2022 Environment of Care, Life Safety Code, and Emergency Management Updates

ALABAMA SOCIETY FOR HEALTHCARE ENGINEERING
Building, Maintaining, and Improving the Healthcare Environment Responsibly

May 5, 2022

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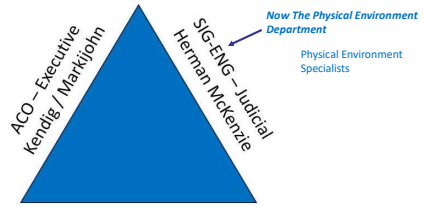

Now The Physical Environment Department

Physical Environment Specialists

DSSM – Legislative
Herman McKenzie
Kendig / Markijohn

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Jim Kendig, MS, CHSP, HEM

Field Director – Life Safety Code Surveyors

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MBA, CHSP
Director – Physical Environment Department

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What's New, Our Focus

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What's New and What We Are Working On

- NEW water management standard and EP – January 2022
- New Tools
- What LSCSs want you to know
- Updating eapp > BBI
- New name for SIG -The Physical Environment Department
- NEW EM Standards and Eps – July 2022 – Surveyor education May 2022 – customer education follows
- NEW WPV standards and Eps – January 2022 (July *Perspectives)*
- NEW document review checklist

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We need your help!

- Please take the time to reconcile your sq ft between the eapp (Quality Dept) and the BBI! Thanks!

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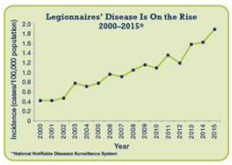
What's the Risk?

- More Legionella pneumophila in the environment
- More susceptible patient population
- Increased awareness and testing
- 1 in 4 patients who acquire their infection in healthcare facility will die



In the United States, reported cases of Legionnaires' disease have increased by nearly four and a half times since 2000. More illness occurs in the summer and early fall but can happen any time of year.

Source: https://www.cdc.gov/legionella/downloads/toolkit.pdf

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Legionella Bacteria Found in New York City Hospital: Officials

'Inadequate disinfection' blamed in Legionnaires' outbreak

4 Cases of Legionnaires' Disease Investigated at Hospital

Health officials warn of possible Legionnaires' exposure at Missouri cancer center

Vets' Home Legionnaires' Outbreaks Spur New Disease Notification Law

Legionella outbreak investigated by Hawaii Health Department

7 patients at new Ohio hospital diagnosed with Legionnaires'

by The Associated Press | Saturday, June 1st 2019

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'Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities.'

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTER FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety and Oversight Group

Ref: QSO-17-30- Hospitals/CAHs/NHs
REVISED 07.06.2018

DATE: June 02, 2017

TO: State Survey Agency Directors

FROM: Director
Quality, Safety and Oversight Group (*formerly Survey & Certification Group*)

SUBJECT: Requirement to Reduce *Legionella* Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD)

****Revised to Clarify Expectations for Providers, Accrediting Organizations, and Surveyors****

Memorandum Summary

- ***Legionella* Infections:** The bacterium *Legionella* can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least 50 years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as showerheads, cooling towers, hot tubs, and decorative fountains.
- **Facility Requirements to Prevent Legionella Infections:** Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of *Legionella* and other opportunistic pathogens in water.
- This policy memorandum applies to Hospitals, Critical Access Hospitals (CAHs) and Long-Term Care (LTC). However, this policy memorandum is also intended to provide general awareness for all healthcare organizations.
- *This policy memorandum clarifies expectations for providers, accrediting organizations, and surveyors and does not impose any new expectations nor requirements for hospitals, CAHs and surveyors of hospitals and CAHs. For these provider types, the memorandum is merely clarifying already existent expectations.*
- *This policy memorandum supersedes the previous Survey & Certification (S&C) 17-30 released on June 02, 2017 and the subsequent revisions issued on June 9, 2017.*

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Where can I Find Information regarding Legionella and other opportunistic water borne pathogens?

- *EC News/Perspectives*
  - Sept 2017 – Mitigating Legionnaires' Disease
  - Feb 2019 – "A water shield against legionella
  - Oct 2019 – Toolbox, Preventing Legionella in Healthcare Facilities
  - April 2021 – New standards and EPs (*Perspectives*)
  - August 2021 - New Water Management Standard—What You Need to Know

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Legionella New standards and Eps

Standard EC.02.05.02

- This standard will go into effect January 1, 2022: The organization has a water management program that addresses Legionella and other waterborne pathogens.
- Note: The water management program is in accordance with law and regulation.

