A PRESENTATION FOR

Healthcare Facilities Management Society of New Jersey

Life Safety Accreditation Challenges

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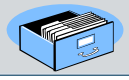

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Learning Objectives

- Understand the importance of being accredited
- Understand the areas most cited during 2010 TJC surveys for hospitals
- Understand testing & drilling time frames
- Understand TJC's Life Safety chapter scoring pitfalls & vulnerabilities
- Understand how to handle disputed survey findings

Accreditation

What Me Worry?

What's the Big Deal?

How can I jeopardize my hospital's accreditation?

Why Worry?

- Lack of Resources?
- Lack of Capital?
- Lack of Staff?
- Lack of Time?
- Lack of Technical Support?
- Lack of Administrative Support?
- Concerns about AHJ Visits?
- Concerns about TJC Readiness?
- Lack of Documentation?

(Can I jeopardize my hospital's accreditation**?**)

The Joint Commission

- Only accredited orgs are eligible for Medicare/Medicaid reimbursement costs ($$)
- Most hospitals rely on Medicare reimbursements ($$)
- Roughly 46% of revenue at an average hospital comes from government reimbursements as a result of being accredited ($$)

  Note: TJC accredits approximately 88% of the nation's hospitals

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Federal Deemed Status

- Accreditation is voluntary and seeking deemed status through accreditation is an option, not a requirement.
- Organizations seeking Medicare approval may choose to be surveyed either by an accrediting body, such as TJC, AOA, or DNV, or by state surveys on behalf of CMS.

Hospital Accreditation Organizations

CMS "deeming authority" to:

- The Joint Commission (TJC)
- American Osteopathic Association (AOA)-Healthcare Facilities Accreditation Program (HFAP)
- Det Norske Veritas Healthcare (DNVHC)-National Institute for the Accreditation of Healthcare Organizations (NIAHO)
- State Survey Programs on behalf of Centers for Medicare & Medicaid Services (CMS)

Most Challenging Top 5 Requirements for Hospital Accreditation in 2010

- 65% RC*.01.01.01 The hospital maintains complete and accurate medical records for each patient. (**Record of Care, Treatment, and Services*)
- 51% LS.02.01.20 The hospital maintains the integrity of the means of egress. (32 EPs)
- 49% LS.02.01.10 Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. (10 EPs)

Most Challenging Top 5 Requirements for Hospital Accreditation in 2010

- 42% EC.02.03.05 The hospital maintains fire safety equipment and fire safety building features. (20 EPs)
- 40% LS.02.01.30 The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke. (25 EPs)

Noncompliance Issues (Hospital)LS.02.01.20

Std: The hospital maintains the integrity of the means of egress. (50%)

- EP 1- Locked doors in the direction of egress from the hospital
- EP 13- Corridor (hallway) clutter
- EP 30- "No Exit" signs missing
- EP 31- Visible exit signs for any path missing

Noncompliance Issues (Hospital)LS.02.01.10

Std: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. (44%)

- EP 4- Openings in 2-hour fire rated walls not fire rated for 1-1/2 hours
- EP 5- Fire door issues (hardware, positive latching, self-closing devices, gaps, undercuts)
- EP 9- Unsealed spaces around pipes, conduits ducts, etc. penetrating fire walls/floors

Noncompliance Issues (Hospital)EC.02.03.05

Std: The hospital maintains fire safety equipment and fire safety building features. (38%)

- EP 1- Supervisory signal devices not tested quarterly
- EP 2- Valve tamper switches & water flow devices not tested every six months
- EP 3- Duct detectors, electromechanical releasing devices, heat detectors, manual fire alarm boxes, and smoke detectors not tested annually

Effective July 1, 2011 EC.02.03.05, EP 2

For hospitals that use TJC accreditation for deemed status purposes: At least quarterly, the hospital tests water-flow devices. Every 6 mos., the hospital tests valve tamper switches. The completion date of the tests is documented.
Note: For additional guidance on performing tests, see NFPA 25, 1998 edition- Section 2-3.3/3-3.3 and NFPA 72, 1999 edition- Table 7-3.2.

