<table>
<thead>
<tr>
<th>Standard/NPSG</th>
<th>2012 Non Compliance</th>
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</tr>
<tr>
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<td>19%</td>
<td>18%</td>
</tr>
</tbody>
</table>
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 50 sqft space.

Carts Allowed:
- Crash Carts
- Isolation Carts
- Chemo Carts
“IF THE CORRIDOR LOOKS CLUTTERED...IT PROBABLY IS”

Education Staff

What is the Risk?
- Patient movement
- Staff movement
- Additional Staff responding to emergency patient care
#4 EC.02.05.01 EP 6

- 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
VENTILATION

Based on how much air is exhausted and how much air is supplied, the area is either negative, neutral or positive

- More air out, negative pressure
- Same air in and out, neutral
- More air in, positive pressure

Normally the cleanest location should be more positive, and the least clean the most negative
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
**HLD Self Contained Units (i.e. GUS)**

High Level Disinfection (HLD) for semi-critical devices are found in and outside the Central Sterile areas

- Glutaraldehyde User Stations (GUS) disinfection soak stations, or similar self-contained HLD units such as those using 0.55% ortho-phthalaldehyde (OPA)

The Joint Commission will focus on the processes and Personal Protective Equipment (PPE)

- Many of the chemical disinfectants are potentially toxic and may require adequate precautions, including face/eye shields and gloves

Ventilation Requirements: None. Rooms must meet specific room requirements however

- Storage: in a manner that will protect from contamination or damage, such as hanging in a cabinet with doors
NOTE: THIS JUST IN

ASHRAE voted in July 2013 to move endoscopy procedure rooms from positive to N/A. FGI is planning on releasing this in the November publication of the 2014 FGI Guidelines.

Therefore, if an organization had made a documented decision based on risk assessment to no longer monitor endoscopy procedure rooms as per the 2013 ASHRAE action, we would accept this.

If the organization has not made a documented decision, the room should be evaluated as per the below table and construction date.

No change to bronchoscopy procedure rooms.
# Guidelines Ventilation Table: Endoscopy & Bronchoscopy

<table>
<thead>
<tr>
<th>Edition</th>
<th>Procedure</th>
<th>Processing (Cleaning)</th>
<th>Procedure</th>
<th>Pressure</th>
<th>Direct Exhaust</th>
<th>Pressure</th>
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</tr>
</tbody>
</table>
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

Together we can make the Environment of Care a SAFE Environment of Care

Mission Statement
To provide concise, accurate education at no cost to the attendee, resulting in excellent barrier system management in healthcare buildings
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
#6  EC.02.03.05

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

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
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
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
EP 9: There are 18” or more of open space maintained below the sprinkler deflector to the top of storage.

NOTE: Perimeter wall and stack shelving may NFPA 13-1999, 5-6.6
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
#11 EC.02.02.01 EP 3 – 5

EP’s 3 – 5: Personal Protective Equipment and the process to manage hazardous materials and waste handling and exposures

EP’s 6 – 7: Hazardous energy sources
- Escorts to Hot Lab based on organization policy
  - Perspectives, July 2012
Eyewash 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
Eye Wash Station: Recommended Locations (I.E. OSHA)

Medical services and first aid 1910.151(c)
The eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use.

Formaldehyde 1910.1048(i)(3)
If there is any possibility that an employee's eyes may be splashed with solutions containing 0.1 percent or greater formaldehyde, the employer shall provide acceptable eyewash facilities within the immediate work area for emergency use.

Battery charging and changing 1917.157(i)
Facilities for flushing the eyes, body and work area with water shall be provided wherever electrolyte is handled, except that this requirement does not apply when employees are only checking battery electrolyte levels or adding water.
Controlled, low velocity flow completely rinses eyes and face and is not injurious to user. (Section 6.1.1)

Unit must deliver at least 3.0 gallons (11.4 liters) of water per minute for 15 minutes. (Section 6.1.6, 6.4.5)

Outlet heads shall be positioned between 33" (83.8 cm) and 45" (114.3 cm) from the floor and at least 6" (15.3 cm) from the wall or nearest obstruction. (Section 6.4.4)

Protect spray heads from airborne contaminants. (Section 6.1.3)

Valve actuator shall be easy to locate and readily accessible to user. (Section 6.2)

“Hands-free” stay-open valve shall activate in one second or less. (Section 6.1.4, 6.2)

