	$0.00	1.482
- Qty 1	PMC03049/024828	3/5/2003	$4,319.26		Ceased to serve	$0.00	1.482
Precor Steppers - Qty 1	PMC02966/028573	11/9/2005	$4,775.00		Ceased to serve	$0.00	1.482
- Qty 1	PMC02965/028574	11/9/2005	$4,775.00		Ceased to serve	$0.00	1.482
- Qty 1	PMC02974/028575	11/9/2005	$4,775.00		Ceased to serve	$0.00	1.482
- Qty 1	PMC02956/028576	11/9/2005	$4,775.00		Ceased to serve	$0.00	1.482
- Qty 1	PMC02972/028577	11/9/2005	$4,775.00		Ceased to serve	$0.00	1.482
- Qty 1	PMC02971/028578	11/9/2005	$4,775.00		Ceased to serve	$0.00	1.482

- Qty 1	PMC02957/028579	11/9/2005	$4,775.00		Ceased to serve	$0.00	1.482
- Qty 1	PMC02955/028580	11/9/2005	$4,775.00		Ceased to serve	$0.00	1.482
SPIN CYCLES							
Spinner Cycles - Qty 1	PMC3015/	N/A			Ceased to serve	$0.00	1.482
- Qty 1	PMC3016/	N/A			Ceased to serve	$0.00	1.482
- Qty 1	PMC3017/	N/A			Ceased to serve	$0.00	1.482
- Qty 1	PMC3020/	N/A			Ceased to serve	$0.00	1.482
- Qty 1	PMC3022/	N/A			Ceased to serve	$0.00	1.482
- Qty 1	PMC3023/	N/A			Ceased to serve	$0.00	1.482
- Qty 1	PMC3033/	N/A			Ceased to serve	$0.00	1.482
- Qty 1	PMC2985/	N/A			Ceased to serve	$0.00	1.482
CHILDREN'S JUNGLE GYM & TOYS							
Various - Not inventoried - Qty	N/A	N/A			Ceased to serve		1.482
Health and Wellness Location							
Shoulder Press, Plate Loaded (pod 14)	N/A	N/A	N/A		Ceased to serve	$0.00	1.485
Hammer Strength Row (pod 13)	PMC03001/KN023122	3/24/1999	$1,979.00		Ceased to serve	$0.00	1.485

Requesting Department: 1.482 & 1.485 Department Director: [signature]

Net Book Value (Finance): $0.00 EMC Member: [signature] 2.3.2023

VP Finance: President/CEO: [signature] 2/28/23

Board Approval: (Date) VP Finance Signature [signature] 2/27/23

Requestor Notified Finance

Asset Disposed of or Donated

Removed from Asset List (Finance)

Requested Public Entity for Donation

Entity Contact

Telephone

12/19/18

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)	Department No.
Gift Shop POS System	029896	3/22/13	$2,332.18		Obsolete/no longer needed	0	1.737
Floral Cooler	027774	3/22/13	$2,378.00		Obsolete/no longer needed	0	1.733

Requesting Department Communications Department Director

Net Book Value (Finance) EMC Member

Sr. VP Finance/CFO President/CEO

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

Healing Families – Healing Communities®

parrishmed.com

Finance Committee

FYTD January 31, 2023 – Performance Dashboard

Indicator	FYTD 2023 Actual	FYTD 2023 Budget	FYTD 2022 Actual
IP Admissions	1,523	1,799	1,660
LOS	4.8	4.7	5.5
Surgical Cases	1,596	1,798	1,651
ED Visits	10,220	10,300	9,705
OP Volumes	27,467	26,411	25,792
Hospital Margin %	0.53%	9.71%	6.54%
Investment Income $	$6.9 Million	$1.1 Million	$0.1 Million

EXECUTIVE COMMITTEE

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

DRAFT AGENDA
EXECUTIVE COMMITTEE
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MONDAY, MARCH 6, 2023
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5
IMMEDIATELY FOLLOWING FINANCE COMMITTEE

CALL TO ORDER

I. Approval of Minutes

Motion to approve the minutes of the January 9, 2023 meeting.

II. Reading of the Huddle

III. Attorney Report – Mr. Boyles

IV. Other

V. Executive Session (if needed)

ADJOURNMENT

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

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 9, 2023 in Conference Room 2/3/4/5, First Floor. The following members were present:

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

Members Absent:
Maureen Rupe (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. Retz called the meeting to order at 1:20 p.m.

REVIEW AND APPROVAL OF MINUTES

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

ACTION TAKEN: **MOVED TO APPROVE THE NOVEMBER 7, 2022 MEETING MINUTES OF THE EXECUTIVE COMMITTEE OF THE BOARD, AS PRESENTED.**

READING OF THE HUDDLE

Dr. Galfo read the Weekly Huddle.

ATTORNEY REPORT

Mr. Boyles indicated that he and Chairman Jordan were continuing work on some options for additional deferred compensation for Dr. Mikitarian. He also encouraged the members of the Board to monitor activity of the Florida legislature as committee meetings were being held in preparation for the session.

Mr. Boyles also presented the updated bylaws for the North Brevard County Hospital District dba Parrish Medical Center (District Bylaws) indicating that lined copies of the updates and revisions had been provided to the board late in 2022. A form resolution was also provided which tentatively approved the updated District Bylaws and per policy submitted these updated District Bylaws to the Medical Executive Committee for review and comment.

UPDATED DISTRICT BYLAW APPROVAL

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

ACTION TAKEN: **MOVED TO APPROVE THE RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT REGARDING THE AMENDED AND RESTATED BYLAWS OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT DBA PARRISH MEDICAL CENTER.**

ABBOTT SERVICE RENEWAL CONTRACT

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

ACTION TAKEN: **MOVED TO APPROVE THE RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT APPROVING ENTERING INTO THE ABBOTT AGREEMENT FOR LABORATORY INSTRUMENT SERVICES.**

OTHER

There was no other business to come before the committee.

ADJOURNMENT

There being no further business to discuss, the committee adjourned at 1:28 p.m.

Stan Retz, CPA
Chairman

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
EDUCATIONAL, GOVERNMENTAL AND COMMUNITY RELATIONS COMMITTEE
MONDAY, MARCH 6, 2023
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 9, 2023 meeting.

III. Healthy People 2030 – Ms. Cottrell

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 9, 2023 at 1:32 p.m. in Conference Room 2/3/4/5, First Floor. The following members were present:

Robert L. Jordan, Jr., C.M.
Ashok, Shah, M.D.
Aluino Ochoa, M.D
George Mikitarian (non-voting)

Member(s) Absent:

Billie Fitzgerald, Chairperson (excused)
Maureen Rupe, Vice Chairperson (excused)

Mr. Jordan as acting Chairperson determined a quorum was present. 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 acted as Chairperson in the absence of the Chairperson and Vice Chairperson and called the meeting to order at 1:32 p.m.

REVIEW AND APPROVAL OF MINUTES

The following motion was made by Mr. Cole, seconded by Dr. Shah, and approved (3 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVED TO APPROVE THE MINUTES OF NOVEMBER 7, 2022 EDUCATION COMMITTEE MEETING, AS PRESENTED.**

HOLIDAY WRAP-UP

Ms. Sellers summarized the 2022 Holiday Outreach program, noting care partner and community involvement. Copies of the Power Point slides presented are appended to the file copy of these minutes. Ms. Sellers recognized the Facilities Team as well as Auxilian, Mr. Terry Deal.

OTHER

No other items were presented.

ADJOURNMENT

There being no further business to come before the committee, the Educational, Governmental and Community Relations Committee meeting adjourned at 1:48 p.m.

Robert L. Jordan Jr. Acting
Chairperson

DRAFT AGENDA
BOARD OF DIRECTORS MEETING - REGULAR MEETING
NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING
PARRISH MEDICAL CENTER
MARCH 6, 2023
NO EARLIER THAN 2:00 P.M.,
FOLLOWING THE LAST COMMITTEE MEETING
FIRST FLOOR, CONFERENCE ROOM 2/3/4/5

CALL TO ORDER

I. Pledge of Allegiance

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

III. Approval of Agenda

IV. Recognitions(s)
   A. Dr. Mathews
   B. New Providers (memo included

V. Review and Approval of Minutes (January 9, 2023 Regular Meeting)

VI. Open Forum for PMC Physicians

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

VIII. Unfinished Business***

IX. New Business***

   A. Resolution adopting Amended & Restated Bylaws
   Motion: To approve the Resolution of the Board of Directors of the North Brevard County Hospital District regarding amendment and restatement of the Amended and Restated Bylaws of the North Brevard County Hospital District.

   B. Environment of Care Annual Review –Mr. Loftin
   Motion: To approve the Annual Environment of Care Report as presented.

   C. Administrative Services Coverage Policy
   Motion: To approve the Administrative Services Coverage Policy, as presented.

X. Medical Staff Report Recommendations/Announcements

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

XII. Consent Agenda***

A. Audit
1. **Motion to recommend the Board of Directors accept the Fiscal Year 2022 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**

B. Finance
1. **Motion to recommend to the Board of Directors to declare the equipment listed in the requests for Disposal of Obsolete or Surplus Property Forms as surplus and obsolete and dispose of same in**

. ***1 Pursuant to PMC Policy 9500-154:
- non-agenda items – 3 minutes per citizen
- agenda items for board action -- 3 minutes per citizen, permitted prior to board discussion for regular agenda action items and prior to board action on consent agenda
- 10 minute total per citizen
- must be related to the responsibility and authority of the board or directly to an agenda item [see items marked ***]

XIII. Committee Reports

A. Quality Committee

B. Budget and Finance Committee

C. Executive Committee

D. Educational, Governmental and Community Relations Committee

E. Planning, Physical Facilities & Properties Committee

XIV. Process and Quality Report – Administration

A. Other Related Management Issues/Information

B. Hospital Attorney - Mr. Boyles

XVI. Other

XVII. Closing Remarks – Chairman

XVIII. Executive Session (if necessary)

ADJOURNMENT

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

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

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

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

Healing Families – Healing Communities®

parrishhealthcare.com

Welcome New Provider

Paul Bucolo, MD – Primary Care

Medical School: University of Science Arts & Technology (Olveston, Montserrat)

Residency: Family Medicine – University of Arkansas (Fayetteville, Arkansas)

Welcome New Provider

Gaurav Mathur, MD – Hospitalist

Medical School: American University of Antigua College of Medicine (Coolidge, Antigua)

Residency: Internal Medicine – St. Vincent Charity Medical Center (Cleveland, OH)

Fellowship: Addiction Medicine – St. Vincent Charity Medical Center (Cleveland, OH)

Welcome New Provider

Christopher Murray, D.O. – Diagnostic Radiology

Medical School: Kirksville College of Osteopathic Medicine (Kirksville, MO)

Residency: Diagnostic Radiology – Michigan State University & Garden City Hospital (Garden City, MI)

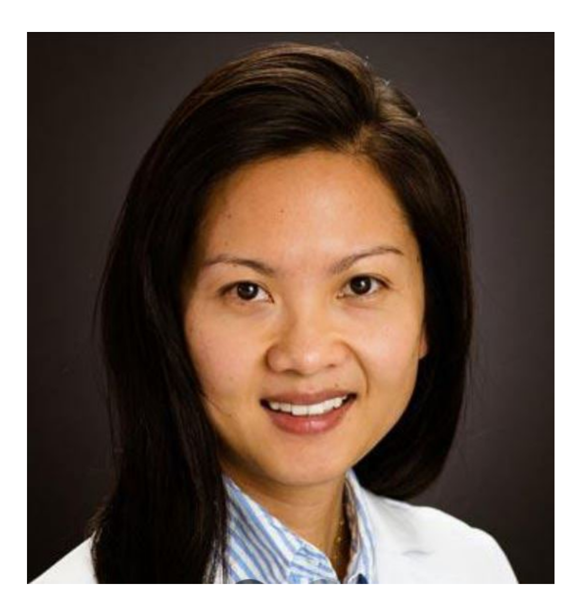
Fellowship: Diagnostic Radiology – Wayne State University & Detroit Medical Center (Detroit, MI)

Welcome New Provider

Beibei Oelrich, MD, PhD – Urology

Medical School: Humboldt University (Berlin, Germany)

Residencies: Urology – Charité University Hospital (Berlin, Germany) & University of Cincinnati (Cincinnati, OH)



Welcome New Provider

Jill Wang, DNP, PMHNP-BC, FNP-BC, CARN-AP

BSN: RN – University of Central Florida (Orlando, FL)

MSN: Family Nurse Practitioner – University of Central Florida (Orlando, FL)

Postmaster: Psychiatric Mental Health – University of Miami (Miami, FL)

DNP: Doctor of Nursing Practice – University of North Florida (Jacksonville, FL)

Healing Families–Healing Communities®

parrishhealthcare.com

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

A regular meeting of the Board of Directors of the North Brevard County Hospital District operating Parrish Medical Center (the District) was held at 2:02 p.m. on January 9, 2023 in Conference Room 2/3/4/5, First Floor. The following members were present:

Robert L. Jordan, Jr., C.M., Chairperson
Stan Retz, Vice Chairperson
Herman A. Cole, Jr.
Billy Specht
Elizabeth Galfo, M.D.
Ashok Shah, M.D.

Member(s) Absent:
Jerry Noffel (excused)
Billie Fitzgerald (excused)
Maureen Rupe (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 2:02 p.m. and determined a quorum was present per Article 1.1.4 of the District Bylaws.

PLEDGE OF ALLEGIANCE

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

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

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

APPROVAL OF MEETING AGENDA

Mr. Jordan requested approval of the meeting agenda in the packet as revised. Discussion ensued and the following motion was made by Mr. Cole, seconded by Dr. Galfo and approved (6 ayes, 0 nays, 0 abstentions).

***ACTION TAKEN*: MOVED TO APPROVE THE REVISED MEETING AGENDA OF THE BOARD OF DIRECTORS OF THE DISTRICT AS PRESENTED.**

RECOGNITIONS

Mr. Jordan recognized Chaplain Jerald Smith for his 18 years of service and dedication to Parrish Medical Center. Chairperson Jordan presented Chaplain Smith with a plaque commemorating his service and wished him a happy retirement.

SECRETARY'S REPORT & ELECTION OF OFFICERS

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

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

Election of Chairperson

Dr. Galfo indicated that Mr. Jordan had been nominated as Chairperson and no other names were presented. Mr. Cole moved to close the nominations, seconded by Dr. Galfo and the Board approved the motion (6 ayes-0 nays-0 abstentions). Mr. Jordan was elected Chairperson. Mr. Jordan as Chairperson continued with the conduct of the meeting.

Election of Vice-Chairperson

Mr. Jordan indicated that Mr. Retz had been nominated as Vice Chairperson and no other names were presented. Mr. Cole moved to close the nominations, seconded by Dr. Galfo and the Board approved the motion (6 ayes-0 nays-0 abstentions). Mr. Retz was elected Vice Chairperson.

