2014

The Healthcare Environment

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The Joint Commission

The Joint Commission

Risk Icon

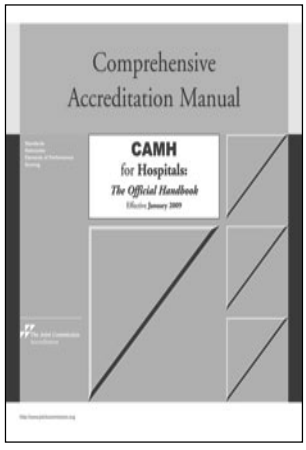
R

Risk
- Proximity to patient
- Probability of harm
- Severity of harm
- Number of patients at risk

- Integrated into the Manuals, E-dition, AMP, & FSA Tool
- All products will display a single icon at the EP level for three risk-focused categories:
  1. National Patient Safety Goals
  2. Accreditation program-specific risk area standards
  3. Selected direct/indirect impact standards
- In addition, the FSA Tool will use the R icon to identify the fourth risk category:
  4. RFI standards from current cycle survey events.

2013/2014 CHALLENGING STANDARDS

THE TOP 20 ISSUES



Standard/NPSG	2013 Non Compliance	2014 Non Compliance 1st 6 months
EC.02.05.01	47%	53% ⇧
LS.02.01.20	52%	52%
EC.02.06.01	39%	51% ⇧
EC.02.03.05	45%	50% ⇧
IC.02.02.01	46%	50% ⇧
LS.02.01.10	48%	49% ⇧
RC.01.01.01	52%	49% ⇩
LS.02.01.30	45%	46% ⇧
LS.02.01.35	36%	44% ⇧
EC.02.02.01	34%	36% ⇧

Standard/NPSG	2013 Non Compliance	2014 Non Compliance 1st 6 months
MM.03.01.01	35%	32% ⇩
PC.01.03.01	27%	29% ⇧
EC.02.05.09	22%	27% ⇧
PC.02.01.03	22%	27% ⇧
MM.04.01.01	22%	24% ⇧
PC.03.01.03	20%	24% ⇧
LD.01.03.01	19%	23% ⇧
LD.04.01.05	14%	22% ⇧
EC.02.05.07	23%	21% ⇩
MM.05.01.01	16%	20% ⇩

Top 10 Cited EC/LS Standards: 2011 – 2014 (YTD)

Standard	2014	2013	2012	2011
EC.02.05.01: Utility Systems Risks	#1	#4	#10	#13
LS.02.01.20: Means of Egress	#2	#1	#2	#2
EC.02.06.01: Built Environment	#3	#8	#7	#11
EC.02.03.05: Fire Safety Systems	#4	#7	#5	#5
LS.02.01.10: General Bldg Req's	#6	#3	#3	#3
LS.02.01.30: Protection	#8	#6	#6	#4
LS.02.01.35: Extinguishment	#9	#9	#9	#10
EC.02.02.01: HazMat & Waste	#10	#11	#11	#15

#1 EC.02.05.01 EP 6 53%

- Ventilation system is unable to provide appropriate pressure relationships, air-exchange rates and filtration efficiencies
  - Specific areas lack
    - negative or positive pressures in relationship to adjacent areas
      - i.e. Endoscopy Processing Room should be negative to the egress corridor
    - the correct number of air changes per hour
    - Improper filtration
      - MERV = minimum efficiency reporting value

What is Ventilation?

- Ventilation is moving air from one location to another
- Supply Air
  - Outside air is conditioned by cooling or heating as the air moves through a series of coils
    - To save energy in some systems the returned air is blended with outside air
  - Next the air is cleaned by filters and discharged into the occupied space
  - As the air moves through the building in ducts, the ducts pass through barriers (walls)
    - To protect the barrier dampers are in place

Ventilation

- Exhaust System
  - Removing the air from an occupied space is accomplished by the exhaust system
  - Exhausted air is either removed from the building or re-conditioned and re-used
  - As air is removed, it is replaced by supply air
    - This is how air exchanges occur
    - New air in, old air out

Screening

- Tissue test: only to be used as a pre-screening tool to evaluate if further investigation needs to occur
  - To perform the flutter test take a tissue and let it hang just off the floor near the bottom edge of a door
  - If the tissue indicates incorrect air flow, stabilize the area by closing doors and windows, wait a few minutes and re-test
  - If the organization presents a Testing & Balancing report the following questions should be asked
    - when was the balancing done (seasonal issues)
    - are any specific requirements (such as keeping a door closed) needed to achieve satisfactory results

Survey Process

- EC.02.05.01 EP 6 will generate a CLD
  - If the organization can repair the ***process*** that led to non-compliance the LSCS may review
  - Following LSCS review, the LSCS may contact the Central Office to discuss the ***possibility*** of reducing the CLD to SLD, with no change to the finding
  - Resolution should include the area affected by the equipment identified as non-compliant, not just the identified room/area
    - i.e. ensure zone is balanced
    - Is there an ongoing process to assess