- EC.02.05.02, EP 1
- This element of performance will go into effect January 1, 2022: The water management program has an individual or team responsible for the oversight and implementation of the program, including but not limited to, development, management, and maintenance activities.

- Published July 2021. Effective January 2022.

EC.02.05.02, EP 2

This element of performance will go into effect January 1, 2022: The individual or team responsible for the water management program develops the following:
- A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points
Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth.
- A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions can most likely occur in areas with slow or stagnant water)
Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment.
- A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period. (for example, unoccupied or temporarily closed areas)
- An evaluation of the patient populations served to identify patients who are immunocompromised
- Monitoring protocols and acceptable ranges for control measures
Note: Hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. Additionally, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range.

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New standards and Eps cont.

EC.02.05.02, EP 3

This element of performance will go into effect January 1, 2022: The individual or team responsible for the water management program manages the following:
- Documenting results of all monitoring activities
- Corrective actions and procedures to follow if a test result outside of acceptable limits is obtained, including when a probable or confirmed waterborne pathogen(s) indicates action is necessary
- Documenting corrective actions taken when control limits are not maintained
Note: See EC.04.01.01, EP 1 for the process of monitoring, reporting, and investigating utility system issues.

EC.02.05.02, EP 4

This element of performance will go into effect January 1, 2022: The individual or team responsible for the water management program reviews the program annually and when the following occurs:
- Changes have been made to the water system that would add additional risk.
- New equipment or at-risk water system(s) has been added that could generate aerosols or be a potential source for Legionella. This includes the commissioning of a new wing or building.
Note 1: The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) do not require culturing for Legionella or other waterborne pathogens. Testing protocols are at the discretion of the hospital unless required by law or regulation.
Note 2: Refer to ASHRAE Standard 188-2018 "Legionellosis: Risk Management for Building Water Systems" and the Centers for Disease Control and Prevention Toolkit "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings" for additional guidance on creating a water management plan. For additional guidance, consult ANSI/ASHRAE Guideline 12-2020 "Managing the Risk of Legionellosis Associated with Building Water Systems."

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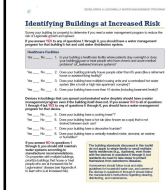
From the CDC Toolkit page 2 & WICRA



Comprehensive Accreditation Manual for Hospitals

Note: *Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment.*

- A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas)
- An evaluation of the patient populations served to identify patients who are immunocompromised
- Monitoring protocols and acceptable ranges for control measures

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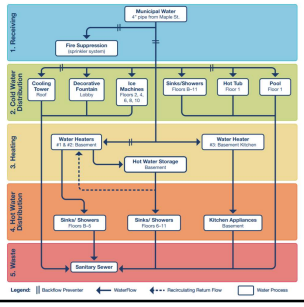
Flow Diagram – CDC Toolkit page 10



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Workplace Violence

Elements of Performance for EC.02.01.01

17. ⚙ The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis.

Note: *A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.*

(*See also* EC.04.01.01, EP 1)

Standard EC.04.01.01

The hospital collects information to monitor conditions in the environment.

Elements of Performance for EC.04.01.01

1. The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following: ✚
   - Injuries to patients or others within the hospital's facilities
   - Occupational illnesses and staff injuries
   - Incidents of damage to its property or the property of others
   - Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence
   - Hazardous materials and waste spills and exposures
   - Fire safety management problems, deficiencies, and failures
   - Medical or laboratory equipment management problems, failures, and use errors
   - Utility systems management problems, failures, or use errors

6. Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence.

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Workplace Violence

HR.01.05.03

29. As part of its workplace violence prevention program, the hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leadership, staff, and licensed practitioners. The hospital determines what aspects of training are appropriate for individuals based on their roles and responsibilities. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows:
- What constitutes workplace violence
- Education on the roles and responsibilities of leadership, clinical staff, security personnel, and external law enforcement
- Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents
- The reporting process for workplace violence incidents

(*See also* LD.03.01.01, EP 9)

LD.03.01.01

9. The hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes the following:
- Policies and procedures to prevent and respond to workplace violence
- A process to report incidents in order to analyze incidents and trends
- A process for follow up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary
- Reporting of workplace violence incidents to the governing body

(*See also* HR.01.05.03, EP 29)

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WPV Resources

Prepublication Report: https://www.jointcommission.org/standards/prepublication-standards/new-and-revised-workplace-violence-prevention-requirements/

- R3: https://www.jointcommission.org/standards/r3-report/r3-report-issue-30-workplace-violence-prevention-standards/
- Compendium of Resources: https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/compendium-of-resources/
- Also, please see this great (but disturbing) article regarding workplace violence: https://www.inquirer.com/news/philadelphia/pennsylvania-hospital-patient-doctor-stabbing-lawsuit-20210616.html?utm_source=email&utm_campaign=edit_social_share_email_traffic&utm_medium=email&utm_content=&utm_term=&int_promo=

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New tools…from LSCSs!