Connect unit to uninterruptible water supply delivering at least 3.0 GPM. (Section 6.4.5)

Identification
Identify eye/face wash with highly visible sign. Area around eye/face wash shall be well lighted. (Section 6.4.3)

Location
Install eye/face wash unit within 10 seconds of hazard, on the same level as hazard and with unobstructed travel path. (Section 6.4.2)

Water Temperature
Water delivered by eye/face wash shall be tepid (lukewarm). (Section 6.4.6)

Training
Instruct all employees in the location and proper use of eye/face washes. (Section 6.5.4)

Maintenance/Inspection
Activate eye/face wash at least weekly. (Section 6.5.2) Inspect annually for compliance with standard. (Section 6.5.5)
Missed Generator & Automatic Transfer Switch (ATS) Tests

- 12 times per year between 20 & 40 days
  - 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
#15 EC.02.05.09 EP 3

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
Fire Safety (EP 1)
- Open junction boxes
- More than 300 cuft of nonflammable medical gases (i.e. oxygen) per smoke compartment, open to the egress corridor

Fire Plan (EP 9 & 10)
- Lack of fire safety training as per fire plan
  - Surgical site fires
2012 Life Safety Code Update

The following are available with certain provisions. These are 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.

  - The action is a series of Categorical Waivers.
BACKGROUND

CMS first issued a *Categorical Waiver* in S&C 13-25-LSC & ASC to align with the 2010 FGI *Guidelines for Design & Construction of Health Care Facilities* use of ASHRAE 170-2008

- Reduced the relative humidity (RH) in certain areas to a range of 20 – 60%
- This 2013 CMS action matched the Joint Commission’s 1/2011 adoption of the 2010 Guidelines and the 20 – 60% RH range provided

The S&C had two criteria

1. Document the decision
2. Declare at the beginning of a survey the decision
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
18/19.2.1 which allow, under certain circumstances, existing openings to exit enclosures to mechanical room spaces as provided at section 7.1.3.2 Exits and more specifically the requirements at 7.1.3.2(9)(c)
EXISTING OPENINGS TO MECHANICAL SPACES

18/19.2.1 requires compliance with Chapter 7, including Section 7.1.3.2.1(9)(c):

- (c) Existing openings to mechanical equipment spaces protected by approved existing fire protection–rated door assemblies shall be permitted, provided that the following criteria are met:
  - The space is used solely for non-fuel-fired mechanical equipment.
  - The space contains no storage of combustible materials.
  - The building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.
18/19.2.5.7 SUITES

- 18/19.2.5.7.2.1(B) which allow, under certain circumstances, one of the exit access doors in a sleeping suite be permitted to be directly to an exit stair, exit passageway or exit to the exterior;

- 18/19.2.5.7.3.1(B) which allow, under certain circumstances, one of the exit access doors in a non-sleeping suite be permitted to be directly to an exit stair, exit passageway or exit to the exterior;

- 18/19.2.5.7.1.2 which allow, under certain circumstances, suites to be separated by corridor wall requirements;
MEANS OF EGRESS 18/19.2.2.2

- 18/19.2.2.2.4 which allow, under certain circumstances, more than one delayed egress in the egress path
- 18/19.2.2.2.6 which allow, under certain circumstances, remote control of locks for the rapid removal of occupants
MEANS OF EGRESS 18/19.2.2.2

18/19.2.2.2.5.1 which allow, under certain circumstances, door locking arrangements where clinical needs of patients require specialized security measures or where patients pose a security threat.

18/19.2.2.2.5.2 which allow, under certain circumstances, door locking arrangements based on the patient special needs requiring specialized security measures for their safety.
Suites

18/19.2.5.7.2.3(B) and 18/19.2.5.7.2.3(C) which allow, under certain circumstances, patient sleeping suites up to 10,000 square feet.

18/19.2.5.7.2.2(C) which allow, under certain circumstances, one of the two required exits in a sleeping suite to exit into another suite.

18/19.2.5.7.3.2(C) which allow, under certain circumstances, one of the two required exits in a non-sleeping suite to exit into another suite;
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 not be stored in a room identified as hazardous storage.