#2 LS.02.01.20 EP 13 52%

- The hospital maintains the integrity of the means of egress
- Anything in the egress corridor more than 30 minutes is storage
- Dead end corridors may be used for storage
  - Less than or equal to 50sqft space
- Carts Allowed:
  - Crash Carts
  - Isolation Carts
  - Chemo Carts

"If the corridor looks cluttered…it probably is"

- Educate Staff
  - What is the Risk?
    - Patient movement
    - Staff movement
    - Additional Staff responding to emergency patient care

Suites

- Not identified on drawings
  - Boundaries
  - Dimensions
  - Exits

LS Drawing Information

- A legend that clearly identifies features of fire safety
- Areas of the building that are fully sprinklered (if the building is partially sprinklered)
- Locations of all hazardous storage areas
- Locations of all rated barriers
- Locations of all smoke barriers
- Suite boundaries, including the size of the identified suites—both sleeping (max 5,000 sq ft) and non-sleeping (max 10,000 sq ft)
- Locations of designated smoke compartments
- Locations of chutes and shafts
- Any approved equivalencies or waivers

#3 EC.02.06.01 EP 1 & 13 51%

- EP 1 Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment and services provided
  - The organization must provide a safe environment
    - Unsecured oxygen cylinders
    - Outdoor safety is scored at EC.02.01.01 EP 5

EC.02.06.01 EP 13

- EP 13 The organization maintains ventilation, temperature and humidity levels suitable for the care, treatment and services provided
  - Ventilation:
    - i.e. doors held open by air pressure; odors
  - Temperature:
    - Hot / Cold calls
  - Humidity
    - Primary concern is for areas >60%RH
      - Mold growth is possible
- EP 20 Patient care areas are clean and free of offensive odors

#4 EC.02.03.05 50%

- The hospital maintains fire safety equipment and fire safety building features.
  - Features of fire protection
    - Inventory required to ensure all devices are tested
    - Documentation of testing is required

Need for Inventory

- EC.02.03.05 EP 1 – 20:
  - Each device that is required to be tested must be documented in an inventory
    - If ***x*** devices were tested last year, and ***x-1*** were tested this year, which device was missed?
      - Each device must be on the inventory to identify which device was missed
      - Total number of devices (quantity) is not adequate
  - Lack of an inventory (written, electronic or other) results in a finding at the EP
    - Findings solely for lack of inventory is **not** scored at EC.02.03.05 EP 25

EC.02.03.05

EPs 1 -20:

- Missing documentation: score the EP as non-compliant
  - Also write a finding at EP 25 for *documentation not being readily available to the AHJ*
    - If acceptable documentation appears, finding at EP 1 – 20 might be removed during survey
    - EP 25 remains

- LD.04.01.05 EP 4: Staff held accountable
  - If 3 or more findings at EC.02.03.05 EP 1 – 20

EC.02.03.05

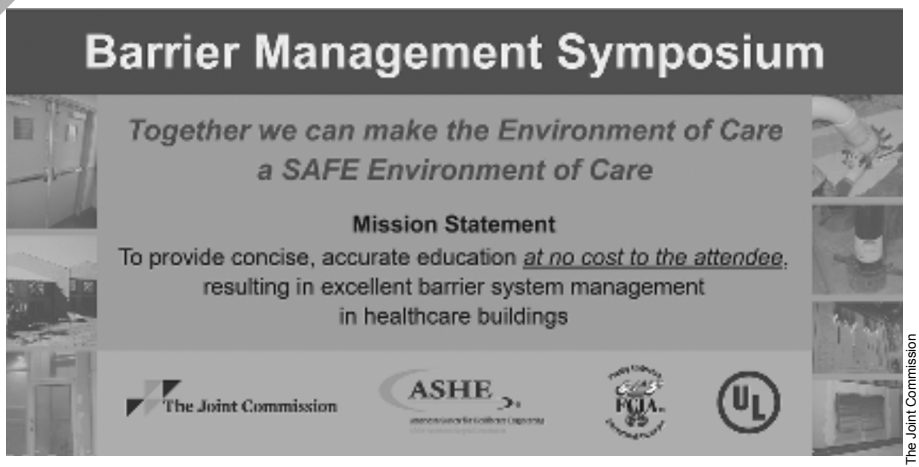
- During survey specific documentation is reviewed
- If the documentation for a specific EP is not available a finding is written as non-compliant for that EP
  - The documentation should be readily available
- If the organization clarifies after survey:
  - Joint Commission Engineers will review and evaluate compliance
  - LD.04.01.05 EP 4 remains

#6 LS.02.01.10 EP 5 – 7 & 9 49%

- Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.
  - EPs 5 – 7 Door issues
  - EP 9 Fire Barrier Penetrations
- Barrier Management

Barrier Management Symposium

. . .at no cost to the attendee . . .