Election of Secretary

Mr. Jordan indicated there were currently no nominees for the position of Secretary of the Board of Directors. Mr. Cole nominated Dr. Galfo to serve as Secretary and moved to close the nominations, seconded by Dr. Shah and the Board approved the motion (6 ayes-0 nays-0 abstentions). Dr. Galfo was elected Secretary.

Election of Treasurer

Mr. Jordan indicated that Mr. Cole had been nominated as Treasurer with no other names presented, and moved to close the nominations, seconded by Mr. Retz and the Board approved the motion (6 ayes-0 nays-0 abstentions). Mr. Cole was elected Treasurer.

Election of Member-at-Large

Mr. Jordan indicated that Ms. Rupe had been nominated as Member-at-Large and no other names were presented. Mr. Cole moved to close the nominations, seconded by Dr. Galfo and the Board approved the motion (6 ayes-0 nays-0 abstentions). Ms. Rupe was elected Member-at-Large.

REVIEW AND APPROVAL OF MINUTES

Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Cole and approved (6 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: **MOVE TO APPROVE THE MINUTES OF THE NOVEMBER 7, 2022 REGULAR MEETING, AS PRESENTED.**

OPEN FORUM FOR PMC PHYSICIANS

There were no physician comments.

PUBLIC COMMENTS

There were no public comments.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

North Brevard Medical Support Liaison Report

Mr. Retz presented the North Brevard Medical Support Liaison report from its November 17, 2022 meeting.

Workplace Violence Prevention Program Policy

This revised Policy was presented. Discussion ensued and the following motion was made by Dr. Galfo, seconded by Mr. Cole and approved (6 ayes, 0 nays, 0 abstentions).

ACTION TAKEN: MOTION TO APPROVE THE WORKPLACE VIOLENCE PREVENTION PROGRAM POLICY, AS PRESENTED.

CONSENT AGENDA

The revised consent agenda was presented. Discussion ensued regarding the consent agenda, and 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 FOLLOWING REVISED CONSENT AGENDA ITEMS:**

Consent Agenda

A. Finance

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

B. Executive

1. Motion to recommend the Board of Directors approve the Resolution of the Board of Directors of the North Brevard County Hospital District regarding the amended and restated bylaws of the North Brevard County Hospital District.

2. Motion to recommend the Board of Directors approve the Resolution of The Board of Directors of The North Brevard County Hospital District approving entering into the Abbott Agreement for Laboratory Instrument Services.

COMMITTEE REPORTS

Quality Committee

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

Finance Committee

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

Executive Committee

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

Educational, Governmental and Community Relations Committee

Mr. Jordan (as acting Chairperson) reported all items were covered during the Education, Governmental and Community Relations Committee meeting.

Planning, Physical Facilities and Properties Committee

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

PROCESS AND QUALITY REPORT

Mr. Mikitarian noted there was nothing further with the Emergency Department issue.

Hospital Attorney

Mr. Boyles noted that Legislature will begin meeting in March. He also expressed how delightful the Gala was and how much he and his wife Laura appreciated everyone's work. Mr. Boyles noted that he is working with Mr. Jordan on the CEO Compensation and will revisit at the February meeting.

OTHER

There was no other business to come before the Board.

CLOSING REMARKS

There were no closing remarks.

ADJOURNMENT

There being no further business to discuss, the Parrish Medical Center Board of Directors meeting adjourned at 2:31 p.m.

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

NORTH BREVARD COUNTY HOSPITAL DISTRICT
OPERATING PARRISH MEDICAL CENTER
MEDICAL EXECUTIVE COMMITTEE MEETING – REGULAR SESSION MINUTES
February 21, 2023 @ 5:30pm

Present: C. Rajan, DO, G. Cuculino, MD, C. Fernandez, MD, C. Jacobs, MD, L. Stuart, MD, B. Mathews, MD, K. Patel, MD, C. Manion, MD, A. Ochoa, MD, G. Mikitarian, M. Navas, MD, J. Zambos, MD, P, Carmona, MD

Absent: C. McAlpine, K. George, MD, R. Patel, MD

The meeting of the Medical Executive Committee of the North Brevard County Hospital District operating Parrish Medical Center was called to order on January 17, 2023 at 5:30 pm in the Conference Center. A quorum was determined to be present.

CALL TO ORDER.

Dr. Ochoa called the meeting to order at 5:31pm.

I. REVIEW AND APPROVAL OF MINUTES

Motion to approve the Regular Session minutes of January 17, 2023 as written and distributed ***was made by Dr. Mathews, seconded by Dr. Cuculino and unanimously approved.***

2. OLD BUSINESS: None.

3. NEW BUSINESS:

a. ***Motion to approve the North Brevard County Hospital District (operating Parrish Medical Center) Bylaws as written and distributed*** was made by Dr. Stuart, seconded by Dr. Cuculino and unanimously approved.

b. Per PMC Policy 9900-67 Department Procedure for Financial Interest Medical Executive Committee financial disclosure forms for the year 2023 were distributed, collected and notarized. ***(Noted for the minutes).***

c. The Consent Agenda

- General Admission (E3289abc) - Changed second Promethazine order on page 3 to Prochlorperazine order. Updated "Admit to Inpatient" order to reflect time span of two midnights.

Motion to approve as written and distributed was made by Dr. Cuculino, seconded by Dr. K. Patel and unanimously approved.

- Obstetric - Induction/Augmentation - Pitocin (E342ab) - **Removed:** Parturifacient Agents: Oxytocics and Tachysystole orders. Removed "IV 1000 ml LR.   " line under Vital Signs. **Added:** All text and
check boxes under Oxytocin Drip. **Changed:** Everywhere it stated Pitocin, we changed to Oxytocin for consistency. Changed Vital signs from every 30 minutes to every hour.

Motion to approve as written and distributed was made by Dr. Cuculino, seconded by Dr. Mathews and unanimously approved.

- PACU Standing Orders Age 13 & Up (E95) - We replaced the Vicodin order with the Hydrocodone order, removed the Promethazine IM order, and added "PO x1 for pain score >=5" after Percocet 5 mg/325 mg.

The order was tabled at the request of Dr. Chris Jacobs pending further review. Noted for the minutes.

- Bronchiolitis Pediatric (E1221abc) - Multiple Revisions review as if new.
- Eat Sleep Console Order Set (E3518) - New Order Set. Will be replacing the Neonatal Opioid Withdrawal (NOWS) Order Set
- Eat Sleep Console Score (E3382ab) - New Protocol. Will be Replacing the Neonatal Abstinence Syndrome (NAS) Protocol.

Motion to approve the three Pediatric orders was made by Dr. L. Stuart, seconded by Dr. Navas and unanimously approved.

- Gynecology Postoperative (E168ab) - We removed the Promethazine IM order and added Prochlorperazine 10 mg iv q6h prn nausea/vomiting not responding to ondansetron. We updated the following label comments: for Cefazolin 1 gm IVPUSH q8, Total 2 doses: Label Comments: 1g: Dilute with 7.5 ml sterile water, IV Push over 3 minutes. For Clindamycin 600 mg IV q8, Total 2 doses: Label Comments: Do not refrigerate.

Motion to approve was made by Dr. Navas, seconded by Dr. Mathews and unanimously approved.

- Sepsis (E3154abcde) - Changed Blood Cultures from Routine to Stat. Magnesium stat order is now prechecked and q12 unchecked on page 3. We also updated the format to match LIVE (Removed duplicate names/abbreviations, removed "Today + 7" throughout form.)

Motion to approve as written and distributed was made by Dr. Carmona, seconded by Dr. Cuculino and unanimously approved.

4. **Report from Administration:** None.

5. **Report from the Board.** None

6. **Committee Reports:** *entered into the minutes as written and distributed.*

   Board of Directors Quality Committee December 5, 2022

   CMEC Regular Session, February 13, 2023

   Regular Meeting minutes, Board of Directors, December 5, 2022

7. **Open Forum:**

   a. K. Patel, MD. Trauma cases. Admitting should consult surgeon.
   b. G. Cuculino, MD – P. Carmona, MD , Poison Control vs. Best Practice's.

   Motion that lab results mirror the mathematics used by Poison Control for the purpose of reporting was made by Dr. Cuculino, seconded by Dr. Manion and unanimously approved.

   c. K. Patel, MD – Dialysis consent. Dr. Ochoa will speak with Nephrology re: gaining consent.

   d. Upcoming EMR meeting, delete the Physician on Call pull down, box. Look up actual on call posted on iCare, otherwise likelihood of the consultant not seeing the request in a timely manner.

   e. EKG strips. ED. Medic's run EKG strips, and are often lost in the initial shuffle. Results in patients being charged. The information can be accessed, see ED.

   f. Dr Manion introduced the opportunity for utilizing CAA's (Certified Anesthesiology Assistants) to supplement the need for CRNA's. Surgeries continue to rise in volume, addition of several surgeons require increased qualified OR personnel. CAA's qualifications and educational requirements were reviewed.

   Motion to approve the use of Certified Anesthesia Assistants, develop a set of delineated privileges and associated job description was made by Dr. Manion, seconded by Dr. Jacobs and unanimously approved.

Adjournment: There being no further business the meeting adjourned at 6:10 pm.

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

NEXT MEETING: MARCH 21, 2023

RESOLUTION

of the

BOARD OF DIRECTORS

of the

NORTH BREVARD COUNTY HOSPITAL DISTRICT

REGARDING AMENDMENT AND RESTATEMENT OF THE AMENDED AND RESTATED BYLAWS OF THE NORTH BREVARD COUNTY HOSPITAL DISTRICT ("RESOLUTION")

RECITALS

Whereas, the members of the Board of Directors (the "Board") of the North Brevard County Hospital District (the "District), d/b/a/ Parrish Medical Center (the "Hospital"), a special hospital district in Brevard County, Florida, tentatively adopted the amendment to the Amended and Restated Bylaws of the North Brevard County Hospital District including certain editorial revisions; and

Whereas, such tentative approval was given at the Board's January 9, 2023 Board Meeting at which time certain editorial revisions concerning the Amended and Restated Bylaws of the North Brevard County Hospital District were approved; and

Whereas, these editorial revisions were made and included in the latest version of such Amended & Restated Bylaws of the North Brevard County Hospital District; and

Whereas, pursuant to policy #9900-30, the Board found that the amendments should be submitted to the Medical Executive Committee (MEC) of the Parrish Medical Center Medical Staff for review; and

Whereas, the MEC has approved the amendment and restatement of the Amended and Restated Bylaws of the North Brevard County Hospital District attached hereto as Exhibit "A."

RESOLVED

Resolved that the Board, pursuant to the terms of the District's enabling legislation in Chapter 2003-362, *Laws of Florida*:

1. determines that the District would be best served by amended and restating the Amended and Restated Bylaws of the North Brevard County Hospital District to make certain editorial changes set forth therein.

2. hereby adopts the amendment and restatement of the Amended and Restated Bylaws attached hereto as Exhibit "A" and incorporated into this Resolution for the purpose of making certain editorial changes as set forth therein and as the Amended and Restated Bylaws of the North Brevard County Hospital District.

This Resolution shall take effect immediately upon its adoption.

PASSED, APPROVED AND ADOPTED this ______ day of March, 2023.

BOARD OF NORTH BREVARD COUNTY
HOSPITAL DISTRICT

By: ____
Robert L. Jordan Jr., Chairman

ATTEST:

By: __________________________________
Elizabeth Galfo, M.D., Secretary

PARRISH
MEDICAL CENTER

TITUSVILLE, FLORIDA

NORTH BREVARD COUNTY HOSPITAL DISTRICT

AMENDED AND RESTATED BYLAWS

Adopted by the Board of Directors
March 6, 2023

BYLAWS

OF

NORTH BREVARD COUNTY HOSPITAL DISTRICT

OPERATING

PARRISH MEDICAL CENTER

TABLE OF CONTENTS

OBJECTIVES 1

DEFINITIONS 2

ARTICLE I. BOARD OF DIRECTORS 3

1.1 LOCATION OF PRINCIPAL OFFICE 3

1.2 LOCATION OF MEETINGS 3

1.3 ORDER OF BUSINESS AT REGULAR AND SPECIAL MEETINGS 4

1.4 QUORUM 4

1.5 PARTICIPATING MANNER OF VOTING 4

1.6 MEETING DATE 5

1.7 MINUTES 5

1.8 ATTENDANCE AND REMOVAL 6

1.9 CODE OF ETHICS 6

ARTICLE II. OFFICERS 7

2.1 OFFICERS 7

2.2 ELECTION AND TENURE 8

2.3 VACANCIES 8

2.4 DUTIES OF OFFICERS 9

2.4-1 CHAIRPERSON 9

2.4-2 VICE CHAIRPERSON 9

2.4-3 TREASURER 9

2.4-4 SECRETARY 10

2.5 LEGAL COUNSEL 10

TABLE OF CONTENTS
(continued)

Page

ARTICLE III. BOARD COMMITTEES 10

3.1 GENERAL 10

3.1-1 APPOINTMENT AND TERM 10

3.1-2 REPORTS AND AUTHORITY OF BOARD COMMITTEES 11

3.1-3 MEETINGS 11

3.1-4 QUORUM 11

3.1-5 OTHER COMMITTEE MEMBERS 12

3.2 EXECUTIVE COMMITTEE 13

3.2-1 COMPOSITION 13

3.2-2 FUNCTIONS 13

3.3 FINANCE COMMITTEE 15

3.3-1 COMPOSITION 15

3.3-2 FUNCTIONS 15

3.4 PLANNING, PHYSICAL FACILITIES, AND PROPERTIES COMMITTEE 16

3.4-1 COMPOSITION 16

3.4-2 FUNCTIONS 16

3.5 EDUCATIONAL, GOVERNMENTAL, AND COMMUNITY RELATIONS COMMITTEE 17

3.5-1 COMPOSITION 17

3.5-2 FUNCTIONS 17

3.6 JOINT CONFERENCE COMMITTEE 19

3.6-1 COMPOSITION 19

3.6-2 FUNCTIONS 19

3.6-3 AGENDA 19

3.6-4 REPORTS 20

3.7 AUDIT COMMITTEE 20

3.7-1 COMPOSITION 20

3.7-2 FUNCTIONS 20

TABLE OF CONTENTS
(continued)

Page

3.8 COMPENSATION COMMITTEES FOR THE PRESIDENT/CHIEF EXECUTIVE OFFICER AND FOR OTHER HOSPITAL SENIOR MANAGEMENT 23

3.8-1 (a) COMPOSITION OF THE COMPENSATION COMMITTEE FOR THE PRESIDENT/CHIEF EXECUTIVE OFFICER 23

3.8-1 (b) COMPOSITION OF THE COMPENSATION COMMITTEE FOR OTHER HOSPITAL SENIOR MANAGEMENT 23

3.8-2 FUNCTIONS 23

3.9 QUALITY COMMITTEE 25

3.9-1 COMPOSITION 25

3.9-2 FUNCTIONS 25

3.10 INVESTMENT COMMITTEE 27

3.10-1 COMPOSITION 27

3.10-2 FUNCTIONS 27

ARTICLE IV. CHIEF EXECUTIVE OFFICER 27

4.1 APPOINTMENT 27

4.2 AUTHORITY AND DUTIES 28

ARTICLE V. MEDICAL STAFF 30

5.1 ORGANIZATION 30

5.2 MEDICAL STAFF BYLAWS 30

5.3 MEMBERSHIP 30

5.4 INSTITUTIONAL NEED 31

5.5 CONTRACT PHYSICIANS 32

ARTICLE VI. QUALITY ASSESSMENT AND IMPROVEMENT 32

6.1 BOARD RESPONSIBILITY 32

6.2 DELEGATION TO ADMINISTRATION AND TO THE MEDICAL STAFF 32

6.2-1 TO ADMINISTRATION 32

6.2-2 TO THE MEDICAL STAFF 33

6.3 INDEMNIFICATION 34

TABLE OF CONTENTS
(continued)

Page

ARTICLE VII. HOSPITAL AUXILIARY 35

7.1 NAME AND PURPOSE 35

7.2 ORGANIZATION AND GOVERNMENT 35

7.3 OTHER VOLUNTEER SERVICES 35

ARTICLE VIII. THE ACT 35

ARTICLE IX. AMENDMENTS 36

ARTICLE X. PROCEDURES 36

APPENDIX 1.9-1(I) 38

POLICY 39

ACTIVE MEMBER ATTESTATION STATEMENT I

APPENDIX 3.7 II

BYLAWS

OF

NORTH BREVARD COUNTY HOSPITAL DISTRICT

OPERATING

PARRISH MEDICAL CENTER

PREAMBLE

In accordance with Chapter 2003-362, Laws of Florida, as amended by the Florida Legislature from time to time, the Board of Directors of the North Brevard County Hospital District do hereby make and adopt the following Bylaws for the District and for the governing of the Medical Staff of such Hospital within the District.