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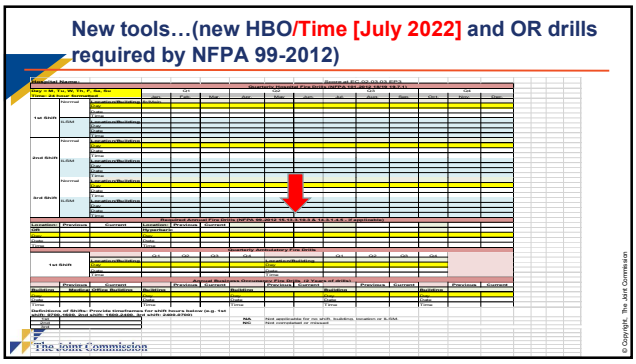
New tools…(new HBO/Time [July 2022] and OR drills required by NFPA 99-2012)



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Hyperbaric Facilities & fire drills

For **July 2022**

14.2.4.5.4 The time required to evacuate all persons from a hyperbaric area with a full complement of chamber occupants all at treatment pressure shall be measured annually during the fire training drill required by 14.3.1.4.5.

14.2.4.5.4.1 The occupants for this training drill shall be permitted to be simulated.

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ILSM Cautions…

- Do not be overly onerous…
- Does everyday mean 7 days a week?
- Who needs to know – keep it simple!
- Fire drill apathy…

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Tied to ILSM is Fire Watch…

- State and local requirements
- NFPA requirements
- OSHA requirements

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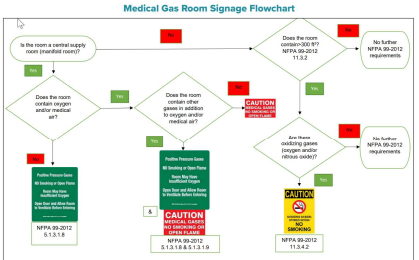
New tools cont. May 2021 *EC News*

Medical Gas Room Signage Flowchart



Further Guidance from the NFPA

It is important to note the following additional guidance from the National Fire Protection Association (NFPA) *Health Care Facilities Code* (NFPA 99-2012):

- Per section 11.3.3.1, individual cylinder storage associated with patient care areas, not to exceed 22,500 ft³ of floor area, is not required to be stored in an enclosure.
- Per section 11.3.3.4, individual small-sized (A,B, D, or E) cylinders available for immediate use in patient care areas are not considered to be in storage.
- Per section 11.3.2, when determining the volume of storage, do not consider cylinders and containers that are in use.
- There is no limit on the amount of nonflammable gas cylinders or containers that can be stored within a smoke compartment, provided nonflammable gas cylinders and containers in excess of 300 ft³ are stored in an enclosure that meets the requirements of sections 11.3.2.1 through 11.3.2.3.
- If <300 ft³ stored in room, no signage is required.

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Requirements Life Safety Code Surveyors Want <u>You</u> to Know About (cont.)

- EC.02.05.07 EP4
  - Every week, the hospital inspects the EPSS, including all associated components and batteries.
    - –ATS's
    - –Generator Batteries (maintenance free)
      - –Monthly Specific Gravity – or – Monthly Conductance

8.3.7* Storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications.

8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.

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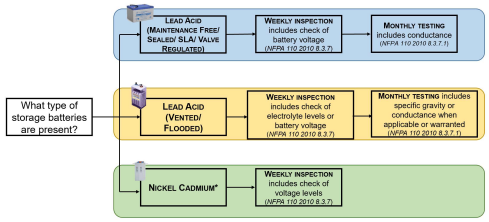
New tools cont. Generator Battery Testing EC.02.05.07 EP-4



* Note: Storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications.

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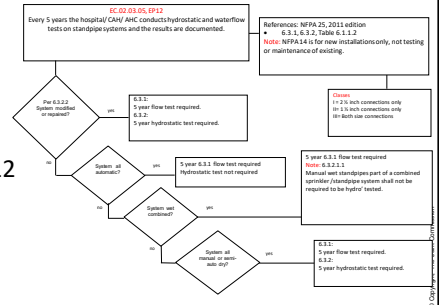
EC.02.03.05 EP 12 & NFPA 25-2011



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What Life Safety Code Surveyors want you to Know…

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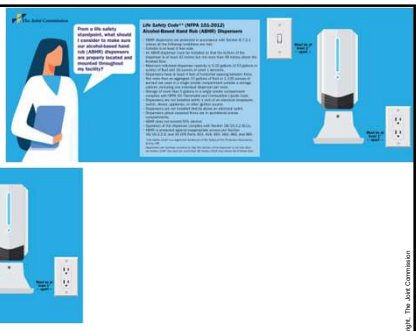

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Life Safety Code Surveyor Days July 2020

- **REMINDER:** LSCS added one day for each free-standing emergency department and ambulatory surgery center.