Barrier Management Symposium

- Program Developers:
  - Joint Commission
  - Firestop Contractors International Association
  - Underwriters Laboratories
- Participating Organizations:
  - American Society for Healthcare Engineering
  - AWCI & Gypsum Institute
  - Fire Damper Industry
  - Fire Rated Glazing Industry
  - National Concrete Masonry Association

#8 LS.02.01.30

46%

- The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.
  - EP2 Hazardous Areas
    - Primarily door issues
  - EPs 16 – 23 Smoke Barriers & Doors

#9 LS.02.01.35 44%

- EP 4: Piping for the AASS is not used to support any other item
- EP 5: Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint
- EP 14: Meets all other *Life Safety Code* automatic extinguishing requirements related to NFPA 101-2000

LS.02.01.35, EP 14

- Missing escutcheons
- Ceiling tiles misplaced in rooms
- Blocked access to fire extinguishers
- Missing signage required in NFPA 13-1999
- Quick response sprinklers mixed with other types in patient sleeping smoke compartments

#10 EC.02.02.01 EP 3 – 5 36%

- EPs 3 – 5: Personal Protective Equipment and the process to manage hazardous materials and waste handling and exposures
- EPs 6 – 7: Hazardous energy sources
  - Escorts to Hot Lab based on organization policy
    - Perspectives, July 2012
  - Lead aprons

Eye Wash Station
Federal Requirements: OSHA

- Score Eye Wash issues at EC.02.02.01 EP 5
- Risk assess location / application based on OSHA recommendation to
  - reduce the risk of injury from contact with caustic and corrosive materials in areas such as
    - Power Plant
    - Lab
  - Placed so that the eyewash is within 10 seconds or 55 feet from where the corrosive chemicals is used
- Weekly flush until clear is required
- Annual inspection to ensure the system is fully functional
- Mixing valve recommended to achieve tepid
  - Risk assess potential exposure to determine if cold water only would be acceptable

In 1975, Steven Spielberg directed an epic film about a killer great white shark.

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#13 EC.02.05.09 EP 3 27%

- Medical Gas Systems
  - EP 1: Inspection Testing and Maintaining
  - EP 2: Test when modified, installed or repaired
  - EP 3: Obstructions
  - EP 3: Labeling
    - Contents of piping
    - Areas served
      - Accuracy

MEDICAL GAS SAFETY

- Score EC.02.03.01 EP 1 …fire risk
  - 12 'E' cylinders (<300ft_) per smoke compartment (22,500ft_) may be open to the egress corridor in a rack or appropriate holders
  - Between 300 and 3000ft_ must be stored in a room that is limited construction with doors that can be locked
  - "In use" verses "in storage"
    - Properly secured to a gurney is considered "in use"
    - Properly racked is "in storage"
    - *Empty* are NOT considered part of the 12 *in storage*
    - *Empty* and *full* must be stored (racked) separately

MEDICAL GAS SAFETY

- Score EC.02.06.01 EP 1 …unsafe condition
  - **Unsecured cylinders**
    - Laying on top a gurney mattress; leaning against the wall
    - Free standing
    - Comingling of full and empty cylinders
  - **Transfilling liquid oxygen**
    - Transfer of any gases from one cylinder to another in patient care areas of health care facilities is prohibited.
    - Transfilling of liquid oxygen only in an area that is:
      - mechanically ventilated
      - sprinklered
      - ceramic or concrete flooring
      - separated with at least 1 hour construction from any patient care areas

Medical Gas Safety

- 5 Key Steps to ensuring Medical Gas Safety
  - Make sure all medical gas cylinders are always secured.
  - Make sure full and partial or empty cylinders are physically separated to prevent staff confusion when retrieving a cylinder during an emergency.
  - Consider any open cylinders as “empty” and keep these cylinders physically separated from full cylinders.
  - Monitor and manage the amount of nonflammable medical gases stored in patient care areas
  - Make sure all repairs are completed by qualified staff
- See also December 2012 *Perspectives*

#18 LD.4.01.05 22%

- The hospital effectively manages its programs, services, sites, or departments
  - Problematic EP:
  - EP 4: Staff are held accountable for their responsibilities
    - Used when leadership has allowed non compliance to exist without correction
    - Sometimes used when situation is serious but does not warrant a "decision rule"

#19 EC.02.05.07 EP 6 21%

EPs 4 – 7

- Missed Generator & Automatic Transfer Switch (ATS) Tests
  - Exercise monthly
    - Each emergency generator must be tested with a load of at least 30% of nameplate
    - Each ATS must be tested
- Missed triennial 4 hour test

Dashboard

Standard	Status	Action Plan	Q1	Q2	Q3	Q4
EC.02.05.01	OR 1, 4 & 5	Upgrade AHU controls; update monitoring software		Start		
LS.02.01.20	OK					
EC.02.06.01	2E, 2W	Patient rooms cold: Begin trap program	Start			
EC.02.03.05	OK					
LS.02.01.10	OK					
LS.02.01.30	Problematic	Attend Barrier Mgmt Symposium	OK			
LS.02.01.35	3W; 4N	Train 3W & 4N staff regarding shelved storage		OK	OK	
EC.02.02.01	OK					
EC.02.05.09	OK					
EC.02.05.07	OK					

Equipment Management

Medical Equipment: EC.02.04.01, EC.02.04.03

Utility Systems: EC.02.05.01, EC.02.05.05

*APPLIES TO **HOSPITAL & CAH** PROGRAMS*

EC.02.05.01

Standard EC.02.05.01

The hospital manages risks associated with its utility systems.