OBJECTIVES

The objectives of the North Brevard County Hospital District shall be:

- To establish, construct, own, operate, equip, repair, lease and maintain a Hospital or Hospitals, and other health care facilities within the North Brevard County Hospital District service area, with permanent facilities that include inpatient beds, emergency services and outpatient medical services to provide diagnosis and treatment for the sick and injured and associated services such as may be developed.
- To carry on any educational activities and scientific research related to rendering care to the sick and injured, or to the promotion of health, that in the opinion of the Board of the North Brevard County Hospital District may be justified by the facilities, personnel, funds, and other requirements that are, or can be, made available.
- To do or perform any other act consistent with the Enabling Act, the purposes enumerated in these Bylaws and any other activity not otherwise prohibited by law.

- To participate, so far as circumstance may warrant, in any activity designed and, carried on to promote the general health of the community.

DEFINITIONS

1. AUXILIARY means the Parrish Medical Center Auxiliary which is a group of volunteers that serves as a part of the Hospital under the authority of the Board and management of the District to render service to the Hospital, its patients, and visitors.

2. BOARD COMMITTEE means standing and special committees established by the Board of Directors.

3. BOARD OF DIRECTORS or BOARD means the governing body of the Hospital.

4. CHAIR means an individual serving as a presiding member of a Board Committee as set forth in the Bylaws.

5. CHAIRPERSON means the individual elected by the Board to serve as its Chairperson and presiding officer of the Board.

6. CHIEF EXECUTIVE OFFICER/PRESIDENT means the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.

7. CLINICAL PRIVILEGES mean the rights granted to a practitioner to render those diagnostic, therapeutic, medical, dental, podiatric, or surgical services, specifically delineated to him or her.

8. EX-OFFICIO means service as a member of a body by virtue of an office or position held and, unless expressly prohibited, means with voting rights.

9. HOSPITAL means the North Brevard County Hospital District as created under The Act, and doing business as Parrish Medical Center.

10. MEDICAL STAFF means all practitioners who are granted privileges by the Board to attend patients or to provide other diagnostic, therapeutic, teaching, or research services in the Hospital.

11. MEDICAL STAFF MEMBERSHIP STATUS means all matters relating to medical staff appointment and reappointment to clinical services and other clinical unit affiliations, and to staff category assignments.

12. MEDICO-ADMINISTRATIVE OFFICER means a practitioner, engaged by the Hospital either full or part-time in an administratively responsible capacity, whose activities also include clinical responsibilities such as direct patient care or supervision of these patient care activities of other practitioners under his direction.

13. PHYSICIAN means an individual with an M.D. or D.O. degree who is fully licensed by the State of Florida to practice medicine in all its phases.

14. PRACTITIONER means, unless otherwise expressly limited, any fully licensed physician, dentist, or podiatrist, applying for or exercising clinical privileges in this Hospital.

15. THE ACT means the law designated as Chapter 2003-362, Laws of Florida, as amended by the Florida Legislature from time to time.

ARTICLE I. BOARD OF DIRECTORS

1.1 LOCATION OF PRINCIPAL OFFICE

The principal office and regular meeting place of the Board of the North Brevard County Hospital District shall be in the Parrish Medical Center, 951 North Washington Avenue, Titusville, Florida.

1.2 LOCATION OF MEETINGS

Regular and special meetings of the Board of the North Brevard County Hospital District shall be held in the Parrish Medical Center, 951 North Washington Avenue, Titusville, Florida. Any

regular or special meetings may also be held in another facility within the North Brevard County Hospital District as determined by the Board and/or if necessary to accommodate public attendance in excess of the meeting facilities available at the Hospital.

1.3 ORDER OF BUSINESS AT REGULAR AND SPECIAL MEETINGS

At regular and special meetings of the Board, business shall be transacted in such order as the Board may from time to time determine. At any meeting called in conformity to the foregoing provisions, there shall be no required limitations upon the nature or number of matters which may be heard and acted upon unless otherwise prohibited by Florida Statutes.

1.4 QUORUM

A quorum at a regular or special meeting of the Board means a majority of members of the Board then holding office, but not less than five (5).

1.5 PARTICIPATING MANNER OF VOTING

Voting upon all matters coming before the Board shall be by voice vote, unless a vote by roll call shall be demanded by a member of the Board in which case the Secretary shall call the roll and the manner of voting of each member shall be noted in the minutes. The Chairperson and all members present shall vote on all matters coming before the Board. No member shall participate in any matter which inures to his or her special private gain or loss or the special private gain or loss of any principal by whom he or she is retained or to the parent organization or subsidiary of a corporate principal by which he or she is retained or which he or she knows would inure to the special private gain or loss of a relative or business associate of the member, without first disclosing the nature of the interest in the matter. Such disclosure, indicating the nature of the conflict, shall be made in a written memorandum filed with the Secretary and shall be incorporated in the minutes; if the disclosure is initially made orally at a meeting attended by the member, the written memorandum disclosing the nature of the conflict shall be filed within

fifteen (15) days with the Secretary and shall be incorporated in the minutes. Voting shall be in conformance with Section 112.3143, Florida Statutes. No member shall vote in an official capacity upon any measure which would inure to his or her special private gain or loss; which he or she knows would inure to the special private gain or loss of any principal by whom he or she is retained or to the parent organization or subsidiary of a corporate principal by which he or she is retained, other than an agency as defined in s. 112.312(2); or which he or she knows would inure to the special private gain or loss of a relative or business associate of the member . Such member shall, prior to the vote being taken, publicly state to the Board the nature of the member's interest in the matter from which he or she is abstaining from voting and, within 15 days after the vote occurs, disclose the nature of his or her interest as a public record in a memorandum filed with the Secretary, who shall incorporate the memorandum in the minutes.

1.6 MEETING DATE

The Board shall annually at its regular January meeting prepare a schedule of the dates and time of its regular meetings and file the same with the Board of County Commissioners of Brevard County and the City of Titusville. Special meetings of the Board may be called at any time by the Chairperson, or in the Chairperson's absence by the Vice Chairperson, or any three members of the Board.

1.7 MINUTES

Board and Board Committee minutes shall be in writing and shall reflect the action taken. In addition, the minutes shall reflect the motion, the names of the members who made motions, and those who made seconds thereto, the fact that discussion was had by the Board (or Board Committee), and the recording of the vote taken, nay votes recorded by name. In addition to the foregoing, the minutes should include the following information:

(a) The date of the meeting;

(b) The members in attendance;

(c) The members who were absent (with or without excuse);

(d) Others present;

(e) When the meeting was called to order and by whom;

(f) Whether the meeting was a regular or special meeting;

(g) That a quorum was present;

(h) The approval of any previous minutes; and

(i) The time of adjournment.

1.8 ATTENDANCE AND REMOVAL

Members are expected to attend all special and regular meetings. Members must have seventy-five percent (75%) attendance unless excused by the Chairperson. Any Board member may be removed from office in the event a request for removal for proven violation of policies and procedures established by the Board is approved by two-thirds (2/3) of the membership of the Board and in the event the majority of the Governing Board responsible for appointing such member approves of such removal without the necessity of any requirement of advice and consent as provided herein for appointment.

1.9 CODE OF ETHICS

1.9-1 In carrying out their responsibilities, the members of the Board, ex-officio and other committee members are obligated:

(a) To acquaint themselves with laws, regulations, and policies relating to public hospitals and specifically to the Hospital, and to observe and enforce them.

(b) To support the principle that the basic function of the members of the Board is policy making, not administrative.

(c) To represent at all times the entire Hospital community.

(d) To transact Hospital business only in Board meetings, realizing that individual members have no legal status to bind the Board outside of such meetings.

(e) To give the Chief Executive Officer full administrative authority for properly discharging his or her professional duties, and to hold him or her responsible for acceptable results.

(f) To recognize that the Chief Executive Officer has full responsibility to represent the full Board for the day to day operation of the Hospital.

(g) To treat all information relating to Hospital employees, patients, and personnel as confidential, except for information deemed public under Florida law.

(h) To accept and support Board decisions once they are made and to make a good faith effort to assist in carrying them out effectively.

(i) To bring to the attention of the other members of the Board and to the Chief Executive Officer any possible conflict of interest, and to support and comply with the Policy regarding Restrictions on Anti-Competitive Activity and Competing Financial Interests of Board members attached to and incorporated herein by reference as Appendix 1.9-1(i).

ARTICLE II. OFFICERS

2.1 OFFICERS

The officers of the Hospital shall be a Chairperson, a Vice-Chairperson, a Secretary, and a Treasurer and such other officers as the Board may elect or appoint, including without limitation additional Vice-Chairpersons, Assistant Secretaries, and Assistant Treasurers. The Board shall appoint a Chief Executive Officer to carry out the duties and responsibilities as outlined in Article IV. The Chief Executive Officer shall have such title as designated by the Board.

2.2 ELECTION AND TENURE

The Board shall, as their first order of business, on the first regular meeting in January every odd year, elect the officers described in Section 2.1 with the exception of the Chief Executive Officer. Officers elected shall serve a term of two (2) years. Members of the Board seeking appointment to an office shall submit their name and proposed office to the Secretary of the Board on or before December 30 preceding the January Board meeting. The Secretary of the Board shall prepare and present a ballot to the Board that contains the names and offices to which members of the Board seek election. Additional nominations for any office may be made from the floor at such meeting.

2.3 VACANCIES

Should a vacancy in Board membership occur, the vacancy on the Board shall be appointed in accordance with the Act and applicable Florida Statutes, as amended. Should any officer of the Board resign his or her office while at the same time retaining membership on the Board or should a vacancy in any office occur due to the discontinuance of Board membership on the part of the officer, the office shall be filled by election of the Board to be held at the next succeeding Board meeting after such vacancy or resignation occurs. As provided in Section 2.2, the Secretary or Chief Executive Officer shall submit any prospective officer's names to the Board. The Secretary shall prepare and present a ballot to the Board that contains the names of any prospective officer. Additional nominations for the office may be made from the floor at such meeting. The Board shall vote upon the names submitted along with any other floor nominations from the Board for the vacant office. The newly elected officer shall serve for the remainder of the term of the resigning officer.

2.4 DUTIES OF OFFICERS

2.4-1 CHAIRPERSON

The Chairperson is the presiding officer of the Board and presides at all meetings of the Board. Except as otherwise specified, the Chairperson shall also serve as an ex-officio member of all Board Committees. The Chairperson may sign on behalf of the Hospital any documents or instruments which the Board has authorized to be executed, except where the signing and execution thereof is expressly delegated by the Board or by these bylaws to some other officer or agent, or required by law to be otherwise signed or executed. The Chairperson shall also perform all duties incident to the office of Chairperson and such other duties as may be prescribed by the Board from time to time. The Chairperson shall be responsible for establishing the agenda and order of business for each Board meeting and shall have full discretion regarding scheduling of pending business.

2.4-2 VICE CHAIRPERSON

The Vice-Chairperson shall perform such duties as may be assigned by the Board or the Chairperson. In the absence of the Chairperson or when, for any reason, the Chairperson is unable or refuses to perform his or her duties, the Vice-Chairperson shall perform those duties with full powers of, and subject to the restrictions on, the Chairperson. When there is more than one Vice-Chairperson, the Vice-Chairperson will assume the Chairperson's responsibilities and authority in the order of their designation or, if no designation, in the order of their election.

2.4-3 TREASURER

The Treasurer shall keep or cause to be kept correct and accurate accounts of the properties and financial transactions of the Hospital and in general perform all duties incident to the office and such other duties as may be assigned from time to time by the Chairperson or the Board. The Treasurer may delegate any of his or her duties to any duly elected or appointed Assistant Treasurers or to the Hospital's Vice President - Finance or Controller, if no Vice President -

Finance is then serving. The Treasurer shall serve at all times as Chairperson of the Finance Committee.

2.4-4 SECRETARY

The Secretary shall provide for the keeping of minutes of all meetings of the Board and Board Committees, and shall assure that such minutes are filed with the records of the Hospital. The Secretary shall give or cause to be given appropriate notices in accordance with these bylaws, or as required by law, and shall act as custodian of all Board records and reports and of the Board seal, assuring that it is affixed, when required by law, to documents executed on behalf of the Board. The Secretary shall also keep or cause to be kept a roster showing the names of the current members of the Board and their addresses. The Secretary shall perform all duties incident to the office and such other duties as may be assigned from time to time by the Board or Chairperson of the Board. The Secretary may delegate any of his or her duties to any duly elected or appointed Assistant Secretary or a Recording Secretary.

2.5 LEGAL COUNSEL

The Board shall retain the services of a qualified licensed attorney to represent the Board, who shall serve at the pleasure of the Board.