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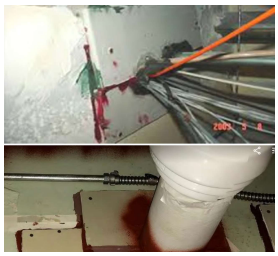
What LSCSs want you to know!

- Confusing exits
- Power strips not installed/used per NFPA 99: 10.2.3.6 (more later)
- Fire drills – one hour apart (looking at 4 quarters)
- New 05 LS standards and eps
- Don't forget about the 'kitchen checklist!' New/Revised 6/2021
- SCAB patches! (see *EC News* Sept 2020)
- New EC 2 3 1 language



See GA-225-2019
REPAIR OF FIRE-RATED
GYPSUM PANEL PRODUCT SYSTEMS

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LSCSs want you to know cont.....

- Let's talk about EXIT signs and 'other signs…'
  - 2nd level review

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Lab hood exhausts

- Let's talk about Lab exhaust labeling
  - NFPA 99 – 2012 > NFPA 45 - 2011 13.2 and A13.2

13.2* Exhaust Systems. Exhaust systems used for the removal of hazardous materials shall be identified to warn personnel of the possible hazards.

A.13.2 The exhaust system should be identified "WARNING — Chemical Laboratory Exhaust" (or "Chemical Fume Hood Exhaust" or other appropriate wording). Exhaust system discharge stacks and discharge vents and exhaust system fans should be marked to identify the laboratories or work areas being served.

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RPT Requirements Life Safety Code Surveyors Want You to Know About (cont.)

- Let's start with the NFPA requirements (NFPA 99-2012)

TIA 12-5 August 2013

10.2.3.6 Multiple Outlet Connection. Two or more power receptacles supplied by a flexible cord shall be permitted to be used to supply power to plug-connected components of a movable equipment assembly that is racks, tables, pedestals, or cart-mounted, provided that all of the following conditions are met:

(1) The receptacles are permanently attached to the equipment assembly.
(2)*The sum of the ampacity of all appliances connected to the outlets does not exceed 75 percent of the ampacity of the flexible cord supplying the outlets.
(3) The ampacity of the flexible cord is in accordance with *NFPA 70, National Electrical Code.*
(4)*The electrical and mechanical integrity of the assembly is regularly verified and documented.
(5)*Means are employed to ensure that additional devices or nonmedical equipment cannot be connected to the multiple outlet extension cord after leakage currents have been verified as safe.

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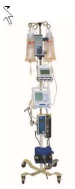
Requirements Life Safety Code Surveyors Want You to Know About (cont.)

- An example of not acceptable - 'RPT on a stick'

- Example of an 'assembly'



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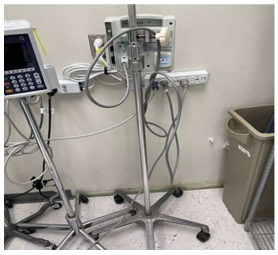
Requirements Life Safety Code Surveyors Want You to Know About (cont.)

- Example of an RPT being used in place of fixed wiring…
- NFPA 70-2011 400-8 and 590.3 (D)



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Requirements Life Safety Code Surveyors Want You to Know About (cont.) Yes…but…

- What about wheeled carts in the corridor (LSC NFPA 101-2012 19.2.3.4)?

(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:
(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm).
(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.
(c) *The wheeled equipment is limited to the following:
i. Equipment in use and carts in use
ii. Medical emergency equipment not in use
iii. Patient lift and transport equipment

A 19.2.3.4(4)(c) Wheeled equipment and carts in use include food service carts, housekeeping carts, medication carts, isolation carts, and similar items. Isolation carts should be permitted in the corridor only where patients require isolation precautions.

Unattended wheeled crash carts and other similar wheeled emergency equipment are permitted to be located in the corridor when "not in use," because they need to be immediately accessible during a clinical emergency. Note that "not in use" is not the same as "in storage." Storage is not permitted to be open to the corridor, unless it meets one of the provisions permitted in 19.3.6.1 and is not a hazardous area.