EC.02.05.01 EP 1

The hospital designs and installs utility systems that meet patient care and operational needs. (See also EC.02.06.05, EP 1)

EC.02.05.01 EP 2

- The hospital maintains a written inventory of all operating components of utility systems or maintains a written inventory of selected operating components of utility systems based on risks for infection, occupant needs, and systems critical to patient care (including all life-support systems). The hospital evaluates new types of utility components before initial use to determine whether they should be included in the inventory. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital maintains a written inventory of all operating components of utility systems. (See also EC.02.05.05, EPs 1, 3-5)

Utility Systems & Operating Components

- Utility Systems are those systems that support the use and function of the physical environment, such as the
  - heating system
  - the cooling system
  - water distribution system

Utility Systems & Operating Components

- Utility Systems are those systems that support the use and function of the physical environment, such as the
  - heating system
  - the cooling system
  - water distribution system
- Components on the inventory would include the equipment that is performance-related and delivers a measurable outcome.
  - For example, the heating system may have the following components:
    - boiler, DA tank (de-aeration tank), feed water pumps, distribution (including circulation pumps, piping, and condensate return).
  - Support parts to the components, such as belts, filters and steam traps, might not need to be individually listed, although they would likely be part of a preventive maintenance program.
    - Support parts of components such as pumps and motors might also be considered sub-components and may or may not be reflected on the inventory, depending on the maintenance strategies used.

EC.02.05.01 EP 3

The hospital identifies high-risk operating components of utility systems on the inventory for which there is a risk of serious injury or death to a patient or staff member should the component fail.

Note: High-risk utility system components include life-support equipment.

EC.02.05.01 EP 4

The hospital identifies the activities and associated frequencies, in writing, for inspecting, testing and maintaining all operating components of utility systems on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance (AEM) program.

Note 1: The strategies of an AEM program must not reduce the safety of equipment and must be based on accepted standards of practice.

- An example of guidelines for physical plant equipment maintenance is the American Society for Healthcare Engineering (ASHE) book *Maintenance Management for Health Care Facilities*.

Note 2: For guidance on maintenance and testing activities for Essential Electric Systems (Type I), see NFPA 99, 1999 edition (Section 3-4.4).

EC.02.05.01 EP 5

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations:

- Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements
- New operating components with insufficient maintenance history to support the use of alternative maintenance strategies

EC.02.05.01 EP 5

- *Note: Maintenance history includes any of the following documented evidence:*
  - *Records provided by the hospital's contractors*
  - *Information made public by nationally recognized sources*
  - *Records of the hospital's experience over time*

*EC.02.**04**.01 EP 5*

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be ir accordance with manufacturers' recommendations:

- Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining 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

EC.02.05.01 EP 6

For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified individual(s) uses written criteria to support the determination whether it is safe to permit operating components of utility systems 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, including seriousness of and prevalence of harm
- Availability of alternative or back-up equipment in the event the equipment fails or malfunctions
- Incident history of identical or similar equipment
- Maintenance requirements of the equipment

For more information on defining staff qualifications, refer to Standard HR.01.02.01

EC.02.05.01 EP 7

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital identifies operating components of utility systems on its inventory that is included in an alternative equipment maintenance program.

EC.02.05.01 EP ~~8~~ 14

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

EC.02.05.01 EP ~~6~~ 15

In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies.

Note: Areas designed for control of airborne contaminants include spaces such as

- operating rooms
- special procedure rooms
- delivery rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis)
- patients in "protective environment" rooms (for example, those receiving bone marrow transplants), laboratories, pharmacies, and sterile supply rooms

EC.02.05.05 EP 1

The hospital tests utility system components on the inventory before initial use and after major repairs or upgrades. The completion date of the tests is documented. (See also EC.02.05.01, EP 2)

EC.02.05.05 EP 3

The hospital inspects, tests, and maintains the following: ~~life-support~~ High-risk utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2 and 4)

- Note: High-risk utility system components includes life-support utility system components.

EC.02.05.05 EP 4

- The hospital inspects, tests, and maintains the following: Infection control utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2 and 4)

EC.02.05.05 EP 5

The hospital inspects, tests, and maintains the following: ~~Non–life-support~~ Non-high-risk utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2 and 4)

Equipment Survey Process

Documentation is completed for High-risk, life support and non-life support devices on the inventory

- Accuracy of Inventory
  - All High-risk and Life Support equipment must be on the inventory and identified
  - Preventive maintenance frequencies must be clearly defined in writing
- Confirm work done as per scheduled activities
  - Ensure appropriate work is scheduled based on maintenance strategies
  - Evaluate equipment failure and scheduled actions

Survey Process: Staff Interviews

- Department Leader
  - Evaluate the qualifications of the leader
    - Review appropriate documentation
  - Evaluate how the inventory was created
  - If an alternative maintenance program is in use, evaluate the inclusion process
  - Evaluate the Monitoring processes
  - Evaluate the effectiveness of the program
    - What criteria is used to evaluate
    - Evaluate the Completion rate of maintenance activities