- Soiled linen or trash receptacles shall not exceed 32 gallons and comply with 18/19.7.5.7.1
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

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
  - ≤ 50sqft with 10’ between groupings
    - Groupings must be on same side of the egress corridor
MODIFIED S&C 12-21-LSC

CATEGORICAL WAIVER NOW APPLIES:
CORRIDOR COOKING ALLOWED

18/19.3.2.5 Cooking Facilities, more specifically the requirements at 18/19.3.2.5.2 - 18/19.3.2.5.5 which allow certain types of alternative kitchen cooking arrangements

- One cooking area may be open to the egress corridor per smoke compartment
  - Any additional cooking areas must be in protected room similar to hazardous areas

- Provisions:
  - No deep fat fryers
  - Safety equipment to de-activate fuel supply
  - Grease baffles installed
  - No solid fuel (i.e. charcoal)
MODIFIED S&C 12-21-LSC
CATEGORICAL WAIVER NOW APPLIES:
FIREPLACES PLACEMENT MODIFIED

18/19.5.2 Heating, Ventilating, and Air Conditioning more specifically the requirements at 18/19.5.2.3(2), (3) and (4) which allow

- the installation of direct vent gas fireplaces in smoke compartments containing patient sleeping rooms and
- the installation of solid fuel burning fireplaces in areas other than patient sleeping areas
MODIFIED S&C 12-21-LSC

CATEGORICAL WAIVER NOW APPLIES:
COMBUSTIBLE DECORATIONS ADJUSTED

18/19.7.5 Furnishings, Mattresses, and Decorations including sections 18/19.7.5.6 which allow the installation of combustible decorations on walls, doors and ceilings.

1. On non-fire rated doors and do not interfere with latching or area limits at 18/19.7.5.6(b), (c), (d)

2. ≤ 20% of wall, ceiling and door, inside a room or space of a smoke compartment that is not protected throughout with approved automatic sprinkler system
MODIFIED S&C 12-21-LSC
CATEGORICAL WAIVER NOW APPLIES:
COMBUSTIBLE DECORATIONS ADJUSTED

Continued:

3. ≤ 30% of wall, ceiling and door inside a room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system

4. ≤ 50% of wall, ceiling and door, inside a patient sleeping room with capacity of ≤ 4 persons in a smoke compartment that is protected throughout with approved, supervised automatic sprinkler system
101-2012 Section 2.2 refers to the 2012 edition of the Health Care Facilities Code, and more specifically 5.1.9.2.2 which allows a centralized computer system to be permitted to be substituted for one of the medical gas master alarms required at 5.1.9.2.1 if the computer system complies with 5.1.9.4.
ANNUAL LOAD BANK TEST REDUCED
25% SAVINGS

18/19.2.9 Emergency Lighting, more specifically the requirements at 8/19.2.9.1 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%
WEEKLY CHURN NOW MONTHLY: ELECTRIC MOTOR DRIVEN FIRE PUMP

LSC sections 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 8.3.1.2. which requires the electric motor driven fire pump exercise to be monthly;

Cost savings of reducing a weekly test to monthly is a 77% cost savings
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
CMS ISSUE

- Joint Commission met with CMS and discussed manufacturers’ recommendations, Life Safety Code adoption and other issues
  - CMS has indicated that The Joint Commission may continue to use their current process for equipment and utilities management
    - State agents will not be so instructed
- ASHE & AAMI met with CMS to continue to discuss the concerns related to equipment management
  - Responded by clarifying several issues
CMS Issues

- January 2011 the Joint Commission adopted the 2010 FGI Guidelines for Design & Construction of Health Care Facilities
  - Included in the Guidelines is the ASHRAE 170-2008 document with >20% RH lower limit

- April 2013 CMS Issued S&C-13-25-LSC & ASC which is “a categorical LSC waiver permitting new and existing ventilation systems to operate with a RH of >20 percent, instead of >35 percent...”
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
2013

THE HEALTHCARE ENVIRONMENT

STATEMENT OF CONDITIONS™
UPDATE

George Mills, Director
Engineering Department
The Joint Commission
The Statement of Conditions has received an update.

- Most of the update was to the operating system and updating the appearance of the site
- There are no significant functional changes to the program that affect how the organization uses the SOC

Management of the Statement of Conditions™ is required for Hospitals, Critical Access Hospitals, Behavioral Health Care, and Ambulatory Health Care (not business) (LS.01.01.01)
ILSM ASSESSMENT: Y/N

For NEW PFIS:

- ILSM Assessment Y/N
  - This must be answered as either Yes or No
    - Yes indicates that the organization assessed based on the ILSM policy
    - No indicates that the organization has not assessed based on the organization ILSM policy
  - The View All screen has a column that identifies this decision.
For existing PFIs (prior to the update)

For all open PFIs during the update on 7/15/2013 the default in the PFI Deficiency screen is UNKNOWN for ILSM Assessment.