Wheeled portable patient lift or transport equipment needs to be readily available to clinical staff for moving, transferring, toileting, or relocating patients. These devices are used daily for safe handling of patients and to provide for worker safety. This equipment might not be defined as "in use" but needs to be convenient for the use of caregivers at all times.

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LSC Business Occupancy Effective July 1, 2022 HAP\CAH\BHC LS.05

- These new standards (LS.05) were developed since the LS chapter only has standards that address health care occupancies, ambulatory care occupancies, and residential board and care occupancies. The new business occupancy standards will provide accredited customers and surveyors with clear guidance on business occupancy requirements resulting in a more consistent approach in the evaluation of all occupancy locations based upon NFPA 101-2012. (January 2021 Perspectives) (replaces EC.02.03.01 eps 1 & 4).
- Please note: For the BHC program, these standards only apply to buildings that are business occupancies where individuals receive services.

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New LS.05 standards (Jan 2021 *Perspectives*)

NEW: *Life Safety Code*® Business Occupancy Requirements

Effective July 1, 2021, The Joint Commission will add new standards to its "Life Safety" (LS) chapter to address business occupancy requirements for **behavioral health care and human services** organizations, **critical access hospitals**, and **hospitals**. The LS chapter is based on the National Fire Protection Association (NFPA) *Life Safety Code*™ (101–2012) and addresses key structural components of a building that help protect occupants from fire. The following table lists the three occupancy classifications for both medical facilities and behavioral health care and human services facilities as identified in the *Life Safety Code*.

Medical Facilities	Behavioral Health Care and Human Services Facilities
1. Health care occupancies	1. Health care occupancies
2. Ambulatory health care occupancies	2. Residential board and care occupancies
3. Business occupancies	3. Business occupancies

Currently, LS requirements address health care occupancies, ambulatory health care occupancies, and residential board and care occupancies only. Any *Life Safety Code* issues identified in business occupancies during a survey have been scored in the "Environment of Care" (EC) chapter, which addresses the management of risks associated with safety, security, fire, hazardous materials and wastes, equipment, and utilities. The new standards provide clear guidance on business occupancy requirements for accredited customers and surveyors, which will result in a more consistent approach to evaluating all applicable occupancy locations.

The new requirements will be posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the spring 2021 E-dition® update of the *Comprehensive Accreditation Manual for Behavioral Health Care and Human Services (CAMBHC), Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH), and Comprehensive Accreditation Manual for Hospitals (CAMH)*. For those customers who purchase them, the hard-copy 2021 *CAMBHC* and *CAMH* spring update will include these revisions.

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Spare Sprinkler Heads Effective Immediately HAP\CAH\BHC

- **LS.02.01.35 EP 7**
- Old - At least six spare sprinkler heads of each type and temperature rating installed in the facility are readily available, with the associated wrench or tool to replace the sprinkler head. The spare sprinkler heads and wrench or tool are stored in a cabinet that does not exceed 100°F.
- New - At least six spare sprinkler heads that correspond to the types and temperature rating of the hospital's sprinkler heads, with associated wrenches, are kept in a cabinet that will not exceed 100°F.

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Aisle Widths in Suites Effective Immediately HAP\CAH

- **LS.02.01.20 EP 42**
- Effective immediately, Joint Commission Life Safety Code®* surveyors will cite noncompliance in suites with aisles that have less than 36 inches of clearance from side to side to facilitate egress. This requirement is in accordance with the National Fire Protection Association's (NFPA) Life Safety Code (NFPA 101–2012), Section 7.3.4.1(2), in the core chapter on egress, which sets the minimum width of any means of egress at 36 inches in all facilities or portions of facilities classified as health care occupancy. (April 2021 Perspectives)

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Condition-Level Deficiency Data – NEED TO UPDATE SLIDE

% of **Hospitals** with at least one Conditional-Level Deficiency (CLD) (excluding Psychiatric Hospitals)

Timeframe	Number of deemed Orgs with CLDs	% of Hospitals with at least one CLD
01/01/2021 – 12/31/2021	336 of 1093	**30.74%**
01/01/2020 – 12/31/2020	145 of 451	32.15%
01/01/2019 – 12/31/2019	439 of 1109	39.59%
01/01/2018 – 12/31/2018	532 of 1207	44.08%
01/01/2017 – 12/31/2017	544 of 1190	45.71%
01/01/2016 – 12/31/2016	386 of 1145	33.71%

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Condition-Level Deficiency Data

% of **Psychiatric** Hospitals with at least one Conditional-Level Deficiency (CLD)