Survey Process: Staff Interviews

- Equipment Maintainers
  - Evaluate their understanding of the maintenance process/strategies
  - Evaluate staff knowledge related to the alternative maintenance program
  - Evaluate assignment of maintenance activities
  - Evaluate competencies based on repeat work orders
  - Evaluate work scheduled against completed

Survey Process: Staff Interview

- Users of the Equipment
  - Evaluate equipment reliability
  - Evaluate response time when equipment fails
    - Evaluate emergency response process
  - Evaluate "Culture of Safety"
    - Appropriate training of staff related to equipment use
  - Customer satisfaction with department
- Contract Services
  - Evaluate the process used to ensure contractors use qualified personnel
  - Evaluate reliability of equipment serviced
  - Evaluate integration of the process

Evaluating Program Effectiveness

- The equipment management programs must have written policies & procedures
- Evaluating the program:
  - How is equipment evaluated to ensure no degradation of performance?
    - Consider mis-calibration of equipment
    - Consider test equipment calibration confirmation
  - How are equipment-related incidents investigated?
    - Could the malfunction have been avoided?
    - Did the alternative maintenance strategy contribute to the malfunction?
    - How to sequester equipment deemed unsafe?

Evaluating Program Effectiveness: Miscellaneous Topics

- Survey should focus on High-risk equipment
  - Are appropriate operation manuals and maintenance schedules available?
- Verify the inspection, testing & maintaining activities and frequencies are documented
- Evaluate the various maintenance strategies used
  - Are they appropriate?
  - Are they effective?
  - Is the equipment reliable?

Relocatable Power Taps (RPTs)

- Healthcare Interpretation Task Force (12/2007) stated NFPA 70, NFPA 99 and NFPA 101 all have regulations that control the electrical components and equipment in a patient room. *It appears that it is the intent of these documents to restrict RPT use so that it is not used in conjunction with medical equipment*
- CMS:
  - "RPT's are not to be used with medical equipment in patient care areas.
    - This includes critical areas such as operating rooms, recovery areas, intensive care areas, and non-critical patient care areas such as patient rooms, diagnostic areas, exam areas, etc."

Relocatable Power Taps

- RPTs may be used in anesthetizing locations ***if*** they are part of the equipment assembly. See NFPA 99-1999 7-5.1.2.5(2)
- Ceiling drops are acceptable. See NFPA 99-1999 7-5.1.2.5(3)
- RPTs **may** be used for non-patient care equipment such as computers/monitors/printers, and in areas such as waiting rooms, offices, nurse stations, support areas, corridors, etc.
- Precautions needed if RPT's are used include:
  - ensuring they are never "daisy-chained"
  - preventing cords from becoming tripping hazards
  - installing internal ground fault and over-current protection devices
  - using power strips that are adequate for the number and types of devices used

EC.02.02.01 EP 18
Effective July 2, 2014

- **For hospitals that use Joint Commission for deemed status purposes:** Radiation workers are checked periodically, by use of exposure meters or badge tests, for the amount of radiation exposure

EC.02.02.01 EP 19
Effective July 2, 2014

- **For hospitals that use Joint Commission for deemed status purposes:** The hospital has procedures for the proper routine storage and prompt disposal of trash.

EC.02.03.03 EP 3

- When quarterly fire drills are required, at least 50% are unannounced. **Fire drills are held at unexpected times and under varying conditions.**

- Added: "Fire drills are held at unexpected times and under varying conditions."

EC.02.03.03 EP 4

EP 4 Staff who work in buildings where patients are housed or treated participate in drills according to the hospital's fire response plan.

Note: When drills are conducted between 9:00 p.m. and 6:00 a.m., the hospital may use alternative methods to notify staff instead of activating **audible alarms.**

- *Replaced "building's fire alarm system."*
- *See NFPA 101-2000, 19.7.1.2 "…a coded announcement shall be permitted to be used instead of audible alarms."*

2012 Life Safety Code
Update

The following are available with certain provisions based on CMS S&C 13-58-LSC

Background

- The Joint Commission provided CMS with a list of items, based on later editions of the Life Safety Code, that would immediately have a positive impact on all healthcare
- CMS acted on the Joint Commission recommendation in the form of a State & Certification letter (S&C 13-58-LSC)
  - *The action is a series of Categorical Waivers*

Process

If the organization decides to adopt these categorical waivers they must

1. Ensure full compliance with the appropriate code reference
2. Document the decision to adopt the categorical waiver
   - For Life Safety Code items annotate the "Additional Comments" Section in the Statement of Conditions™ Basic Building Information (BBI)
   - For Environment of Care items document by Minutes in discussion at the Environment of Care Committee (or equivalent)
3. Declare the decision at the beginning of any survey

See also November 2013 *Perspectives*

S&C 13-58-LSC

1. Openings in exit enclosures
2. Emergency generators and standby power systems
3. Doors, locking arrangements
4. Suites
5. Extinguishing requirements
6. Clean waste and patient record recycling containers
7. Medical gas alarms

Plus five: see S&C 12-21-LSC

1. Wheeled equipment in egress corridors
2. Fixed seating in egress
3. One alternative kitchen cooking arrangement
4. Direct vent gas fireplaces and solid fuel-burning fireplaces
5. Combustible decorations on walls, doors, and ceilings