Effective July 1, 2011 EC.02.03.05, EP 2

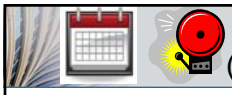
For hospitals that do not use accreditation for deemed status purposes: Every 6 months, the hospital tests valve tamper switches and water-flow devices. The completion date of these tests is documented.
Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).

Effective July 1, 2011 EC.02.03.05, New EP 25

For hospitals that use accreditation for deemed status purposes: Documentation of maintenance, testing, and inspection activities for fire alarm and water-based fire protection systems includes the following:

- Name & date of activity
- Required frequency of activity
- Name and contact information, including affiliation, of the person who performed the activity
- NFPA standard(s) referenced for the activity
- Results of the activity

Note: For additional guidance on documentation activities see NFPA 25, 1998 edition (Section 2-1.3) and NFPA 72 1999 edition (Section 7-5.2)



Noncompliance Issues (Hosp.)EC.02.03.05 (cont.)

- EP 5- Fire alarm equipment for notifying off-site fire responders not tested quarterly
- EP 10- Fire Dept. water supply connections for auto. sprinkler system not inspected quarterly
- EP 13- Kitchen automatic fire-extinguishing system not inspected every six months
- EP 15- Portable fire extinguishers not inspected at least monthly
- Note: Noncompliance may be due to documentation issues!

Noncompliance Issues (Hospital)LS.02.01.30

- Std: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke. (37%)
- EP 2- Hazardous areas are not protected with 1-hour construction or sprinkler protection or both (depending if existing or new occupancy)
- EP 11- Corridor door issues (hardware, positive latching, gaps, undercuts)
- EP 18- Smoke barriers not continuous or have unsealed penetrations

Top 5 Noncompliance Issues for Critical Access Hospitals

Note: Standards and EP findings similar to those found in hospitals for the following (*).

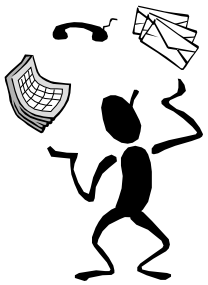
*EC.02.03.05 (48%)

*LS.02.01.10 (45%)

EC.02.05.07 (40%) - CAH only

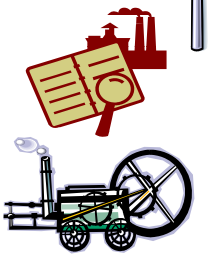
*LS.02.01.20 (32%)

*LS.02.01.30 (31%)



Noncompliance Issues EC.02.05.07 for CAH

The organization inspects, tests, and maintains emergency power systems. (40%)



EC.02.05.07 Common Issues

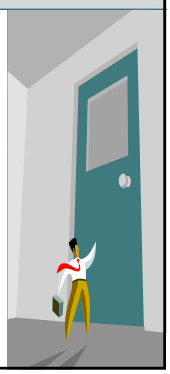
- EP's not having sufficient documentation to show compliance with the specific requirements.
- EP 3: Not understanding what constitutes a SEPSS.
- EP 4: Not documenting test duration meets the 30 min rqmts.
- EP 6: Not operating all ATS's every time.
- EP 7/EP 8: Just accepting and filing a testing company's 4-hour test report without looking at it, and then finding that the first 30 minutes is below 30%. (this invalidates the entire test!) Many testing companies tell hospitals they know what they are doing, but they DO NOT know the rqmts of this std.
- EP 9: Not doing (or documenting) consideration of "measures" if a test has failed. Not doing the ILSM assessment if a generator fails a test and is down for some period of time.
- EP 10: Not doing the retest after the problem is fixed.