Timeframe	Number of deemed Orgs with CLDs	% of Hospitals with at least one CLD
01/01/2021 – 12/31/2021	54 of 235	**22.98%**
01/01/2020 – 12/31/2020	22 of 77	**28.57%**
01/01/2019 – 12/31/2019	80 of 212	**37.7%**
01/01/2018 – 12/31/2018	78 of 187	**41.71%**
01/01/2017 – 12/31/2017	95 of 186	**51.08%**

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Life Safety Code Surveyors Average RFI's per Survey
Full Hospital Surveys

2021	2020	2019	2018	2017	2016	2015	2014
15.5	14.01	17.04	16.33	13.13	10.96	11.17	10.52

COVID

SAFER & "See it / Cite it"

"C" Category & OFI's

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Survey Process…what we've done and we want to hear from you!

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LSCS Survey Process

Standardized agenda

- Standardized morning of day 1 facility orientation (0800-0900)
- Standardized fire drill matrix
- Standardized agenda

Three Questions

- Fire Stop…
- Above ceiling…
- HLD…

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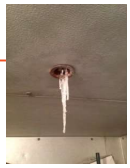
LSCS Survey Process

- Hard stop…
- Real Time Calls (RTCs)…
- EC session…
- EM session…
- Building tour
  - Critical pressure relationship areas



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Now I want to hear from you…what can we do to enhance the survey process!

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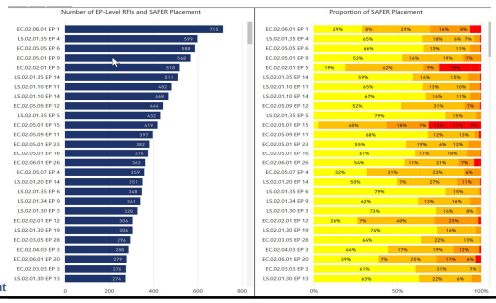
U.S. Most scored during surveys…1/1/21 to 12/31/21



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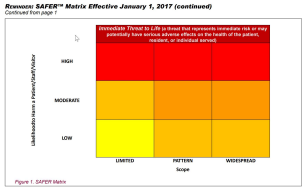
Reminder – SAFER definition (*Perspectives* Jan 2017)



- **High**—Occurrence of harm is likely; that is, the finding could directly lead to harm without the need for other significant circumstances or failures.
- **Moderate**—Occurrence of harm is possible; that is, the finding could cause harm directly but is more likely to cause harm as a contributing factor in the presence of special circumstances or additional failures.
- **Low**—Occurrence of harm is rare; that is, the finding undermines safety/quality or contributes to an unsafe environment is but very unlikely to directly contribute to harm.

Operational definitions along the *x* axis—"Scope"—are as follows:

- **Widespread**—Issue is described as "pervasive at the organization"; that is, the finding is the result of a process or systemic failure and could impact a majority of patients.
- **Pattern**—Issue is described as having the potential to "impact more than a limited number of patients impacted"; that is, the finding involves process variation.
- **Limited**—Issue is described as a "unique occurrence"; that is, the finding is considered an outlier and not representative of routine or regular practice.

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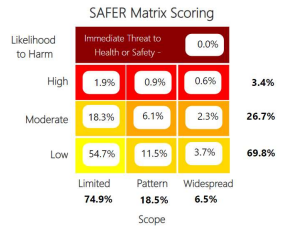
SAFER National



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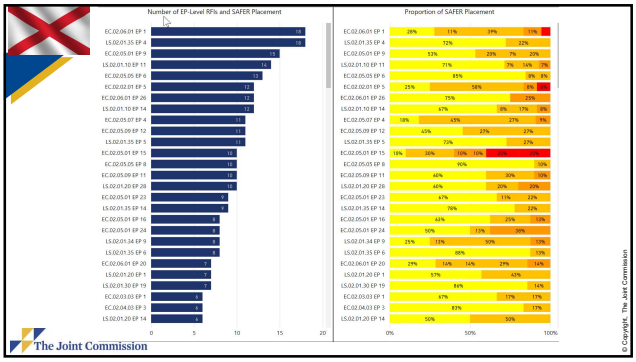