96 Gallon Containers

- 18/19.7.5.1 which allow, under certain circumstances container used
  - solely for recycling clean waste or
  - patient records awaiting destruction
    - up to 96 gallons are not required to be stored in a room identified as hazardous storage.
- Soiled linen or trash receptacles shall not exceed 32 gallons and comply with 18/19.7.5.7.2

Modified S&C 12-21-LSC
Categorical Waiver Now Applies: Wheeled Equipment Expanded

- 18/19.2.3 Capacity of Means of Egress and more specifically the requirements at 18/19.2.3.4 which allow, under certain circumstances, projections into the means of egress corridor width for wheeled equipment including lifts and transport equipment
- Provided
  - 5ft clear corridor width is maintained
  - Fire plan addresses management of storage
  - Accommodates current "equipment in use" criteria

Modified S&C 12-21-LSC
Categorical Waiver Now Applies: Fixed Seating Allowed

- 18/19.2.3 Capacity of Means of Egress and more specifically the requirements at 18/19.2.3.4 which allow, under certain circumstances, projections into the means of egress corridor width for fixed furniture
- Provided
  - provided 6ft clear width
  - $\leq$ 50sqft with 10' between groupings
    - Groupings must be on same side of the egress corridor

Annual Load Bank Test Reduced 25% savings

- 18/19.2.9 Emergency Lighting, more specifically the requirements at 18/19.2.9.1 which refers to 7.9, which refers to NFPA 110-2010 which includes requirements for annual load bank tests as follows:
  - 30 minutes at 50% of nameplate, and
  - 60 minutes at 75% of nameplate
    - see NFPA 110-2010 8.4.2.3
- **Cost savings of 25%** based on reduction of two hour test by 25%

Water Flow Alarm Test Semi-Annually

- 18/19.3.5 Extinguishment Requirements, and more specifically the requirements at 9.7.5 Maintenance and Testing which refers to NFPA 25-2011. This edition of NFPA 25, the *Standard for the Inspection, Testing & Maintaining of Water-Based Fire Protection Systems* section 5.3.3.2 which requires the vane type pressure switch water flow alarm to be tested every six months;
- **Cost savings of 50%** when reducing a quarterly test to semiannual

PRA EC.02.06.05 EPs 2 & 3

Preconstruction Risk Assessment (PRA)

Construction or renovation in occupied healthcare facilities can result in environmental problems such as:

- Noise
- Vibration
- Creation or spread of contaminants
- Disruption of essential services
- Emergency Procedures
- Air quality

Interim Life Safety Measures

- Order of Standards (LS.01.02.01)
  - EP 1 & 2 regardless of ILSM policy
  - EP 3 must clearly define the ILSM policy including
    - AFS 10 Process
    - When to implement
    - What to do to protect occupants
    - Both construction related and non-compliance with the LSC
  - EPs 4 – 14 align with policy and implementation strategies

Statement of Conditions™

- Plan For Improvement Modifications
- Equivalency Process Modifications

The Joint Commission

Background

- Organizations conduct routine building inspections
  - During inspections deficiencies are discovered
  - Resolution of deficiencies occurs either
    - Immediately
    - Scheduled activity (i.e. corrective maintenance)
    - Scheduled activity (i.e. Plan For Improvement)

Background

- In 1995 the Joint Commission introduced the Statement of Conditions™ (SOC) *[electronic in 2006 – 2007]*
  - Basic Building Information
  - Plan For Improvement
- Plan For Improvement (PFI) are the documented observation of a deficiency with a Projected Completion Date
- Interim Life Safety Measures (ILSM) are an important part of the PFI process
  - ILSM ensures the building remains safe for occupants as interim measures are implemented

PFI: A Proactive Process

- When a Life Safety Code deficiency is found during survey it results in a survey action:
  - If the organization has a PFI already identifying the deficiency, the finding (RFI) is not written
    - All open PFIs will be imported into the final survey report
    - No ESC required as the PFI has the Projected Completion Date already identified
  - If the organization does not have a PFI identifying the deficiency, then a finding is written as a RFI

PLAN FOR IMPROVEMENT

IMPORTED INTO THE FULL SURVEY REPORT

Exit Final Report
Equivalency & PFI Summary Page

Equivalencies/Plan for Improvement - Summary

Equivalencies are only granted if the identified Life Safety Code deficiency is off-set by alternative "systems, methods, or devices or equivalent or superior quality, strength, fire resistance, effectiveness, durability, and safety" over those prescribed by Life Safety Code (LSC). If an equivalency has been granted, the surveyor will incorporate a review of the equivalency conditions into the building tour.

During survey your existing approved Equivalencies were evaluated and found to be non-compliant. An RFI was created and your organization will need to either correct the deficiency or re-submit an updated Equivalency to the Joint Commission Central Office.

The following Plan For Improvement (PFI) items were extracted from the organizations Statement of Conditions™ (SOC) and represent all open PFIs during this survey. The number of open PFIs does not impact the organizations accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 2

A full description of your organization's locked PFIs can be found within the Statement of Conditions on your organization's Joint Commission Connect Extranet and will be included in the final report which will be posted to your organization's extranet site.