For all open PFIs during the update on 7/15/2013 the default in the View All screen for ILSM Assessment is N.
UNKNOWN & N INDICATORS

During survey the surveyor will review the PFI status by reviewing the View All screen

- If the PFI required ILSM implementation and the View All screen indicates N
  - the surveyor will open the PFI
  - if seeing UNKNOWN the surveyor may ask for ILSM status of the PFI
    - UNKNOWN indicates a default setting associated with the one-time update

7/15/2013
Another feature is a management tool which displays PFI status in a pie chart.

Filter by:
- One Building
- All Buildings
- Open
- Closed
- All PFIs
## Entering the Statement of Conditions™

### Sites and Buildings

**Sites and Buildings for this HCO**

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<thead>
<tr>
<th>Site</th>
<th>SiteID</th>
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<tbody>
<tr>
<td>LD new hospital clinic site</td>
<td>524699</td>
<td>NEW STREET ADDRESS</td>
<td>Hialeah, FL</td>
</tr>
<tr>
<td>Site</td>
<td>SiteID</td>
<td>Address</td>
<td>City/State</td>
</tr>
<tr>
<td>TEST @^ - Site name changed</td>
<td>342473</td>
<td>23 Royal Blvd.</td>
<td>Hialeah, FL</td>
</tr>
<tr>
<td>Site</td>
<td>SiteID</td>
<td>Address</td>
<td>City/State</td>
</tr>
<tr>
<td>Test 73 - Hospital site name</td>
<td>342457</td>
<td>25 Center Street</td>
<td>Hialeah, FL</td>
</tr>
</tbody>
</table>

**Building**

<table>
<thead>
<tr>
<th>Building</th>
<th>BuildingID</th>
<th>Primary Occup. Type</th>
<th>% Sqr. Ft.</th>
<th>% Renovated</th>
<th>Sqr. Ft. Range</th>
<th>Beds</th>
<th>Sprinkled</th>
<th>Gov. Env. Susp</th>
<th># open PFI</th>
<th>Delete?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main HAP</td>
<td>4632</td>
<td>HAP - LTC</td>
<td>100</td>
<td>less than 5K</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SBI/SCI

- BBI
- PFI

### Connect™ / SOC

Statement of Conditions
### Basic Building Information (BBI)

**Building Information [Hospital]**

- **Test 73 - Hospital site name revised has CERT 25 Center Street Hialeah FL**
- **Main_HAP 934 Center Street Elgin IL**
- **Primary Occupancy: Hospital or LTC**
- **Total Square Footage: less than 5K**

**Patients**

- **Total Licensed Beds**: 350
- **Total Monitored Critical Care beds (OR, ER, ICU, PACU, Telemetry)**: 65
- **Total OR Rooms**: 15

**Building construction Type**

- [Click here to see constructionType](#)

**Building Size and Type**

- **Total Stories or levels occupied by the organization that are classified for healthcare delivery**
  - 1
  - 2
  - 4
  - 5

- New Healthcare Construction (18.1.6.2)
- Existing Healthcare Construction (19.1.6.2)

Is there more than one building construction type present in this building, or is the building construction type one homogenous type throughout

- One building construction type throughout
- More than one building construction type used in adjacent buildings or other years of construction

### Pop-up box for each type (New and Existing):

#### New Healthcare Construction (18.1.6.2)

<table>
<thead>
<tr>
<th>Construction Type</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4 or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>I(443)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>I(332)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>I(222)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>I(111)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>NP</td>
</tr>
<tr>
<td>II(000)</td>
<td>X</td>
<td>NP</td>
<td>NP</td>
<td>NP</td>
</tr>
<tr>
<td>III(211)</td>
<td>X</td>
<td>NP</td>
<td>NP</td>
<td>NP</td>
</tr>
<tr>
<td>III(200)</td>
<td>NP</td>
<td>NP</td>
<td>NP</td>
<td>NP</td>
</tr>
<tr>
<td>IV(211)</td>
<td>X</td>
<td>NP</td>
<td>NP</td>
<td>NP</td>
</tr>
<tr>
<td>V(111)</td>
<td>X</td>
<td>NP</td>
<td>NP</td>
<td>NP</td>
</tr>
<tr>
<td>V(000)</td>
<td>NP</td>
<td>NP</td>
<td>NP</td>
<td>NP</td>
</tr>
</tbody>
</table>

X: Permitted type of construction.
NP: Not permitted.