ARTICLE III. BOARD COMMITTEES

3.1 GENERAL

3.1-1 APPOINTMENT AND TERM

Except as specified in these Bylaws, all Board Committee members shall be appointed by the Chairperson of the Board at the annual meeting of the Board, or at the next meeting. All appointments shall be subject to the approval of the Board. Each Board Committee at its organizational meeting shall select a Chair and Vice Chair unless otherwise provided herein. In the event of the absence of the Chair, the Vice- Chair shall serve as Chair. The Chair and all

other members of each standing committee shall hold office until the next annual meeting of the Board, or until their successors are appointed and approved. The Chair and all other members of any special committee shall hold office until the sooner occurrence that the assigned task of such special committee is completed or the next annual meeting of the Board. The Chairperson of the Board shall have the power to fill any vacancies that occur on Board Committees for the remaining term of any vacancy.

3.1-2 REPORTS AND AUTHORITY OF BOARD COMMITTEES

All Board Committees shall maintain written minutes of their meetings available to the Board and shall report in writing to the Board, as necessary or requested. The functions and responsibilities of each standing committee of the Board shall be as provided in these Bylaws or as otherwise assigned by the Chairperson or specified by resolution of the Board. The functions and responsibilities of any special committee shall be limited to the scope and term of such assigned task as specified by resolution of the Board.

3.1-3 MEETINGS

Each committee of the Board shall meet at such dates and times as necessary to accomplish its duties and as designated by the Board at its regular January meeting. Special meetings of any Board committee may be called at any time by its Chair or any three members of the committee.

3.1-4 QUORUM

A majority of the voting members of a Board Committee constitutes a quorum for the transaction of business at any meeting of such committee. A majority vote of the members present shall be required for committee actions. In the absence of a quorum, a committee Chair may designate any Board member present at such meeting to serve as a voting alternate. If in attendance, the President of the Medical Staff shall serve as a voting alternate for any absent physician member of a committee. Any voting alternate so appointed shall participate during the continuation of

such meeting until a quorum is later established by appearance of the regular committee member for whom such voting alternative has been appointed. Any regular committee member shall commence participation upon the conclusion of any discussion and/or vote of the matter under review by the committee at the time of such member's appearance at the meeting.

3.1-5 OTHER COMMITTEE MEMBERS

In order to assist the Board and its various committees in furtherance of the Hospital's mission and goals, the Chairperson of the Board may submit for Board approval additional voting members for each Board Committee who are not members of the Board or the Chief Executive Officer, and if two (2) are selected, consideration shall be given to having at least one (1) an active member of the Medical Staff. The Executive Committee and the Joint Conference Committee shall be exempt from this provision. The prospective members shall be subject to the following:

(a) The qualifications of any potential committee member must be credible and documented. Particular expertise, position in the community, demonstrated abilities, and resumes should be considered.

(b) Any potential committee member must submit his or her application and statement of qualifications in writing, acknowledging that his or her membership on the Board Committee binds them to attend the requisite committee meetings and appropriate Board meetings, he or she is able to vote on Board Committee matters without abstention because of conflict of interest and he or she is bound by all applicable provisions of each section of these Bylaws specifically including Sections 1.8 and 1.9, and the Policy regarding Restrictions on Anti-Competitive Activity and Competing Financial Interests of Board Members attached to and incorporated herein by reference as Appendix 1.9-1(i).

(c) Any potential Board Committee member may not have or may not reasonably plan on having directly or indirectly a significant business or financial relationship with the Hospital. "Indirectly" shall mean, but not be limited to, a relationship through ownership of an artificial entity or by a closely-related family member. "Closely-Related" shall have the meaning set forth in Appendix 1.9-1(i), Section 6a.

(d) Any additional voting member of any Board Committee who is not a member of the Board shall not serve as Chair of that Board Committee.

3.2 EXECUTIVE COMMITTEE

3.2-1 COMPOSITION

The Executive Committee shall be composed of the Chairperson of the Board, the Vice-Chairperson, who shall serve as Chair, the Secretary, the Treasurer and Board member-at-large elected by the Board. The Chief Executive Officer shall serve as a nonvoting member.

3.2-2 FUNCTIONS

The Executive Committee shall be charged with the following responsibilities:

(a) The Executive Committee shall, during intervals between the meetings of the Board, have the authority to take such action as is necessary to meet emergencies arising between meetings of the Board, and in cases where delayed action might be harmful to the institution. The action taken by the Executive Committee shall be confirmed by the Board at its next subsequent meeting. Minutes of the Executive Committee shall be distributed to all members of the Board.

(b) The Executive Committee shall review the Bylaws and Governing Board policies at least every two (2) years. Except as otherwise required, the Executive Committee shall meet in November of every even year and prepare a report to the

Board, recommending revisions or amendments to the same. If no revisions or amendments are recommended, the report shall so state. All proposed amendments to the Bylaws shall be presented to the Board as provided in Article IX.

(c) Upon the request of the Chief Executive Officer, the Executive Committee shall review the action of the Medical Executive Committee with regard to initial medical staff appointments, clinical privileges, and/or reappointments and make recommendations to the full Board prior to final Governing Board action, and any other circumstance felt necessary by the Chairperson.

(d) Assess the general results and effectiveness of the Quality Assessment and Improvement Program, evaluate changes that have been made or should be made to improve the quality and efficiency of patient care within the Hospital and make recommendations as warranted by its findings.

(e) Annually review the peer review procedures conducted by the Hospital.

(f) The Executive Committee shall be responsible and oversee all compliance matters for the Hospital including, but not limited, to those compliance matters relating to Federal and State regulations. As such, the Executive Committee shall work with and coordinate with the Chief Corporate Compliance Officer of the Hospital concerning such compliance matters and shall regularly (at least annually) receive reports from the Chief Corporate Compliance Officer concerning ongoing compliance matters and compliance efforts within the Hospital.

(g) Perform such other related duties as may be assigned.

3.3 FINANCE COMMITTEE

3.3-1 COMPOSITION

The Finance Committee shall consist of the Board Treasurer as Chair and at least three (3) other members of the Board. In addition, one representative of the Medical Staff, nominated by the President of the Medical Staff and appointed by the Chairperson of the Board shall serve on the Finance Committee as a voting member. The Chief Executive Officer shall serve as a nonvoting member.

3.3-2 FUNCTIONS

The Finance Committee shall be charged with the responsibility to:

(a) Review the financial feasibility of Hospital projects and undertakings referred to it by the Board or Chairperson of the Board, and make recommendations thereon to the Board.

(b) Make recommendations to the Board concerning the general fiscal affairs of the Hospital.

(c) Review and make recommendations to the Board concerning the Hospital's annual operating budget, the capital expenditure budget, and requirements for long-term financing.

(d) Routinely review the financial statements and appraise the Hospital's operating performance.

(e) Make recommendations to the Board concerning the financial condition and operation of the Hospital.

(f) Review and make appropriate reports and recommendations to the Board concerning the financial implications of personnel policies of the Hospital;

including compensation, employment practices, employee benefits, employee health and welfare services, retirement programs and staffing practices.

(g) Make recommendations to the Board regarding the Hospital insurance program which is designed to protect the fiscal and financial resources of the Hospital.

(h) Perform such other related duties as may be assigned to it.

3.4 PLANNING, PHYSICAL FACILITIES, AND PROPERTIES COMMITTEE

3.4-1 COMPOSITION

The Planning, Physical Facilities, and Properties Committee shall consist of the Chairperson and at least three (3) other members of the Board. In addition, the President of the Medical Staff will serve as a voting member and the Chief Executive Officer will serve as a nonvoting member.

3.4-2 FUNCTIONS

The Planning, Physical Facilities, and Properties Committee shall be charged with the responsibility to:

(a) Review and make recommendations to the Board concerning short and long-range development plans for the Hospital to assure that a comprehensive program of services is attuned to meeting the healthcare needs of the community and the purposes of the Hospital, to the extent feasible within the Hospital's resources.

(b) Oversee the maintenance of the physical plants, including the planning and maintenance of the grounds, and submit recommendations to the Board.

(c) Develop and review plans for the improvement or expansion of buildings and other permanent improvements including parking areas and streets, and shall generally oversee any construction work from a policy standpoint.

(d) Provide information to the Board on changes and trends in the healthcare field and the community which may influence the modification of Hospital services and facilities.

(e) Perform such other related duties as may be assigned to it.

3.5 EDUCATIONAL, GOVERNMENTAL, AND COMMUNITY RELATIONS COMMITTEE

3.5-1 COMPOSITION

The Educational, Governmental, and Community Relations Committee shall consist of the Chairperson and at least two (2) other members of the Board. In addition, one representative of the Medical Staff, nominated by the President of the Medical Staff and approved by the Board, will serve as a voting member. The Chief Executive Officer will serve as a nonvoting member.

3.5-2 FUNCTIONS

The Educational, Governmental, and Community Relations Committee shall be charged with the responsibility to:

(a) Every six (6) months, review the educational programs to be conducted by the Hospital over the next six month period; review objectives for those educational programs to be offered; make suggestions to improve educational programs; receive and review reports of the educational activities for the previous six (6) months; review the line item budget(s) established for educational programming presented by the Hospital and recommend changes or acceptance of such budget(s) to the Board.

(b) Act as a liaison between the Jess Parrish Medical Foundation, Inc. (the "Foundation"), and the Board to review health related programs presented by the Foundation for the benefit of the Hospital and community, as well as any fund raising activity that benefits the Hospital.

(c) Recommend to the Board the development of community relationships with civic, governmental, educational and professional organizations based on the community's current health care needs, issues, activities, goals and future plans of the Hospital.

(d) Use all reasonable means to educate itself, the Board, the Foundation, the medical staff, Hospital employees, and the community concerning existing, pending and proposed changes to the healthcare system, the restructuring of healthcare financing and any and all issues and activities which may affect the quality of health care.

(e) Study and recommend programs to educate the public as to the essential needs of the Hospital, seek to promote a general understanding and awareness of the Hospital's facilities/services through a planned program of public education and information, cooperating with national, state and local associations to stimulate support in the community for the Hospital's facilities and programs.

(f) Develop and maintain a comprehensive orientation program for new members of the Board based on input from Board members, management, and the medical staff; be responsible for the annual review of existing orientation programs, gathering input from the Board for modifications, deletions, additions and changes to the program; develop and maintain a continuing educational program based on present healthcare issues, future healthcare trends, and the identified informational needs of the Board.

(g) Distribute to the Board in October of every odd year a Board self-evaluation with results tabulated and reported at the November Board meeting for discussion.

(h) Make periodic reports and recommendations to the Board as requested.

(i) Perform such other related duties as may be assigned.

3.6 JOINT CONFERENCE COMMITTEE

3.6-1 COMPOSITION

The Committee shall be composed of four (4) members from the Board, the Chief Executive Officer, and four (4) members of the Medical Staff who shall be the President, Vice President, and two (2) members of the Medical Executive Committee appointed by the President of the Medical Staff. Members of Hospital senior management shall attend as directed from time to time by the Chief Executive Officer. All recommendations shall require a two-thirds (2/3) vote of the total membership of the committee. The Chair of the Joint Conference Committee shall alternate with the Chairperson of the Board serving as Chair during even numbered years and the President of the Medical Staff during odd numbered years.

3.6-2 FUNCTIONS

The Committee shall serve as an educational and liaison group to promote open communication between the Board, Administration and the Medical Staff regarding appropriate matters, including, but not limited to the following:

(a) Communication

(b) Bylaws

(c) Reports of the Medical Staff

(d) Credentials

(e) Quality Improvement

(f) The Joint Commission and its Standards

3.6-3 AGENDA

The agenda shall be prepared jointly by the Chairperson of the Board, the Chief Executive Officer and the President of the Medical Staff.

3.6-4 REPORTS

The Joint Conference Committee shall transmit written reports of its actions to the Board and the Medical Staff.

3.7 AUDIT COMMITTEE

3.7-1 COMPOSITION

The Audit Committee shall be comprised of a Chair and three (3) other members of the Board all appointed by the Chairperson of the Board.

3.7-2 FUNCTIONS

The Audit Committee shall be charged with the following responsibilities:

(a) Make regular reports to the Board.

(b) Review the annual audited financial statements with management, including major issues regarding accounting and auditing principles and practices as well as the adequacy of internal controls that could significantly affect the Hospital's financial statements.

(c) Review an analysis prepared by management and the independent auditor of significant financial reporting issues and judgments made in connection with the preparation of the Hospital's financial statements.

(d) Meet periodically with management to review the Hospital's major financial risk exposures and the steps management has taken to monitor and control such exposures.

(e) Review major changes to the Hospital's auditing and accounting principles and practices suggested by the independent auditor or management.

(f) Recommend to the Board the appointment of the independent auditor, which firm is ultimately accountable to the Committee and the Board.

(g) Recommend the fees to be paid to the independent auditor for approval by the Board.

(h) Receive periodic written reports from the independent auditor regarding the auditor's independence (including, without limitation, describing all relationships between the independent auditors and the Hospital) discuss such reports with the auditor, and if so determined by the Committee, recommend that the Board take "appropriate action to satisfy itself of the independence of the auditor."

(i) Evaluate together with the Board the performance of the independent auditor and, if so determined by the Committee, recommend that the Board replace the independent auditor.

(j) Meet with the independent auditor prior to the audit to review the planning and staffing of the audit.

(k) Discuss with the independent auditor the matters required to be discussed pursuant to Public Company Accounting Oversite Board auditing standards for audits of financial statements for fiscal years ending on or after December 15, 2020 including those applicable to governmental entities and specifically AU Section 800 relating to the conduct of the audit.

(l) After the audit, review with the independent auditor the result of the audits, any problems or difficulties the auditor may have encountered, and any management letter provided by the auditor and the Hospital's response to that letter. Such review should include any difficulties encountered in the course of the audit work, including any restrictions on the scope of activities or access to required information and any changes and recommendations made as a result of the audit

including, without limitation, change in internal control and in accounting methods.

(m) Advise the Board with respect to the Hospital's policies and procedures regarding compliance with the Hospital's Code of Conduct related to or disclosed by the audit.

(n) Review with the Hospital's legal counsel legal matters that may have a material impact on the financial statements.

(o) Meet at least annually with the Vice President - Finance/Chief Financial Officer and the independent auditor in separate sessions.

(p) Conduct investigations (including but not limited to the engagement of outside experts as approved by management and the Executive Committee of the Board, so long as such experts' fee are less than Ten Thousand Dollars ($10,000)) to resolve disagreements, if any, between the independent auditor and management, or to assure compliance with the Hospital's Code of Conduct.

(q) Review quarterly financial statements with management and the independent auditor.

(r) Operate in accordance with the principles and terms of the Audit Committee Charter attached as Appendix 3.7 to these Bylaws. While the Audit Committee has the responsibilities and powers set forth herein and in its Charter, it shall be the duty and responsibility of Hospital management to determine that the Hospital's financial statements are complete and accurate and are in accordance with the U.S. generally accepted accounting principles.