Onsite Report: Equivalency / PFI Summary

- If the equivalency is acceptable, the Onsite Report will state:

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Equivalencies/Plan for Improvement - Summary

Equivalencies are only granted if the identified Life Safety Code deficiency is off-set by alternative "systems, methods, or devices of equivalent or superior quality, strength, fire resistance, effectiveness, durability, and safety" over those prescribed by Life Safety Code (LSC). If an equivalency has been granted, the surveyor will incorporate a review of the equivalency conditions into the building tour.

During survey your existing, approved Equivalencies were evaluated and affirmed consistent with what was submitted previously. It was confirmed that corrective actions may present an ongoing hardship but conditions remain safe for patients, staff and visitors.

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 1

Onsite Report: Equivalency / PFI Summary

- If the equivalency is not acceptable, the Onsite Report will state:

The Joint Commission

Equivalencies/Plan for Improvement - Summary

Equivalencies are only granted if the identified Life Safety Code deficiency is off-set by alternative "systems, methods, or devices of equivalent or superior quality, strength, fire resistance, effectiveness, durability, and safety" over those prescribed by Life Safety Code (LSC). If an equivalency has been granted, the surveyor will incorporate a review of the equivalency conditions into the building tour.

During survey your existing approved Equivalencies were evaluated and found to be non-compliant. An observation(s) was documented and is contained within this report.

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 0

OPPORTUNITIES FOR IMPROVEMENT (OFI)

New Report Contents

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Summary of Findings portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

New page describing the 3 sections of the report

Equivalencies/Plan for Improvement

Equivalencies are only granted if the identified Life Safety Code deficiency is off-set by alternative "systems, methods, or devices or equivalent or superior quality, strength, fire resistance, effectiveness, durability, and safety" over those prescribed by Life Safety Code (LSC). If an equivalency has been granted, the surveyor will incorporate a review of the equivalency conditions into the building tour.

The Plan For Improvement (PFI) items were extracted from the organizations Statement of Conditions™ (SOC) and represent all open PFIs during this survey. The number of open PFIs does not impact the organizations accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

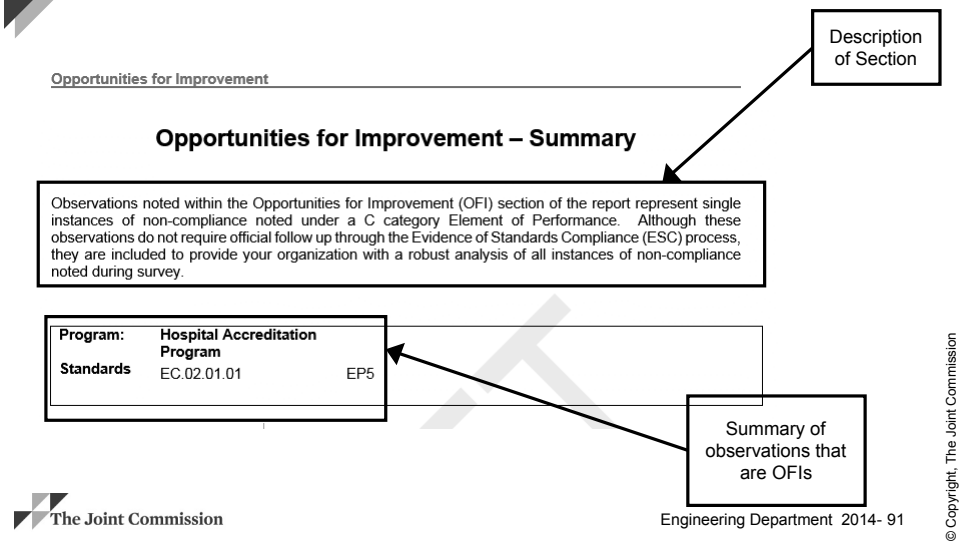
Opportunities for Improvement

- Description for this new section:
  - Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