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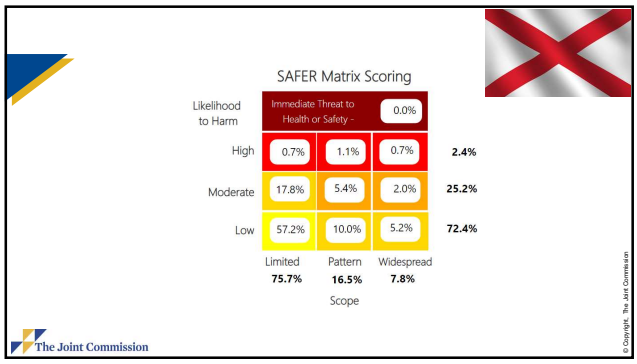
SAFER Matrix Scoring
Likelihood to Harm
Immediate Threat to Health or Safety - 0.0%
High
0.7%
1.1%
0.7%
2.4%
Moderate
17.8%
5.4%
2.0%
25.2%
Low
57.2%
10.0%
5.2%
72.4%
Limited
75.7%
Pattern
16.5%
Widespread
7.8%
Scope
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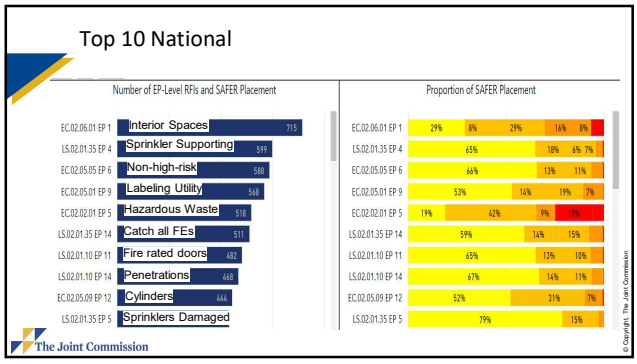
Top 10 National
Number of EP-Level RFIs and SAFER Placement
EC.02.06.01 EP 1 Interior Spaces 715
LS.02.01.35 EP 4 Sprinkler Supporting 599
EC.02.05.05 EP 6 Non-high-risk 588
EC.02.05.01 EP 9 Labeling Utility 568
EC.02.02.01 EP 5 Hazardous Waste 516
LS.02.01.35 EP 14 Catch all FEs 511
LS.02.01.10 EP 11 Fire rated doors 482
LS.02.01.10 EP 14 Penetrations 468
EC.02.05.09 EP 12 Cylinders 444
LS.02.01.35 EP 5 Sprinklers Damaged
Proportion of SAFER Placement
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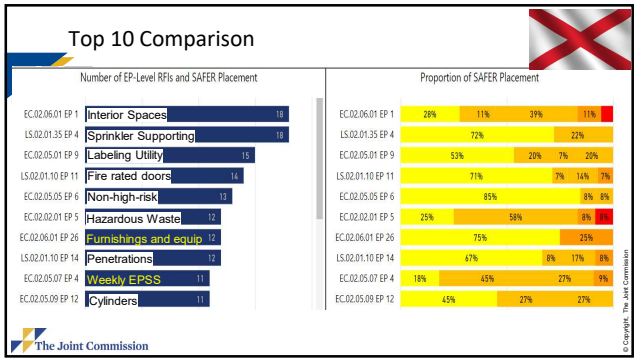
Top 10 Comparison
Number of EP-Level RFIs and SAFER Placement
EC.02.06.01 EP 1 Interior Spaces 18
LS.02.01.35 EP 4 Sprinkler Supporting 18
EC.02.05.01 EP 9 Labeling Utility 15
LS.02.01.10 EP 11 Fire rated doors 14
EC.02.05.05 EP 6 Non-high-risk 13
EC.02.02.01 EP 5 Hazardous Waste 12
EC.02.06.01 EP 26 Furnishings and equip 12
LS.02.01.10 EP 14 Penetrations 12
EC.02.05.07 EP 4 Weekly EPSS 11
EC.02.05.09 EP 12 Cylinders 11
Proportion of SAFER Placement
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Common Compliance Questions

Regarding the Public Health Emergency (PHE)

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PHE Compliance Issues

- **Question** - If rooms are repurposed from neutral to negative or positive to negative due to the current pandemic, should we still let the Joint Commission know prior to survey would the survey than be postponed

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PHE Compliance Issues

- **Answer** – Per QSO 2031 update issued 1/4/2021
- According to the CMS "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers", blanket waivers are in effect with a retroactive effective dated of March 1, 2020 through the end of the emergency declaration (ED). As such, the extent of ITM and associated corrective actions performed is at the discretion of the facility during the ED and ITM deficiencies are not to be cited during the ED. CMS has not issued guidance on ITM requirements post-PHE.

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PHE Compliance Issues

- **Question** - How many air circulations for a room that doesn't have negative pressure?