#### Existing Healthcare Construction (19.1.6.2)

<table>
<thead>
<tr>
<th>Construction Type</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4 or More</th>
</tr>
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<tbody>
<tr>
<td>I(443)</td>
<td>X</td>
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<td>X</td>
</tr>
<tr>
<td>I(332)</td>
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<td>X</td>
</tr>
<tr>
<td>I(222)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
PFI View All Screen
MANAGEMENT
HISTORY AUDIT TRAIL

PFI History

PFI Reports:

Report Version: 3
Create Date: 7/17/2013 11:37:13 AM
Created By: George Mills
Comments: Survey Event Surveyor comments related to survey may appear here, as well as an indicator that the survey occurred with the date.

Report Version: 2
Create Date: 7/17/2013 11:36:50 AM
Created By: George Mills
Comments: This is where equivalency and extension status is documented.

Report Version: 1
Create Date: 4/5/2013 11:07:49 AM
Created By:
Comments: 11:07 am
GENERAL
INTERPRETATIONS
GENERAL INTERPRETATIONS

Alcohol Based Hand Rub (ABHR) placement:

- LS.02.01.20 EP 12 and NFPA 101 19.3.2.6 (6) states, *The dispensers shall not be installed over or directly adjacent to an ignition source.*

- LS.02.01.30 EP 25 The organization meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2000 18/19.3. NOTE: see the Joint Commission web site for ABHR requirements.

- The Joint Commission published information in 2006 defining “adjacent to” as no closer than 6 inches, center of the ABHR to center of the ignition source.
NFPA 101, 2012: 18/19.3.2.6. (8) Dispensers shall not be installed in the following locations:

- Above an ignition source for a horizontal distance of 1 in (25 mm) to each side of the ignition source.
- To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source.
- Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source.
Score EC.02.03.01 EP 1 ...fire risk

- 12 ‘E’ cylinders (<300ft³) per smoke compartment (22,500ft²) may be open to the egress corridor in a rack or appropriate holders
- Between 300 and 3000ft³ 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
Score EC.02.06.01...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
PROPOSED CHANGES TO ELEMENTS OF PERFORMANCE

Standard EC.02.02.01

- EP11: For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and material safety data sheets required by law and regulation.

EC.02.05.07, EP 4

- Twelve times a year, at intervals of not less than 20 days and not more than 40 days, At least monthly, the hospital tests each emergency generator under load for at least 30 continuous minutes. The completion dates of the tests are documented.

EC.02.05.07, EP 6

- Twelve times a year, at intervals of not less than 20 days and not more than 40 days, At least monthly, the hospital tests all automatic transfer switches. The completion date of the tests is documented.
PROPOSED CHANGES TO ELEMENTS OF PERFORMANCE

EC.02.05.07, EP 5

- The emergency generator **monthly** tests for **diesel-powered emergency generators** are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer’s recommended prime movers’ exhaust gas temperature. If the hospital does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 4, then it must test each the emergency generator once every 12 months using supplemental (dynamic or static) loads of 25% of nameplate rating for 30 minutes, followed by 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 2 continuous hours.

- **Note:** For non **diesel-powered generators tests need only to be conducted with available load.**
PROPOSED CHANGES TO ELEMENTS OF PERFORMANCE

EC.02.05.07, EP 7

- At least once every 36 months, hospitals with a diesel-powered generator providing emergency power for the services listed in EC.02.05.03, EPs 5 and 6, test each the emergency generator for a minimum of 4 continuous hours. The completion date of the tests is documented.


EC.02.05.07, EP 8

- The 36-month diesel-powered emergency generator test uses a dynamic or static load that is at least 30% of the nameplate rating of the generator or meets the manufacturer’s recommended prime movers' exhaust gas temperature.