3.8 COMPENSATION COMMITTEES FOR THE PRESIDENT/CHIEF EXECUTIVE OFFICER AND FOR OTHER HOSPITAL SENIOR LEADERSHIP

3.8-1 (a) COMPOSITION OF THE COMPENSATION COMMITTEE FOR THE PRESIDENT/CHIEF EXECUTIVE OFFICER

This Committee shall be composed of one member who shall be the Director serving in the position of Chairperson of the Board. This Committee shall be supported by the Hospital's legal counsel (or his/her representative) and/or such other selected individual(s) in the discretion of the Chairperson of the Board.

3.8-1 (b) COMPOSITION OF THE COMPENSATION COMMITTEE FOR OTHER HOSPITAL SENIOR LEADERSHIP

This Committee shall be composed of two members who shall be those currently serving in the positions of Chairperson of the Board and President/Chief Executive Officer of the Hospital. This Committee shall be supported by the Hospital's legal counsel (or his/her representative) and/or such other selected individual(s) in the discretion of this Committee's members.

3.8-2 FUNCTIONS

(a) FUNCTIONS OF THE COMPENSATION COMMITTEE FOR THE PRESIDENT/CHIEF EXECUTIVE OFFICER

This Committee shall review the Hospital's corporate goals and objectives in the context of the compensation arrangements provided for the President/Chief Executive Officer. This Committee shall develop and integrate a compensation program for the President/Chief Executive Officer into the Hospital's strategic planning process.

The principal functions of this Committee are:

(i) Periodically (at least annually) review and analyze Hospital compensation arrangements with the President/Chief Executive Officer.

(ii) Work with the Hospital's legal counsel or external consultants to evaluate and compare hospital senior management compensation trends on national,

regional, and local levels to ensure that the President/Chief Executive Officer compensation is reasonable and appropriately established.

(iii) Develop Hospital compensation arrangements and programs for the President/Chief Executive Officer, including the base salary, systems for incentive compensation, non- cash compensation, and other supplemental compensation programs for approval by the Board.

(iv) Negotiate, on behalf of the Board, compensation arrangements regarding the President/Chief Executive Officer employment contract and/or severance and retirement packages.

(b) FUNCTIONS OF THE COMPENSATION COMMITTEE FOR OTHER HOSPITAL SENIOR LEADERSHIP

This Committee shall review the Hospital's corporate goals and objectives in the context of the compensation arrangements provided for the Hospital Senior Leadership consisting of those individuals whose title is commonly known as Vice Presidents, Senior Vice Presidents, Executive Vice President, CFO and similarly titled positions ("Senior Leadership"). This Committee shall develop and integrate a Senior Leadership compensation program into the Hospital's strategic planning process.

The principal functions of the Committee are:

(a) Periodically (at least annually) review and analyze Hospital compensation arrangements with Senior Staff.

(b) Work with the Hospital's legal counsel or external consultants to evaluate and compare hospital Senior Leadership compensation trends on national, regional, and local levels to ensure that the Senior Leadership compensation is reasonable and appropriately established.

(c) Develop Hospital compensation arrangements and programs for Senior Leadership, including the base salary, systems for incentive compensation, non-cash compensation, and other supplemental compensation programs for approval by the Board and the Chief Executive Officer.

(d) Negotiate, on behalf of the Board, and with the authority of the CEO, the compensation packages and/or severance and retirement packages of Senior Leadership members.

3.9 QUALITY COMMITTEE

3.9-1 COMPOSITION

The Quality Committee shall be comprised of a Chair and at least four (4) other members of the Board. In addition, the President of the Medical Staff and the chairs or their designees of the following Medical Staff committees: Medical Staff Bylaws Committee, Utilization Management/Medical Records Committee, and Credentials and Medical Ethics Committee, will serve as voting members, and the Chief Executive Officer will serve as a nonvoting member. The Quality Committee Chair shall be elected annually by a majority of Quality Committee members.

3.9-2 FUNCTIONS

The principle function of the Quality Committee shall be to fulfill the responsibilities outlined in Article VI of these Bylaws regarding Quality Assessment and Improvement. The Committee will provide the mechanism through which Hospital administration and the Medical Staff are held accountable for the activities delegated to them in Article VI. The Quality Committee will take a proactive approach as it advises the Board regarding policies to "improve the overall quality and efficiency of patient care in the Hospital" and in the community, for instance, by setting/recommending adoption of standards and guidelines for quality care. The Quality

Committee is designed to work in collaboration with the Medical Staff and Administration to achieve the Board's safety and quality goals. The Quality Committee shall act in collaboration with Medical Staff committees. In addition, non-standing committees of the Board that deal primarily with quality, clinical outcomes, etc. will report to the Quality Committee. The Committee's responsibilities include, but are not limited to the following:

(a) Receive periodic reports from the Patient Care Improvement Committee, and advise the Board regarding patient care improvement at the Hospital.

(b) Receive periodic reports from the Medical Executive Committee and/or Medical Directors, as they relate to quality, and advise the Board regarding what action, if any, is to be taken regarding the reports.

(c) Establish measures for clinical outcomes and identify appropriate comparative standards; monitor the hospital's performance against these standards; report findings and recommended actions to the Board.

(d) Reviews and comment on the clinical findings of all licensure, accreditation, and certification surveys of the Hospital.

(e) Review and comment on the Hospital's Physician Manpower Plan.

(f) Review and comment on all proposed amendments to the Medical Staff bylaws relating to quality of care.

(g) Review and comment on the results of all community services needs surveys or studies involving the Hospital's markets or service areas.

(h) Review and comment on the reasonableness of all proposed physician services agreements with the Hospital or its affiliates.

(i) Request and review, at its discretion, reports from any individual, group, or committee related to quality.

3.10 INVESTMENT COMMITTEE

3.10-1 COMPOSITION

The Investment Committee shall be comprised of no more than five (5) members all of whom shall be members of the Finance Committee and all of whom shall be appointed by the Chairperson of the Board. The Vice President – Finance /Chief Financial Officer shall also be a member of the Investment Committee.

3.10-2 FUNCTIONS

The Investment Committee shall be charged with the responsibility to:

(a) Review investment and performance of the Operating Funds of the Hospital.

(b) Oversee the actions of the Pension Administration Committee and Trustees for the North Brevard County Hospital District Pension Plan and its implementation of the Pension Investment Guidelines of the Board of Directors (Policy Number 9500-5004).

(c) Implement the provisions of the Operating Funds Investment Policy of the North Brevard County Hospital District (Policy Number 9500-5003).

(d) Report, from time-to-time, to the Board concerning the performance of the Operating Funds and implementation of Policy Number 9500-5003.

(e) Recommend institutions which will serve as depositories for operating funds and investments.

(f) Perform such other actions as may be assigned from time-to-time by the Board.

ARTICLE IV. CHIEF EXECUTIVE OFFICER

4.1 APPOINTMENT

The Board of Directors shall select and appoint a competent experienced Hospital administrator to serve as the Chief Executive Officer and to be the direct executive representative of the Board in the management of the Hospital. The Chief Executive Officer shall be given the necessary authority and be held responsible for the management of the Hospital in all its departments

subject only to the policies enacted by the Board and to such orders as may be issued by the Board pertaining to the administration of the Hospital.

4.2 AUTHORITY AND DUTIES

The Chief Executive Officer, subject to the directions of the Board, shall have the following authority and duties:

(a) Prepare and submit to the Board for approval a plan for the organization of the personnel concerned with the operation of the Hospital.

(b) Select, employ, control and have authority to discharge any Hospital employee. Employment shall be subject to budget authorization granted by the Board.

(c) Report to the Board at regular and special meetings all significant items of business of the Hospital and make recommendations concerning the disposition thereof.

(d) Submit regularly, in cooperation with the appropriate committees of the Board, periodic reports showing the patient care and professional services rendered and the financial activities of the Hospital, and prepare and submit any budget data that may be required by the Board.

(e) Attend all meetings of the Board when possible and attend meetings of the various committees of the Board when so required by the Committee Chairperson.

(f) Serve as a liaison between the Board and the Medical Staff of the Hospital. The Chief Executive Officer will cooperate with the Medical Staff and will endeavor to secure like cooperation on the part of all concerned with rendering professional services to the end that the patients may receive the best possible care.

(g) Make recommendations concerning the purchase of equipment, supplies, and services by the Hospital.

(h) Keep informed of all new developments in the medical and administrative areas of Hospital administration.

(i) Oversee the physical plant, Hospital building and grounds; and keep them in good state of repair, conferring with the appropriate committee of the Hospital Board in major matters, but carrying out routine repairs and maintenance without such consultation.

(j) Supervise all business affairs such as the records of financial transactions, collection of accounts and purchase and issuance of supplies, and be certain that all funds are collected and expended to the best possible advantage.

(k) Supervise the preservation of the permanent medical records of the Hospital and act as designated custodian of all Hospital records.

(l) Select, secure and keep in force, in companies duly authorized to do business in Florida, or in such other programs as approved by the Board, such insurance as is necessary including but not limited to physical property, liability, malpractice, vehicle, fire, extended coverage insurance, and such other insurance, and in such amounts as may be deemed proper.

(m) Designate, in writing, other individuals by name or position who are, in order of succession, authorized to act during any period of absence of the Chief Executive Officer from the Hospital.

(n) Perform such other duties as the Board shall from time to time direct.

ARTICLE V. MEDICAL STAFF

5.1 ORGANIZATION

The Board of the Hospital has the ultimate authority for the management of the Hospital. Pursuant to this authority, the Board has created a Medical Staff organization to be known as the Medical Staff of Parrish Medical Center. Membership in this Medical Staff organization is a prerequisite to the exercise of clinical privileges in the Hospital, except as otherwise specifically provided in the Medical Staff Bylaws.

5.2 MEDICAL STAFF BYLAWS

The Medical Staff shall collaborate with the Board in drafting the Medical Staff Bylaws, Rules and Regulations. Procedures for the review and consideration of all applications for appointment or reappointment to the Medical Staff or any action to suspend, terminate, modify or restrict the privileges of any member of the Medical Staff shall be established in the Medical Staff Bylaws. Neither the Medical Staff nor the Board may unilaterally amend or suspend the Medical Staff Bylaws, Rules and Regulations and when adopted by the Medical Staff and approved by the Board, they shall become binding jointly upon both bodies. Nothing contained in the Medical Staff Bylaws and Rules and Regulations shall be contrary to any State or Federal laws, the terms of the Act, or the provisions of these Bylaws. In the event there should exist any conflict or any inconsistency between these Bylaws and the Bylaws, Rules and Regulations of the Medical Staff, the inconsistency will be referred to the Joint Conference Committee for recommendation to and final determination by the Board.

5.3 MEMBERSHIP

Medical Staff membership status shall be granted by the Board in its sole discretion on such terms and conditions as the Board deems proper in order to provide the best available professional care to Hospital patients. All applications for membership to the Medical Staff

and/or the granting of clinical privileges shall be presented in writing to and on forms prescribed and provided only by the Chief Executive Officer.

5.4 INSTITUTIONAL NEED

The needs and resources of the Hospital will be considered in making appointments to the Medical Staff and in granting clinical privileges to staff members. All appointments and grants of privileges must be consistent with the needs and resources of the Hospital which include:

(a) Preservation of a relationship between the facilities available and the number of practitioners requiring access to these facilities which will allow the most effective patient care. Such facilities include the number of hospital beds, operating rooms and special equipment and/or treatment areas.

(b) Provision of both general and special medical services, particularly those not otherwise available either in the Hospital or in the primary service area.

(c) Satisfactory participation by all members of the Medical Staff in the professional activities of that body and demonstrated support of the Hospital's mission and goals.

(d) Satisfactory demonstration of the capability to work cooperatively and professionally with fellow members of the Medical Staff and with all categories of Hospital employees.

(e) Preservation of the Hospital's Quality Assessment and Improvement Program to include assurances and findings that the quality of patient care will not be adversely affected by any practitioner's inability to maintain an appropriate level of proficiency because of an insufficient number of patients or applicable procedures, the Medical Staff's inability to assure necessary assistance or qualified supervision, or the Hospital's inability to provide sufficient facilities.

(f) Satisfactory adoption and adaptation related to electronic medical records and other technology implemented by the Hospital.

(g) Satisfactory performance related to quality measures adopted by the Hospital or its payors.

5.5 CONTRACT PHYSICIANS

A practitioner employed by the Hospital, either part-time or full-time, in a purely administrative capacity or with no patient admitting privileges is subject to the regular personnel policies of the Hospital and to the terms of his or her contract or other conditions of employment and need not be a member of the Medical Staff.

ARTICLE VI. QUALITY ASSESSMENT AND IMPROVEMENT

6.1 BOARD RESPONSIBILITY

The Board shall establish, maintain, support and exercise oversight of an ongoing Quality Assessment and Improvement Program that includes specific and effective review, evaluation and monitoring mechanisms to assess, preserve and improve the overall quality and efficiency of patient care in the Hospital.

6.2 DELEGATION TO ADMINISTRATION AND TO THE MEDICAL STAFF

6.2-1 TO ADMINISTRATION

The Board delegates to the administration and holds it accountable for providing the administrative assistance reasonably necessary to support and facilitate the implementation and ongoing operation of the Hospital's Quality Assessment and Improvement Program as it concerns non-medical professional personnel and technical staffs and patient care units, and for analyzing information and acting upon problems involving technical, administrative and support services and Hospital policy.

6.2-2 TO THE MEDICAL STAFF

The Board delegates to the Medical Staff and holds it accountable for conducting specific activities that contribute to the preservation and improvement of the quality of patient care provided by the Medical Staff members in the Hospital. These activities include:

(a) Systematic evaluation of practitioner performance against explicit, pre-determined criteria.

(b) Ongoing monitoring of critical aspects of care, including but not limited to antibiotic and drug usage, transfusion practices, surgical outcomes, infections, morbidities and mortalities, and monitoring of unexpected clinical occurrences.

(c) Review of utilization of the Hospital's resources to provide for their proper and timely allocation to patients.

(d) Review and recommend to the Board only those clinical privileges to practitioners that are consistent with the recognized needs and facilities of the Hospital as provided in Section 5.4 of these Bylaws.

(e) Provision for continuing professional education, including needs identified through the review, evaluation and monitoring activities of the Quality Assessment and Improvement Program developments.

(f) Definition of the clinical privileges which may be appropriately granted within the Hospital and within each service, delineation of clinical privileges for members of the Medical Staff commensurate with individual credentials and demonstrated ability and judgment, and participation in assigning patient care responsibilities to other health care professionals consistent with individual qualifications and demonstrated ability.

(g) Management of clinical affairs, including enforcement of clinical policies and consultation requirements, initiation of disciplinary actions, surveillance of requirements for performance monitoring and for the exercise of newly- acquired clinical privileges, and like clinically-oriented activities.