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PHE Compliance Issues

- **Answer** - The amount of air changes will depend upon the space in question. There is no way to list them in this presentation. In addition to minimum air changes per hour (ACH) some spaces require minimum outdoor air changes per hour. You should reference the ASHRAE 170 2008 ventilation table for the specifics. In addition, your organization should be conducting period air balance testing to verify that all spaces are compliant.

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PHE Compliance Issues

- **Question**- Will extension of time be granted for Ligature Risk Extension Request due to manufacture shut down during COVID-19 and difficulty obtaining hardware?

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PHE Compliance Issues

- **Answer** - Organizations that have difficulty obtaining resources which will cause a delay in completing corrective actions can request additional time. This should be done as part of your monthly update.

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PHE Compliance Issues

- **Question** - Please provide information regarding using the pandemic as one of the emergency management drills. I believe that there are six topic that must be addressed.

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PHE Compliance Issues

- **Answer** - Documentation should be broken down into the six critical areas:
  - Communication – what worked well and what did not
  - Resources and assets – what was abundant, adequate, lacking
  - Safety and security – what issues arose and how resolved
  - Staff responsibilities - what issues arose and how resolved
  - Utilities - what issues arose and how resolved
  - Patient clinical and support activities - what was abundant, adequate, lacking

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New / Revised Standards and EPs

Effective January 1, 2022

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EC 04.01.01 EP 1

- Medical or laboratory equipment management problems, failures, and use errors
- Utility systems management problems, failures, or use errors

Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.

Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, and services, or to prevent similar incidents, are not lost as a result of following the legal process. (See also EC.02.01.01, EP 17)

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Risk Assessments

Where, When, How

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Why Develop a Risk Assessment?

- When a standard or EP calls for a process or action in which the elements being measured or evaluated are of such a variable nature that a further assessment be conducted.
- When an EP specifically calls for a risk assessment

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Risk Assessment Considerations

- An organization cannot risk assessment out of a code requirement
  - Monthly generator testing (NFPA 99-2012, 6.4.4.1)
- Cannot substitute risk assessment when an EP calls for a specific requirement or actionable task
  - Managing MRI risks i.e., safe zones, screening

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Environment of Care EPs That Address Risk Assessments

- EC 02.01.01 EP 1
- EC 02.05.01 EP 20
- EP 02.05.02 EP 2
- EC 02.06.05 EP 2
- EM 02.01.01 EP 16
- EM 04.01.01 EP 1
- NPSG 15.01.01 EP 1

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Risk Assessment – EC 02.01.01 EP 1

- The organization implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the organization's facilities.
  Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

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Risk Assessment – EC 02.05.01 EP 20

- 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. (For full text, refer to NFPA 99-2012: 6.3.2.2.8.4; 6.3.2.2.8.7; 6.4.4.2)

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Risk Assessment – EC 02.05.02 EP 2

- The individual or team responsible for the water management program develops the following:
  - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points
  Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth.
  - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water)

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EC 02.05.02 EP 2, continued

- Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment.
  - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas)
  - An evaluation of the patient populations served to identify patients who are immunocompromised
  - Monitoring protocols and acceptable ranges for control measures

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EC 02.05.02 EP 2, continued

- Note: Hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and ph. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range.

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Risk Assessment – EC 02.06.05 EP 2

- When planning for demolition, construction, renovation, or general maintenance, the organization conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services.
  Note: See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation.

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Risk Assessment – EM 02.01.01 EP 16

- For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has one or more emergency management policies based on the emergency plan, risk assessment, and communication plan. Procedures guiding implementation are defined in the emergency management plan, continuity of operations plan, and other preparedness and response protocols. Policy and procedure documents are reviewed and updated at least every two years; the format of these documents is at the discretion of the hospital.

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Risk Assessment – EM 04.01.01 EP 1

- For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital demonstrates its participation in the development of its system's integrated emergency preparedness program through the following:
  - Designation of a staff member(s) who will collaborate with the system in developing the program
  - Documentation that the hospital has reviewed the community-based risk assessment developed by the system's integrated all-hazards emergency management program

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EM 04.01.01 EP 1, continued

- Documentation that the hospital's individual risk assessment is incorporated into the system's integrated program
- Documentation that the hospital's patient population, services offered, and any unique circumstances of the hospital are reflected in the system's integrated program
- Documentation of an integrated communication plan, including information on key contacts in the system's integrated program
- Documentation that the hospital participates in the review at least every two years of the system's integrated program

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Risk Assessment - NPSG 15.01.01. EP 1

- For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).

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NPSG 15.01.01 EP 1, continued

- For nonpsychiatric units in general hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital.

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NPSG 15.01.01 EP 1, continued

- Note: Nonpsychiatric units in general hospitals do not need to be ligature resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible).

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