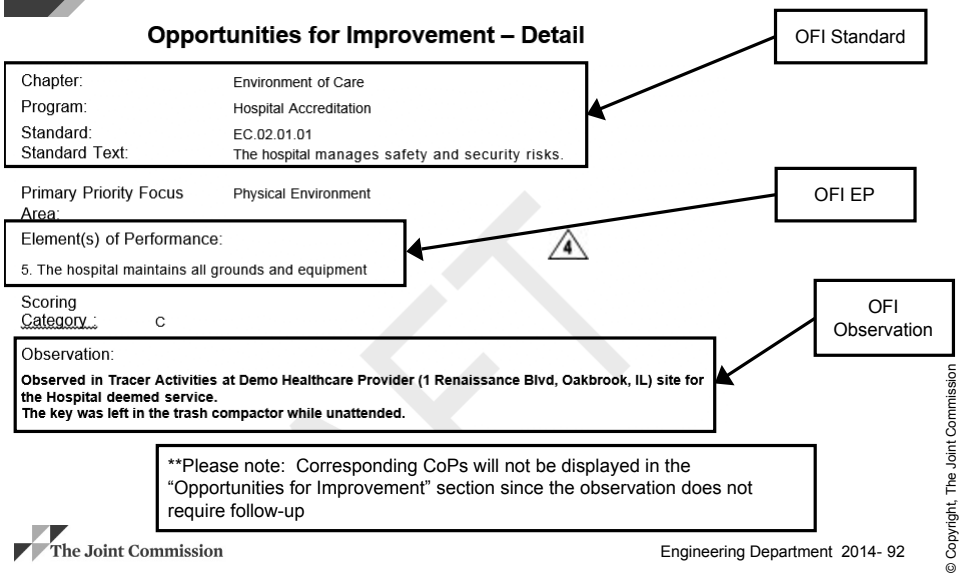
New Report Contents

- Single observations at C category EPs will be included in a separate section of the accreditation report
- The new section will be titled “Opportunities for Improvement” (OFIs)
- OFIs will not require an Evidence of Standards Compliance (ESC).
- Organizations will not be able to use the clarification process on OFIs.

Report Screenshots



Report Screenshots



One more change:
Bolding the Observation Text

Chapter: Environment of Care
Program: Hospital Accreditation

Standard: EC.02.02.01 ESC 45 days
Standard Text: The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance:

6. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of radioactive materials. 3

Scoring
Category : A
Score : Insufficient Compliance

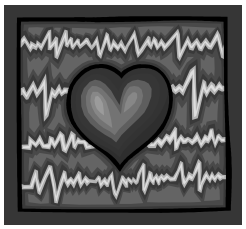
Observation(s):

EP 6
§482.53(b) - (A-1035) - §482.53(b) Standard: Delivery of Service

Radioactive materials must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice.
This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at Demo Healthcare Provider (1 Renaissance Blvd, Oakbrook, IL) site for the Hospital deemed service.
During a tour of the Radiation Therapy department of the Cancer Center, the Hot Lab door was found unsecured. The Hot Lab was identified in the Hospital Security Plan as a risk area.

Based on feedback from organizations we are now bolding the observation text to make this text easier to find during closing conferences



CLINICAL ALARM SAFETY

The Alarming Problem

- More and more devices and alarms
- More patients connected to alarms or alarm-based devices
- 150-400+ alarms per patient per day in a typical critical care unit
- Alarm-based devices are not standardized in many organizations
- Inconsistent use of alarms due to flexible alarm setting features

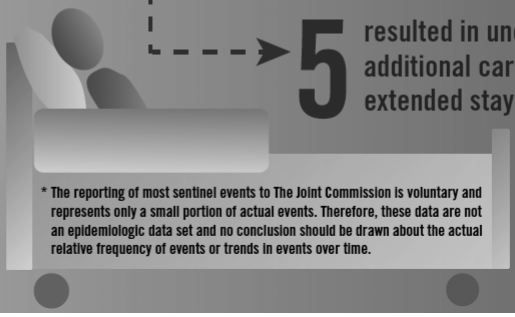
Joint Commission Sentinel Event database

from June 2009-June 2012,

98 alarm related events reported* → **80** resulted in death

→ **13** resulted in permanent loss of function

→ **5** resulted in unexpected additional care or extended stay



* The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small portion of actual events. Therefore, these data are not an epidemiologic data set and no conclusion should be drawn about the actual relative frequency of events or trends in events over time.

Alarm Fatigue

Clinicians become desensitized, overwhelmed or immune to the sound of an alarm.

Fatigued clinicians may:

- Turn down alarm volume
- Turn off alarm
- Adjust alarm settings

These actions can have serious or fatal consequences.

PSG on Alarm Mgmt

- **In Phase I (beginning January 2014)**

Hospitals will be required to:

- (by 7/14) establish alarms as an organization priority
- (during 2014) identify the most important alarms to manage based on their own internal situations.
  - Input from medical staff and clinical depts
  - Risk to patients due to lack of response, malfunction
  - Are specific alarms needed or contributing to noise/fatigue
  - Potential for patient harm based on internal incident history
  - Published best practices/guidelines

NPSG on Alarm Mgmt

- **In Phase II (as of January 2016)**

Hospitals will be expected to:

- develop and implement specific components of policies and procedures that address at minimum:
  - Clinically appropriate settings
  - When they can be disabled
  - When parameters can be changed
  - Who can set and who can change parameters and who can set to “off”
  - Monitoring and response expectations
  - Checking individual alarm signals for accurate settings, proper operation and detectability
- educate those in the organization about alarm system management for which they are responsible

Questions to Consider

- Have you identified clinical alarm safety as a priority?
- Who is on the team addressing the NPSG?
- How far along are you in identifying the most important alarm signals to manage?
- What is your biggest challenge?
- Remember that the entire goal must be fully implemented by January of 2016!

REVISED REQUIREMENTS FOR DIAGNOSTIC IMAGING

Diagnostic Imaging

- Can be found on www.jointcommission.org prepublication standards section
- The new EPs can be found in the following chapters:
  - EC.02.04.01; EC.02.06.05; HR.01.02.05; HR.01.05.03
  - MM.06.01.01
  - PC.01.02.15; PC.01.03.01
  - PI.01.01.01; PI.02.01.01

Questions?

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