(h) Such other measures as the Board may deem necessary for the preservation and improvement of the quality and efficiency of patient care, after giving due consideration to the advice of the Medical Staff, Hospital administration, or other professionals.

6.3 INDEMNIFICATION

The Hospital shall indemnify, each Board member, officer, employee and agent of the Hospital in the manner and to extent provided by the laws of the State of Florida, as amended from time to time. The indemnification shall apply to all matters whenever arising. The right of indemnification herein provided shall be in addition to any and all rights to which any director, officer, agent or employee might otherwise be entitled and the provision hereof shall neither impair nor adversely affect such rights. Such indemnification shall extend to each member of the Medical Staff serving as an officer of the Medical Staff or on any committee or department of the Hospital or Medical Staff, or otherwise participating in any Hospital or Medical Staff activity conducted pursuant to these or the Medical Staff bylaws, against any claims made against any Medical Staff member as a result of good faith actions taken on behalf of the Hospital, as long as there is no evidence of misconduct on the part of the staff member and the staff member follows all Hospital approved procedures in connection with any peer review, credentialing or other activities.

ARTICLE VII. HOSPITAL AUXILIARY

7.1 NAME AND PURPOSE

The Board has authorized the creation of a volunteer group under the oversite and direction of the Board of Directors of the Hospital and management of the Hospital to provide volunteers services at the Hospital called "The Parrish Medical Center Auxiliary". The purpose of this group of volunteers is to render volunteer services to the Hospital, its patients, and visitors subject to the direction and oversite of the administration of the Hospital. Any funds which may accumulate as a result of these activities will be used in such a manner as will benefit the Hospital or the Jess Parrish Medical Foundation, Inc., as determined from time to time by the Administration of the Hospital. Such funds shall be the property of the Hospital.

7.2 ORGANIZATION AND GOVERNMENT

The Auxiliary will be organized to be of service to the Hospital and is responsible to the Hospital Board through the Chief Executive Officer or his designee.

7.3 OTHER VOLUNTEER SERVICES

Other individuals or organized groups who wish to perform volunteer services in the Hospital, shall first obtain a letter of agreement delineating the authorized term and scope of services from the Chief Executive Officer or his designee.

ARTICLE VIII. THE ACT

The exercise any of the authorities or duties of the Board by these Bylaws, shall be guided by the provisions contained in Chapter 2003-362, Laws of Florida, as amended from time to time by the Florida Legislature, creating the Hospital District, and defining the procedures, requirements and limitations, pertaining to such authorities or duties.

ARTICLE IX. AMENDMENTS

Amendments to these Bylaws may be made by a majority vote of not less than five (5) members of the Board present at any regular or special meeting of the Board, provided that the proposed amendment shall have been presented either at a prior meeting or through the mail to each director not less than ten (10) days prior to the meeting and further provided such amendment has been reviewed in accordance with such additional policies or procedures as adopted by the Board.

ARTICLE X. PROCEDURES

All meetings and affairs of the Board, the Hospital, the Medical Staff, and all committees thereof shall be conducted in accordance with Robert's Rules of Order, as revised from time to time, except as otherwise provided by law, or these bylaws, or unless a majority of those in attendance and entitled to vote at any such meeting shall elect not to do so. Provided, failure to comply with Robert's Rules of Order, as revised, from time to time shall not invalidate any action of the Board or any Committees of the Board.

APPROVED and adopted by the Governing Board this _______ day of ______________, 20___.

____
_________________________., Chairperson

____
_____________________________, Secretary

Adopted: November 15, 1983
Implemented: January 1, 1984
Amended: July 19, 1988
Implemented: August 1, 1988
Amended: Article 1.5, September 20, 1988
Amended: Article 1.5, February 28, 1989
Amended: Article 2.2, September 26, 1989
Amended: Article 3.2-1(d), October 28, 1990
Amended: Article 3.5-2 (k) change to (l) December 18, 1990
Amended: Article 5.5-5 December 18, 1990
Amended: Definition #12 March 26, 1991
Amended and Restated: December 15, 1992
Amended: Article 3.5-2, September 8, 1993
Amended: Article 3.1-5, 3.2-1, February 7, 1994
Amended: Article 3.1-4, September 11, 1995
Amended: Article 1.1.1, June 2, 1997
(New Section: Article 1.1.2, June 2, 1997)
Amended: November 2, 1998
Amended: September 8, 1999
Amended: December 02, 2002
Amended: April 3, 2006
Amended: June 6, 2007
Amended: January 5, 2009
Amended: August 6, 2012
Amended: October 5, 2015
Amended: December 5, 2016
Amended: January 7, 2019
Amended: December 7, 2020
Amended: March 6, 2023

APPENDIX 1.9-1(i)

NORTH BREVARD COUNTY HOSPITAL DISTRICT POLICY REGARDING RESTRICTIONS ON COMPETING FINANCIAL INTERESTS AND ANTI-COMPETITIVE ACTIVITY OF MEMBERS OF THE BOARD OF DIRECTORS

RECITALS

WHEREAS, the North Brevard County Hospital District ("District"), d/b/a Parrish Medical Center (the "Hospital"), pursuant to its public mission, is committed to providing District residents with a broad range of cost-effective, quality patient care services;

WHEREAS, the Hospital Board of Directors (the "Board"), pursuant to the District's enabling legislation and bylaws, has the duty and authority to establish appropriate policies and procedures for the governance, management, and operation of the Hospital including, but not limited to, a policy regarding competing financial interests and anti-competitive activity of Active Members (as defined in Section 1 of this Appendix 1.9-1(i)) to protect the integrity of Board decision-making and fiscal soundness of the Hospital;

WHEREAS, if individuals with competing financial interests are allowed to serve on the Board or committees of the Board, such individuals might use their relationship with the Hospital and information obtained from the Hospital to benefit themselves or their competing financial interests at the expense of the Hospital, thus undermining the ability of the Hospital to continue to serve its public purpose and provide a broad range of quality, cost effective services for District residents;

WHEREAS, if Active Members are allowed to engage in activities that promote the interests of Hospital competitors at the expense of the Hospital then such activities could also undermine the ability of the Hospital to continue to serve its public purpose;

WHEREAS, the Board has determined that it is in the best interest of the District to establish a policy prohibiting such Active Members from serving who have an incentive, directly or indirectly, by virtue of possessing competing financial interest or engaging in anti-competitive activity, to jeopardize the fiscal soundness of the Hospital;

WHEREAS, the State of Florida has enacted certain legal standards for public officials regarding conflicts of interest to which Active Members are subject and this Policy is meant to supplement, and not replace, this existing body of law; and

WHEREAS, the federal government also has an interest in preserving the public benefit of certain organizations, including the District, to whom it has granted an exemption from federal income taxation.

NOW, THEREFORE, it is resolved that the Board shall adopt the following policy regarding competing financial interests and anti-competitive activity of Active Members ("Policy"):

POLICY

1. **Duty of Loyalty**. All members of the Board, together with ex-officio and other members of committees of the Board and the President of the Medical Staff (collectively referred to as "Active Members"), have a legal and ethical duty of undivided loyalty and to exercise the utmost good faith in their relationships with and for the Hospital, to act in the best interests of the Hospital, and to exercise their responsibilities with due care and loyalty to the Hospital's interests.

2. **Prohibition on Competing Financial Interests**. Individuals who have a Competing Financial Interest, as defined in this Policy, shall not serve as an Active Member, either on an appointed, elected, or ex-officio basis, unless such Competing Financial Interest violation under this Policy is waived by resolution of the Board under circumstances determined by the Board to be in the Hospital's best interest.

3. **Prohibition on Anti-Competitive Activity**. Active Members are prohibited from engaging in Anti-Competitive Activity, as defined in this Policy, unless such Anti-Competitive Activity violation under this Policy is waived by resolution of the Board under circumstances determined by the Board to be in the Hospital's best interest.

4. **Sanctions**. The Board, in accordance with the Act and its Bylaws, shall proceed to remove any Active Member who violates this Policy and who refuses to resign when requested by the Board.

5. **Board Appointment**. The Chief Executive Officer and Board shall actively encourage public officials and bodies with Active Member appointment power not to appoint to the Board any individual in violation of this Policy.

6. **Definitions**.

For purposes of this Policy:

a. The term "Competing Financial Interest" shall mean a financial interest held by an Active Member, a closely-related family member of an Active Member, or a trust, estate, business, company, partnership, or other organization or enterprise of an Active Member or closely-related family member of an Active Member, in a Hospital Competitor which appears to conflict with his or her decisions or actions as an Active Member. Examples of interests deemed to be Competing Financial Interests under this Policy are included on Exhibit A attached hereto. These examples are not exhaustive and the Board shall be free to determine on a case by case basis whether other circumstances qualify as a Competing Financial Interest.

For purposes of this definition, "closely-related" shall mean related by blood or marriage as father, mother, husband, wife, son, daughter, or any other direct lineal ancestor or descendant, sister, brother, uncle, aunt, nephew, niece, first cousin, mother-in-law, father- in-law, brother-in-law, sister-in-law, son-in-law, or daughter-in-law.

b. The term "Anti-Competitive Activity" shall mean the support of, or engaging in, a policy, transaction or conduct that directly or indirectly provides a financial benefit to a Hospital Competitor to the detriment of the Hospital or District residents. Examples of Anti-Competitive Activities under this Policy are included on Exhibit B attached hereto. These

examples are not exhaustive and the Board shall be free to determine on a case by case basis whether other circumstances qualify as an Anti-Competitive Activity.

c. The term "Hospital Competitor" shall mean a facility or business:

(1) with a level of competition against the Hospital that is substantial in relation to the total business of the Hospital; or

(2) within a 50 mile radius of the Hospital that is an acute care general hospital, a medical/surgical hospital, a specialty hospital, a rehabilitation center, an extended care facility or nursing home, an outpatient or inpatient surgery center, an emergency center, a home health service, a health maintenance organization or similar direct care provider, an ambulance service, a birthing center or an inhalation, respiratory or physical therapy center, a clinic with a primary mission to treat Acquired Immune Deficiency Syndrome or similar diseases, or an entity providing Ancillary Medical Care Services (as hereinafter defined).

For purposes of this definition, "Ancillary Medical Care Services" shall mean and include, (i) any form of testing for diagnostic or therapeutic purposes, (ii) provision or operation of a laboratory (including, without limitation, a pathology laboratory or a clinical laboratory), (iii) diagnostic imaging services (which include, without limitation, the following testing facilities: fluoroscopy, x-ray, plane film radiography, computerized tomography (CT), ultrasound, radiation therapy, mammography and breast diagnostics, nuclear medicine testing and magnetic resonance imaging), (iv) physical therapy services, or respiratory therapy service, and (v) the provision of any medical or related service to or for any person that is in addition to the examination and diagnosis of patients performed directly by a physician or by other health care professionals under the direct supervision of a physician, or a facility operated for the provision of any such service.

Notwithstanding the foregoing, Hospital Competitor shall not mean a physician medical office practice providing laboratory and diagnostic imaging to any such physician's own patients, so long as such services are merely ancillary and incidental to such physician's primary medical practice and do not constitute the physician's primary medical practice or specialty nor the predominant services rendered by such physician to physician's patients and so long as such patients for whom such laboratory or diagnostic imaging services are performed are not referred to such physician primarily for the purpose of obtaining such laboratory or diagnostic imaging services.

7. **Procedures for Addressing Policy Violations**. Whenever there is reason to believe that a violation of this Policy exists, the Board shall consider the matter during a public meeting, unless an exemption is provided under law. A member of the Board subject to the inquiry shall be entitled to vote unless prohibited by law.

8. **Procedures for Investigating Violations of this Policy**. The Hospital shall be authorized to collect and maintain appropriate financial and other data to investigate and support decisions relating to this Policy. To this end, when reasonable suspicion exists that a violation of this Policy has occurred, the Hospital Chief Executive Officer ("CEO") or his/her designee shall have the authority to demand and receive from each Board Member, for review by the Hospital's senior administration or its legal counsel, financial information, records and such other information related to the potential violation under review. Any failure by a Board member to furnish

information requested by the CEO pursuant to this Policy within thirty (30) days shall constitute a violation of this Policy.

9. **Disclosure of Competing Financial Interests and Anti-Competitive Activity**. Active Members shall annually complete a prescribed form (attached and incorporated into this Policy, as may be amended from time to time) to disclose Competing Financial Interests and to verify the absence of Anti-Competitive Activity on the part of the Active Member. Any failure by an Active Member to submit an attestation form as described in this Section 9 by January 30 of each year of the Active Member's service and to update the form within thirty (30) days after acquisition of any Competing Financial Interest or participation in any Anti-Competitive Activity shall constitute a violation of this Policy.

10. **Application of this Policy**. This Policy is intended to supplement, but not replace, any Florida law governing ethical conduct and conflicts of interest applicable to public officials.

EXHIBIT A

Examples of Competing Financial Interests

Examples of Competing Financial Interests that may be considered as disqualifying for Active Members under this Policy include, but are not limited to, the following:

a. Direct or indirect investment in, holding indebtedness of, or having a compensation arrangement with a Hospital Competitor;

b. Employment by, or participation in, the administration, management, or governance of a Hospital Competitor. This description includes, but is not limited to, the following positions: Member of the Board of Directors, Medical Staff Officer, Medical Staff Executive Committee Member, Committee Chairperson or Vice Chairperson, Medical Director or a member of a Planning Committee;

c. Employment by, or practice with, a medical group practice that is primarily or significantly affiliated with a Hospital Competitor; and

d. Affiliation with a Hospital Competitor that may reasonably give rise to a concern that the individual may not be entirely impartial and disinterested in making decisions in the best interests of the Hospital.

The following are examples of financial interests that, without more, generally shall not be considered to be Competing Financial Interests under this Policy:

a. Membership on the medical staff of a Hospital Competitor;

b. Medical practice in the same specialty as employed physicians of the Hospital; and

c. Passive investment(s) in publicly traded stocks of a Hospital Competitor.

EXHIBIT B

Examples of Anti-Competitive Activities

Examples of Anti-Competitive Activities that may be considered as disqualifying for Active Members under this Policy include, but are not limited to, the following:

a. Public or private promotion of a Hospital Competitor at the expense of the Hospital;

b. Diverting away from the Hospital, through referrals unrelated to patient preference or medical needs, or through other means, District residents to a Hospital Competitor;

c. Public display of disruptive actions against the Hospital that harm the Hospital's image or reputation in the community; and

d. Employment by, or participation in, the administration, management, or governance of a Hospital Competitor. This description includes, but is not limited to, the following positions: Member of the Board of Directors, Medical Staff Officer, Medical Staff Executive Committee Member, Committee Chairperson or Vice Chairperson, Medical Director or a member of a Planning Committee.