- Note: For non diesel-powered generators tests need only to be conducted with available load.
TIME RE-DEFINED

The Joint Commission EC chapter defines time as:

- Daily, weekly, monthly are calendar references
- Quarterly will be once every three months +/- 10 days January 1, 2014
- Semi-annual is 6 months from the last scheduled event month +/- 20 days
- Annual is 12 months from the last scheduled event month +/- 30 days
- 3 years is 36 months from the last scheduled event month +/- 45 days

NOTE 1: The above does not apply to required frequencies

NOTE 2: An alternative of developing either a unique, written policy or adopting NFPA definitions when available is acceptable
SEMIANNUAL: +/- 20 DAYS
ANNUAL: +/- 30 DAYS

Frequencies required by Code may not be modified
(i.e. EC.02.05.07 EP 4 & 8)
HLD SELF CONTAINED UNITS (i.e. GUS)

High Level Disinfection (HLD) for semi critical devices are found in and outside the Central Sterile areas

- Gluteraldehyde User Stations (GUS) disinfection soak stations, or similar self contained HLD units such as those using 0.55% ortho-phthalaldehyde (OPA)

The Joint Commission will focus on the processes and Personal Protective Equipment (PPE)

- Many of the chemical disinfectants are potentially toxic and may require adequate precautions, including face/eye shields and gloves

Ventilation Requirements: None. Rooms must meet specific room requirements however

Storage: in a manner that will protect from contamination or damage, such as hanging in a cabinet with doors
HLD SELF CONTAINED UNITS

Chemical sterilants should be used in an area that is properly ventilated.

When general room ventilation is not adequate, a self-contained, freestanding system* or a local exhaust hood should be installed to capture chemical vapor during processing.

When an outside exhaust system is not available, a ductless fume hood* can be used to deliver vapor to a filter system that chemically inactivates the vapor; then clean, filtered air is returned to the room.

Filters for these systems should be replaced in accordance with the manufacturer’s recommendations.

*A ductless fume hood is simply a freestanding system that captures the toxic fumes and vapors and returns clean air to the room. Other names for ductless fume hoods are vapor control systems and disinfection soak stations.

Extracted from AAMI Standards
Too much noise from hospital alarms poses risk for patients

By Lena H. Sun, Published: July 7 at 8:44 pm

Clinical Nurse Elise Ross stands in front of the nurses station’s central monitor for patient vital signs in the Neuro Intensive Care Unit in MedStar Washington Hospital Center in Washington. The Neuro ICU has 14 beds that are often full, with an almost constant ringing of alarms throughout the day. (Photo by Maddie Meyer/The Washington Post)
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
ALARMING PROBLEM

- 100’s of alarms per patient per day
- 1000’s of alarms per patient unit per day
- 10,000 alarms in the hospital each day

- 85 – 99% of alarm signals do not require clinical intervention
NATIONAL PATIENT SAFETY GOAL
**NEW**

**NPSG ON ALARM MGMT**

- In Phase I (beginning January 2014)

Hospitals will be required to:

- establish alarms as an organization priority and
- 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

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NPSG on Alarm Mgmt

In Phase II (beginning 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
RESOURCES
Many medical devices have alarm systems. These alarm-equipped devices are essential to providing safe care to patients in many healthcare settings; clinicians depend on these devices for information they need to deliver appropriate care and to guide treatment decisions. However, these devices present a multitude of challenges and opportunities for healthcare organizations when their alarms create similar sounds, when their default settings are not changed, and when there is a failure to respond to their alarm signals.

Additional resource:
Podcast: Take 5 with The Joint Commission: Medical Device Alarm Safety
OTHER RESOURCES

- ECRI website page on Alarm Management resources: https://www.ecri.org/Forms/Pages/Alarm_Safety_Resources.aspx
SURGICAL SITE FIRES

>50 million hospital

- Estimated 550 – 650 surgery fires per year
  - 30 Serious
  - Multiple fire related deaths annually

Fire sites:

- 34% airway
- 28% head/face
- 38% other
SURGICAL SITE FIRES

- 74% occurred in oxygen enriched environment

- Ignition Source:
  - 68% electrosurgical equipment
  - 13% lasers
RECOMMENDATIONS

Recommendations:

- Fire drills & Staff Education (including how to prevent surgical site fires)
- Review alarm procedures
- Review rescue techniques
- Review shut off locations

Joint Commission response:

- Life Safety Code Surveyors gown and survey
DEPARTMENT OF ENGINEERING  
630 792 5900

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Director

Anne Guglielmo, CFPS, LEED, A.P., CHSP  
Engineer

John Maurer, CHFM, CHSP  
Engineer

James Woodson, P.E., CHFM  
Engineer

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Engineer
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