The following are examples activities that, without more, generally shall not be considered to be Anti-Competitive Activities under this Policy:

e. Non-public efforts, within the Hospital channels, to suggest improvements or to make constructive changes, such as to improve health care quality, access to care, or customer service;

f. Participation in health-related or other educational civic activities in the District;

g. Reporting of legal, professional, or ethical problems of persons or entities, either internally within the Hospital, or to government officials;

h. Membership on the medical staff of a Hospital Competitor;

i. Medical practice in the same specialty as employed physicians of the Hospital;

j. Lawful activities unrelated to the competitive business interests of the Hospital; and

k. Affiliation with a Hospital Competitor that may reasonably give rise to a concern that the individual may not be entirely impartial and disinterested in making decisions in the best interests of the Hospital.

ACTIVE MEMBER ATTESTATION STATEMENT

I have read and understand the North Brevard County Hospital District Policy Regarding Restrictions on Competing Financial Interests and Anti-Competitive Activity of Active Members.

In accordance with this Policy, while I am a member of the Board of Directors, the President of the Medical Staff, or a member of a Board of Directors committee, I shall not engage in any personal or business activity in violation of the Policy. Further, in accordance with this Policy, below I have set forth all my existing Competing Financial Interests and Anti-Competitive Activity as described in this Policy. I agree to either resign my position with the Board or a committee of the Board or to completely divest and disassociate with any activity or interest in violation of this Policy before accepting or continuing my Board position with the Hospital or on a committee of the Board. I further understand that, in accordance with this Policy, I am responsible for providing to the Chief Executive Officer of Parrish Medical ("CEO") or his/her designee within thirty (30) days any information requested by the CEO in order to ensure my compliance with this Policy and any refusal or delay on my part in providing this information will be considered a violation of this Policy.

I understand that the purpose of this Policy is far reaching and it may cover situations not specifically addressed in this Policy. Accordingly, I understand that this Policy is meant to supplement, but not to replace, (i) any applicable laws governing conflicts of interest applicable to members of the governing body of public hospitals, and (ii) good judgment. Thus, I will respect this Policy's spirit and purpose as well as its wording.

My existing Competing Financial Interests and Anti-Competitive Activity are reported in the following space:

____

____

____

____

____

____

I attest that the following is true and correct. I agree to update this statement within thirty (30) days after I acquire any Competing Financial Interest or engage in any Anti-Competitive Activity not previously fully disclosed.

By: ________________________________ Date: __________________________

APPENDIX 3.7

AUDIT COMMITTEE CHARTER

The Audit Committee is appointed by the Chairperson of the Board of Directors (the "Board") of the North Brevard County Hospital District (the "Hospital") to assist the Board in monitoring (1) the integrity of the financial statements of the Hospital, and (2) the independence and performance of the Hospital's external auditors.

There shall be four (4) members of the Audit Committee, including one (1) member appointed as Chair by the Chairperson of the Board. The committee will be composed solely of directors who are independent of the management of the Hospital and are free of any relationship that, in the opinion of the Board, may interfere with their exercise of independent judgment as a committee member.

All members must be or become financially literate and at least one (1) member must have accounting or related financial management experience (i.e., experience as a Chief Executive Officer, or Chief Financial Officer of a business, or as a Certified Public Accountant, or similar experience), in each case it shall be in the judgment of the Chairperson of the Board.

The committee shall meet at least four (4) times per year or more frequently as circumstances require. A majority of the members must be present to constitute a quorum. The committee may ask members of management or others to attend the meetings and provide pertinent information as necessary. Meetings must be conducted in accordance with Florida Statute §286 and Article I, Section 24 of the Florida Constitution, unless the subject matter of the meeting allows the committee to meet in executive session. The committee is expected to maintain free and open communication with management and the independent auditors. The Audit Committee shall:

(a) Make regular reports to the Board.

(b) Review the annual audited financial statements with management, including major issues regarding accounting and auditing principles and practices as well as the adequacy of internal controls that could significantly affect the Hospital's financial statements.

(c) Review an analysis prepared by management and the independent auditor of significant financial reporting issues and judgments made in connection with the preparation of the Hospital's financial statements.

(d) Meet periodically with management to review the Hospital's major financial risk exposures and the steps management has taken to monitor and control such exposures.

(e) Review major changes to the Hospital's auditing and accounting principles and practices as suggested by the independent auditor or management.

(f) Recommend to the Board the appointment of the independent auditor, which firm is ultimately accountable to the Committee and the Board.

(g) Recommend the fees to be paid to the independent auditor for approval by the Board.

(h) Receive periodic written reports from the independent auditor regarding the auditor's independence (including, without limitation, describing all relationships between the independent auditors and the Hospital) discuss such reports with the auditor, and if so determined by the Committee, recommend that the Board take appropriate action to satisfy itself of the independence of the auditor.

(i) Evaluate together with the Board the performance of the independent auditor and, if so determined by the Committee, recommend that the Board replace the independent auditor.

(j) Meet with the independent auditor prior to the audit to review the planning and staffing of the audit.

(k) Discuss with the independent auditor the matters required to be discussed by Auditing Standard No. 16 relating to the conduct of the audit.

(l) After the audit, review with the independent auditor the result of the audits, any problems or difficulties the auditor may have encountered and any management letter provided by the auditor and the Hospital's response to that letter. Such review should include any difficulties encountered in the course of the audit work, including any restrictions on the scope of activities or access to required information and any changes and recommendations made as a result of the audit including, without limitation, change in internal control and in accounting methods.

(m) Advise the Board with respect to the Hospital's policies and procedures regarding compliance with the Hospital's Code of Ethics related to or disclosed by the Audit.

(n) Review with the Hospital's legal counsel legal matters that may have a material impact on the financial statements.

(o) Meet at least annually with the Vice President – Finance / Chief Financial Officer and the independent auditor in separate sessions.

(p) Conduct investigations (including but not limited to the engagement of outside experts as approved by management and the Executive Committee of the Board of Directors, so long as such experts' fee is less than Two Thousand Dollars ($2,000) to resolve disagreements, if any, between the independent auditor and management, or to assure compliance with the Hospital's Code of Ethics.

(q) Review quarterly financial statements with management and the independent auditor. While the Audit Committee has the responsibilities and powers set forth in this Charter, it shall be the duty and responsibility of Hospital management to determine that the Hospital's financial statements are completed and accurate and are in accordance with the U.S. generally accepted accounting principles applicable to the North Brevard County Hospital District.

North Brevard County Hospital District
Environment of Care (EOC) Committee Report:
Annual Report for Calendar Year 2023
Executive Summary

Safety and Security

2022 Goals:

- Ninety percent Ninety percent (90%) of all bags, purses, suitcases, duffels, etc. entering through the Main and ER entrances will have thorough bag checks done prior to entry into the building. This is accomplished through review of cameras at each location for a minimum of 4 bags/persons by each officer per month. UNMET
- Loading dock rounds will be completed every two (2) hours at a minimum of 90% (11 every 24 hours) MET
- Ninety percent (90%) of active care partners will receive education on de-escalation techniques by December 31, 2022 UNMET

2023 Goals:

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

Hazardous Materials

2022 Goals:

- Reduce the number of hazardous waste disposal deficiencies as reports through the monthly audit of the same 10 percent as measured in 2021. UNMET
- 67% of care partners questioned during environmental rounds will be able to speak correctly concerning actions to take when Facility Alert Hazardous Material Alert (formally known as Code Orange) occurs, this is an annual percentage rate. UNMET

2023 Goal(s):

- 70% of care partners questioned during environmental rounds will be able to speak correctly concerning actions to take when a Code Orange (hazardous spill/event) occurs

Emergency Management

2022 Goals

- Perform one Code Black drill at each of the off-site medical offices during calendar year 2022. UNMET This goal was not met but will be on the forefront of the agenda for 2023.
- Have the annual review with any revisions to the Comprehensive Emergency Management Plan prepared for review and delivery to the Brevard County Emergency Management office not later than July 31, 2022. MET This goal was completed on December 5, 2022. There was a delay in the approval from Brevard County due Hurricane Ian and Nicole.

2023 Goals

- Participate in full scale Hospital Medical Surge Exercise with CFDMC
- Expand on fire drill matrix and perform additional tabletop drills in departments not on Fire Matrix within the hospital. Focusing on the patient and care partners head counts, riley points, evacuation routes
- Perform (2) infant/child abduction, (1) hazardous spill, (1) mass casualty drill at main campus
- Perform Code Black drill at offsite buildings via tabletop exercise.
- Coordinating additional Decontamination training, optimally having 50 care partners training in the process. We currently have 32 trained

Life Safety

2022 Goals

- 100% of active Care partners will complete education on the revised fire procedures no later than July 15,2022. MET
- 60% (annual aggregate) of care partners questioned concerning the revised fire procedure will be able to speak correctly to same. MET

2023 Goals

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

- The hospital will achieve compliance with the fire drill program; this will include training on departmental responsibilities with respect to the Fire Response Plans. Training to be accomplished during new hire orientation, CBL and quarterly fire drills. Our goal for this task would be to test the knowledge of 5 care partners weekly during Environment of Care Rounds. This will be monitored and tracked via rosters and monthly monitoring through 12-31-2023.

Utilities Management

2022 Goals

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

2023 Goals

- Proper Storage of Full and Empty O2 (E) Cylinders. This will be checked during EOC Speed Rounds. The results will be monitored and documented through 12-31-2023.

- Increase Care Partner Knowledge of Med Gas valve box locations and shut down procedures during events.

Medical Equipment

2022 Goal(s)

Review 100% of all battery failures to determine: MET

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

2023 Goal(s)

65% compliance for IV pumps being plugged in to achieve

a. Pharmacy medication library be updated.
b. Staff has equipment readily available.
c. To reduce battery failure.

Worker Safety

2022 Goals

1. One Hundred percent (100%) of employees with musculoskeletal injuries during 2022 was referred to Rehabilitation for strengthening and training in proper movement and lifting skills. UNMET
2. There was a slight increase the number of injuries to care partners by percent (1.13%). The overall reported employee injuries during 2022 increased 6%.MET
3. There has been an increase in workplace violence which require a plan establish a threat assessment team. UNMET

2023 Goals

1. Continue to assure that all musculoskeletal injuries are referred to Rehabilitation for strengthening, training in proper movement and lifting.
2. Managing and supporting mental health at work should be maintainable and must play a huge part in an organization's key motivation of accomplishment.
3. During orientation we will train employees to recognize and report warning signs to prevent incidents of workplace violence through recognize warning signs, confidential reporting, no repercussions for reporting and de-escalation training.

EMERGENCY MANAGEMENT PLAN 2023

Leigh Spradling, Emergency Services Specialist

I. MISSION

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

II. PURPOSE

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

III. SCOPE

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

IV. RESPONSIBILITIES AND REPORTING STRUCTURE

- The PHC Hospital Board approves all the Comprehensive Management Plan (CEMP) elements based on regular reporting of emergency management activities by the Environment of Care Committee (EOCC).
- The leadership within the medical staff leadership would provide a physician as an active member of the Incident Command (IC) team.
- Medical Staff Leadership provides a physician leader as an active member of the Incident Command (IC) team who participates in planning activities as part of development, updating or revision of the Emergency Management Plan, including implementation of the plan and actively participating in drills and actual events as the CEMP requires.
- The PHC CEO receives and reviews reports of the CEMP drills and the actual implementation of the CEMP for an event. The PHC CEO works with the executive management team to determine needs and actions in support of the CEMP
- The EOCC Chairperson leads the EOCC activities relevant to emergency management and reports on drills and events pertinent to the CEMP to the CEO and hospital board.
- The EOCC, in conjunction with the PHC Safety Officer, develops, revises, and maintains the PHC CEMP assuring coordination with Brevard County's CEMP. Additionally, EOCC ensures available resources and assets to address the various events under the CEMP.
- The Safety Officer advises the EOCC regarding emergency management issues that affect PHC,

requiring supplies, personnel, orientation, and CEMP procedures.

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

V. PHC EMERGENCY MANAGEMENT PROCESSES and Plans

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

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

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

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

  Senior staff, as available, is assigned responsibilities using the EOP and ensuring critical tasks are completed based on the needs to help mitigate an appropriate response. Most care partners perform

their usual duties; however, in the emergency at hand, care partners may assume additional responsibilities or carry out other obligations based on organizational need and care partner competency.

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

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

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

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

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

- **Goals and Performance Management**
    - 2022 Goals and outcomes
        - Perform one Code Black drill at each of the off-site medical offices during calendar year 2022. This goal was not met but will be on the forefront of the agenda for 2023.
        - Have the annual review with any revisions to the Comprehensive Emergency Management Plan prepared for review and delivery to the Brevard County Emergency Management office not later than July 31, 2022. This goal was completed on December 5, 2022. There was a delay in the approval from Brevard County due Hurricane Ian and Nicole.
    - 2023 Goals
        - Participate in full scale Hospital Medical Surge Exercise in April with CFDMC
        - Expand on fire drill matrix and perform additional tabletop drills in every department within the hospital. Focusing on the patient and care partners head counts, riley points, evacuation routes
        - Perform infant/child abduction, hazardous spill, hostage situation drills at main campus
        - Perform Code Black drill at offsite buildings
        - Coordinating additional Decontamination training, optimally having 50 care partners training in the process

2023 Hazardous Materials Waste Management Plan

By

Taylor Ray, Director of EVS

December 29, 2022

I. SCOPE

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

II. MISSION

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

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

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

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

III. PLAN FUNDAMENTALS

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

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

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

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

E. In the event of a spill, release, or exposure of hazardous materials or waste, rapid effective

response helps to minimize injuries.

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

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

IV. PLAN OBJECTIVES

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

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

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

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

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

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

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

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

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

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

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

V. GOALS

A. 70% of care partners questioned during environmental rounds will be able to speak correctly concerning actions to take when a Code Orange (hazardous spill/event) occurs.

B. Reduce the number of hazardous waste disposal deficiencies by 5 percent as reported through the monthly audit of same.

VI. ORGANIZATION

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

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

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

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

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

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

VII. RISK MANAGEMENT PROCESSES

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

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

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

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

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

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

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

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

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

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

processing**. Trilogy** reusable sharps containers are utilized throughout PHC facilities. Detailed procedures are available in PHC's Biohazard Waste Management Plan which may be found on PHC's iCare page.

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

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

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

M. PHC's HMO develops emergency procedures for the Hazardous Materials and Waste Management Plan. PHC has spill procedures that determine when outside assistance is necessary. Minor (incidental) spills that can be cleaned up by trained Care Partners using PPE does not require outside agency response. Potential spills that requires spill kits are kept in each department. Spills that exceed the capability of the Care Partners to neutralize must be reported to the Safety & Security department at extension 6565. For large spills, dial "11", evacuate the spill area and ensure Code Orange is initiated. Titusville Fire Department (TPD) will take control upon site arrival, and initiate cleanup. When TFD has determined an area is safe, PHC's ES department will finish any remedial cleaning. PHC ES Care Partners are trained to recognize when spills are potentially not safe to handle, and will contact the ES manager, and the HMO. During off-shift times, PHC's AOC will determine spill documentation level necessary.

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

O. Federal regulation requires each hazardous waste shipment from PHC to be manifested. A manifest copy is retained at the time of hazardous waste removal, another copy travels

with the waste, and is returned to PHC ES department after disposal, cross-matched with the 1st copy. The DOT, EPA, and EOCC must be notified of manifests not returned within 120 days.

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

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

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

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

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

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

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

labels are removed or covered, the wastes are handled, as required.

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

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

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

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

IX. REFERENCES

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

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

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

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

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

The Joint Commission 2016 Hospital Accreditation Standards.(2016).

EC.02.02.01.p.EC-8,9

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

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

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

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

The National Fire protection Association.(2012)

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

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

LIFE SAFETY/FIRE SAFETY MANAGEMENT PLAN

2023

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

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

Parrish Medical Center, Parrish Healthcare, Parrish Medical Croup

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

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

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

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

GOALS & PERFORMANCE MANAGEMENT:

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

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

accomplished during new hire orientation, CBL and quarterly fire drills. Our goal for this task would be to test the knowledge of 5 care partners weekly during Environment of Care Rounds. This will be monitored and tracked via rosters and monthly monitoring through 12-31-2023.

Written Management Plan

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

Protecting Individuals and Property

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

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

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

Inspection, Testing, and Maintenance

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

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

Documentation of all maintenance, testing, and inspection includes:

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

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

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

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

Fire Response Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Staff training records are kept in the Human Resource Department.

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

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

Approval Required by EOC Committee

Date: ______________________________

____
Signature
EOC Committee Chairperson

MEDICAL EQUIPMENT MANAGEMENT PLAN

2023

MISSION STATEMENT

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

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

PURPOSE

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

SCOPE

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

Parrish Medical Center

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

OBJECTIVE

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

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

Clinical managers assess the skills and competency of their staff, and their knowledge of systems to report and evaluate information about problems, malfunctions, and user errors. Clinical Engineering reports user errors to department heads and summarizes statistics for the Safety Committee on quarterly reports to the Committee

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

ORGANIZATION & RESPONSIBILITY

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

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

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

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

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

PERFORMANCE ACTIVITIES

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

The performance measures for the Medical Equipment Program are:

- Electrical safety and preventive maintenance completion rate for high risk equipment.
- Electrical safety and preventive maintenance completion rate for non-high-risk equipment.
- ICU Plum 360 IV pumps will be plugged in to maintain battery. The numbers will be pulled mid week and averaged monthly.(Goal is greater than or equal to 60 %)
- Medical Equipment battery failure divided by total correctives for the month (Goal is less thatn or equal to 10%)

MANAGEMENT PLAN

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

PROCESSES FOR MANAGING MEDICAL EQUIPMENT RISKS

Selection & Acquisition

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

Medical Equipment Inventory

PHC maintains a written inventory of all medical equipment.

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

Identify High Risk Equipment

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

Maintenance strategies

PHC identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. These activities and

associated frequencies are in accordance with manufacturers' recommendations or with strategies of the alternative equipment maintenance (AEM) program. The strategies of the AEM program does not reduce the safety of equipment and is based on accepted standards of practice.

Maintaining, Inspecting, & Testing Frequencies

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

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

Qualified persons

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

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

Equipment in the Alternative equipment program

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

Safe Medical Devices Act

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

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

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

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

Emergency Procedures

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

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

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

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

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

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

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

Contacts for spare equipment or repair services.

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

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

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

Hazard Notices and Recalls

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

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

PROCESS FOR INSPECTING, TESTING, AND MAINTAINING MEDICAL EQUIPMENT

Testing medical equipment prior to initial use

The Clinical Engineering Department will test all medical equipment on the inventory before initial use. PHC Clinical Engineering Department performs safety, operational,

and functional checks. The inventory includes, equipment owned by the PHC, leased, and rented from vendors. The inspection, testing and maintenance documents are maintained in the Clinical Engineering Department for review. The Director of Clinical Engineering manages the program of planned inspection and maintenance.

Testing of High-Risk Equipment

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

Testing of non-High-Risk Medical Equipment

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

Testing of Sterilizers

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

Testing of Dialysis Equipment

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

Electrical Equipment in Patient Care Vicinity

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

Inspect, test and calibrate Nuclear Medicine Equipment Annually-

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

Quality Control of CT, MRI, and Nuclear Medicine

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

CT Radiation Dose Measurement

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

Performance Evaluation of CT

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

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

Performance Evaluation of MRI

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

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

Performance Evaluation of Nuclear Medicine

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

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

Testing of Image Acquisition Monitors

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

Defibrillators

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

Annual Evaluation

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

UTILITIES MANAGEMENT PLAN

2023

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

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

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

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

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

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

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

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

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

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

GOALS AND PERFORMANCE MANAGEMENT:

- Proper Storage of Full and Empty O2 (E) Cylinders. This will be checked during EOC Speed Rounds. The results will be monitored and documented through 12-31-2023.

- Increase Care Partner Knowledge of Med Gas valve box locations and shut down procedures during events.

ELEMENTS OF THIS PLAN INCLUDE:

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

Design and Installation

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

Inventory Inclusion

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

Utility Systems Maintenance

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

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

The following equipment is maintained on a predictive maintenance strategy:

- Electrical components – thermal scan

Hospital will achieve 100% completion rate for critical equipment.

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

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

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

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

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

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

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

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

Waterborne Pathogens

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

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

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

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

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

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

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

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

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

Airborne Contaminants

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

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

These areas include, but are not limited to:

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

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

Air exchanges in these areas are measured at least annually and pressure gradients in these areas are checked at intervals set by the EOC Committee. Pressure gradients in isolation rooms are checked at intervals set by the EOC Committee when there is an

isolation patient in the room. The building air balance and proper exchange ratios are maintained by a combination exhaust fan/damper control system. Operating rooms, Catheterization Labs, Special Procedure Rooms, Central Sterile Processing Endoscopy Procedure Rooms, and Sterile Storage are maintained at temperature and humidity ranges and are monitored at intervals set by the EOC Committees

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

Emergency Power Source

For facilities that were constructed, or had a change in occupancy type, or have undergone an electrical system upgrade since 1983, the hospital has a Type 1 or Type 3 essential electrical system in accordance with NFPA 99, 2012 edition. This essential electrical system must be divided into three branches, including the life safety branch, critical branch, and equipment branch. Both the life safety branch and the critical branch are kept independent of all other wiring and equipment, and they transfer within 10 seconds of electrical interruption. Each branch has at least one automatic transfer switch.

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

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

- Areas in which loss of power could result in patient harm, including intensive care, emergency rooms, operating rooms, recovery rooms, obstetrical delivery rooms, and nurseries
- Emergency lighting at emergency generator locations

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

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

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

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

Maintenance, Testing, and Inspection

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

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

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

Line Isolation Monitors (LIM)

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

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

Emergency Power Maintenance and Testing

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

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

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

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

At least every 36 months, each diesel-powered emergency generator is tested for a minimum of four continuous hours, with a dynamic or static load that is at least 30% of the nameplate rating, documenting the test results and completion dates. Tests for non-diesel-powered generators need only be conducted with available load. See NFPA 110-2010 for additional guidance.

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

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

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

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

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

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

- Flexible connectors
- Outlets

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

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

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

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

Pre-Construction Risk Assessment

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

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

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

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

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

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

Hospital Grade Receptacles

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

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

Power Strips and Extension Cords

Power strips in a patient care vicinity are only used for components of movable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL 1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363. Power strips are mounted

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

Reporting Process

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

Annual Evaluation

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

Orientation and Education

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

USERS

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

MAINTAINERS

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

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

Training records are kept in the Human Resources Department.

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

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

Approval Required by EOC Committee

Date:____________________________

____

Signature
EOC Committee Chairperson

WORKER SAFETY MANAGEMENT PLAN 2023

Amie Walker, Employee Health

I PURPOSE

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

II SCOPE

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

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

III FUNDAMENTALS

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

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

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

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

IV OBJECTIVES

A. Minimize safety hazards by conducting Safety Surveillance Inspections & Employee Mental Well-Being.

B. Assure worker safety through education, which includes but is not limited to: general safety topics covered at employee orientation, body mechanics, lifting techniques, safe patient handling with use of equipment, Standard Precautions for infection control and workplace violence prevention. Establish a threat assessment team to proactively assess and prevent potential workplace violence.

C. Improve worker safety based on organization experience, applicable laws and regulations, as well as accepted best practice. This includes monitoring the employee occupational health program and implementing a worker injury prevention, investigation program, and prevent of workplace violence.

V ORGANIZATION AND RESPONSIBILITY

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

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

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

VI PERFORMANCE MEASURE/MONITORING

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

1. In 2022, the following performance measures were conducted:
    a. One Hundred percent (100%) of employees with musculoskeletal injuries during 2022 was referred to Rehabilitation for strengthening and training in proper movement and lifting skills.
    b. There was a slight increase the number of injuries to care partners by percent (1.13%). The overall reported employee injuries during 2022 increased 6%.
    c. There has been an increase in workplace violence which require a plan establish a threat assessment team.

2. For 2023, the following performance measures will be undertaken:
    a. Continue to assure that all musculoskeletal injuries are referred to Rehabilitation for strengthening, training in proper movement and lifting.
    b. Managing and supporting mental health at work should be maintainable and must play a huge part in an organization's key motivation of accomplishment.
    c. During orientation we will train employees to recognize and report warning signs to prevent incidents of workplace violence through recognize warning signs,

confidential reporting, no repercussions for reporting and de-escalation training.

VII PROCESSES OF THE WORKER SAFETY MANANGMENT PLAN

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

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

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

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

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

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

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

Safety and Security Management Plan 2023

I. PURPOSE

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

II. SCOPE

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

X. PERFORMANCE MONITORING 2023

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

1. Care Partners knowledge and skill set when dealing with violent or aggressive encounters with confidence.
2. We will continue monitoring and inspecting sensitive areas, avoiding vulnerabilities, and reviewing and evaluating emergency and incident reports to determine the best-case practices.
3. Review and evaluate emergencies and incident reports to measure the frequency and severity of such events and develop best practice measures.

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

XI. PERFORMANCE INDICATORS 2023

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

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

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

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

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

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

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

XII. PERIMETER PROTECTION 2023

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

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

XIII. SENSITIVE AREAS 2023

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

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

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

XVIII. SECURITY OPERATION 2023

1. Through various forms of communications, the Safety and Security Manager is made aware of safety and security concerns regarding patients, visitors, care partners, and property brought to the Security Manager's attention. Security policies, security post instructions, and other procedures address specific patient, personnel, and property security. Safety and Security respond to all calls regarding eloped patients and proactively assist in the search. Safety and Security will advise the reporting party of the patient's whereabouts.

2. Once we find an elope patient, Safety and Security will require instructions from the nursing staff to determine the next step. Safety and Security will make a reasonable effort to encourage the patient to return to the unit.
3. If the eloped patient appears to have an altered mental status, Safety and Security will make every effort to maintain the patient within the areas. Still, they will require the approval of the Attending Doctor to bring the patient back to the floor physically.
4. Safety and Security have categorized incident reporting in three parts:
    a. ***<u>None Reportable Events</u>*:** Events that can be resolved immediately and do not potentially impact our daily operation (Example: Security discovered a cracked tile.
    b. ***<u>Reportable</u>*:** Events involve events that can disrupt our daily operation (Example: criminal events, environmental events, or events that threaten hospital safety and Security of hospital).
5. **RL Resource Solution:** Our in-house reporting system allows care partners to report violations, concerns, and issues that must be peer-reviewed and resolved. Risk Management conducts the reviews and provides instruction as to the next step.
6. **The CAD System**: the department's computer-aided dispatch software helps organize our investigative reports and provides variance reports and data that helps to identify areas of concern. The Safety and Security Manager, Security Supervisor, or Safety Officer reviews these reports and recommends appropriate action and follow-up.
7. **Identification Procedures**
    a. ***<u>Visitor Identification</u>*** -access to the hospital is controlled and monitored by the Safety and Security Department. A Visitor Pass is required and displayed at all times.
    b. ***<u>Care Partner Identification</u>* –** Care Partners, volunteers, and physicians are issued photo identification badges. These badges are displayed at all times while on duty or in restricted areas.
    c. ***<u>Patient Identification</u>*** - a wristband is fitted to the patient at admission, which helps identify patients.
    d. ***<u>Vendor Identification</u>* -** Vendors are required to sign in and are issued a vendor badge to be worn at all times while on hospital premises.
    e. ***<u>Contractor Identification</u>*** – All sub-contractors and workers are issued a PMC Identification Badge and are required to display them while on-premises. Unless they comply with our identification policy, service contractors who refuse to wear their badges appropriately cannot work within the premises.

2022 Goals:

- Ninety percent Ninety percent (90%) of all bags, purses, suitcases, duffels, etc. entering through the Main and ER entrances will have thorough bag checks done prior to entry into the building. This is accomplished through review of cameras at each location for a minimum of 4 bags/persons by each officer per month.
- Loading dock rounds will be completed every two (2) hours at a minimum of 90% (11 every 24 hours)
- Ninety percent (90%) of active care partners will receive education on de-escalation techniques by December 31, 2022

2023 Goals:

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

Status Pending PolicyStat ID 11899226

Origination	02/1980
Last Approved	N/A
Effective	Upon Approval
Last Revised	11/2022
Next Review	1 year after approval

Initiator	Natalie Sellers: Sr Vice President, Communications, Community & Cor
Areas	Administration
Applicability	Parrish Medical Center
Tags	9500

Administrative Services Coverage

COPY

I. PURPOSE

The purpose of this policy is to provide clarity for Administrative Services Coverage for North Brevard County Hospital District d/b/a Parrish Medical Center and its affiliates ("Parrish Healthcare") for twenty-four (24) hours a day, seven (7) days a week.

II. SCOPE

This policy applies to North Brevard County Hosital District d/b/a Parrish Medical Center and its affiliates ("Parrish Healthcare").

III. POLICY STATEMENT

There will be a representative of Administration on duty or on call twenty-four (24) hours a day, seven (7) days a week. The representatives will include members of the Executive Team as defined by the President/CEO.

The Administrative Office will generally be open from 8:00 am until 5:00 p.m., Monday through Friday. During other hours, one (1) of the Administrative representatives will be on call.

All Revision Dates

11/2022, 12/2018, 08/1993

Approval Signatures

Step Description	Approver	Date
Board of Directors	Robert Jordan: Board Member	Pending
President/CEO	George Mikitarian: President/ CEO [AJ]	02/2023
Executive Management Committee	Executive Management Committee [AJ]	02/2023
Policy Management	Policy Management [PP]	07/2022
	Natalie Sellers: Sr Vice President, Communications, Community & Cor	06/2022