Life Safety Survey Vulnerabilities

EC & LIFE SAFETY VULNERABILITIES

Doors

- Corridor Doors (NFPA 101)
- Smoke Barrier Doors (NFPA 101)
- Fire Barrier Doors (NFPA 80)
- Cross-Corridor Doors (NFPA 101)
- Elevator Doors



Corridor Doors

Swinging type

1¾" solid bonded wood core (existing)

Swing w/ egress

Positive latch

1" undercut

1/8" gap

No coverings, mirrors

No louvers

Unlocked w/ egress

Plates ≤ 48"

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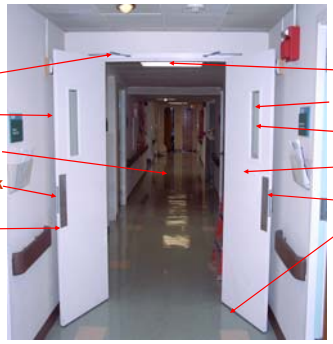
Smoke Barrier Doors



Fire Barrier Doors

SOC PFI Completion Dates

- Automatic 6-month grace period for most original PFI's. No written request necessary.
- For anticipated PFI completions beyond 6-mo. grace period, request an extension from TJC Standards Interpretation Group
  - Each organization typically granted only one
  - No additional 6-month grace period for approved PFI extensions or revisions

Testing & Drilling Time Frames

- Daily, Weekly, Monthly, and Quarterly will be on a calendar basis* (example: beginning of one period, end of another)
- Bi-monthly is every other month (6 times a year)**
- Semi Annual – 6 months +/- 20 days**
- Annual – 12 months +/- 30 days**
- Triennial – 36 months +/- 45 days**

*Per Healthcare Interpretations Task Force (NFPA,TJC,CMS, ASHE,VA,DOD,IHS,IFMA, AHCA)

**Per TJC Nov. 2010 Environment of Care News

Calendar References

Performing something:

- Daily- Once per day [and anytime the next day]
- Weekly- Once per week (Sunday-Saturday) [and anytime the next week]
- Monthly- Within the calendar month [and anytime the next calendar month]
- Quarterly- Within the calendar quarter [and anytime the next calendar quarter]
- Note: For any of these time frames, you may not leave the calendar boundaries.

TJC Time Notations

- Note: The previous definitions do not pertain to or affect specific time frames defined in TJC's elements of performance, e.g., EC.02.05.07 EP 4, "Twelve times a year, at intervals of not less than 20 days and not more than 40 days, the hospital tests each emergency generator for at least 30 continuous minutes. The completion dates are documented." These specific time frames must be complied with.

CMS Medical Gas Storage Requirements per 2005 NFPA 99

- CMS Ref: S&C-07-10
- Memorandum Summary: "Up to 300 cu. ft. of nonflammable medical gas may be accessible as operational supply rather than storage, when properly secured [in a max. 22,500 sq. ft. smoke compartment]. An individual container of medical gas placed in a patient room for "as needed" (but regular) individual use is not required to be stored in an enclosure, when properly secured."

Open Oxygen Cylinder Storage

Oxygen Cylinders

How many "E" sized oxygen cylinders may be stored within 1 smoke compartment without taking any special separation or enclosure precautions?

$300\ ft^3 \div 25\ ft^3$/cylinders = 12 cylinders

Applies to all non-flammable compressed gases

Equivalencies

EQUIVALENCIES

Equivalencies

- Traditional for:
  - Single LSC deficiency
  - Small group of like LSC deficiencies
- Fire Safety Evaluation System (FSES) for:
  - Multiple LSC deficiencies
  - Single LSC deficiency affecting entire building

Traditional Equivalency

- Submit letter & support documentation to SIG Engineers or send via e-mail and complete Online Standards Submission Form:
  - Identifying deficiency(s) and proposed solution(s)
  - Reference applicable LSC section(s)
  - State intent of applicable LSC section(s)
  - Reference applicable LS Std. & EP
  - Attach drwgs (11"x17" max), cost estimates, source and availability of funds, proposed timetable of events
  - Submit written certification from FPE, registered architect or local AHJ that proposed solution(s) either meets the intent of the Code or will provide an equivalent level of safety

FSES Equivalency Process per NFPA 101A Alternative Approaches to Life Safety

(Numeric process to determine if an "equivalent" level of life safety is provided)

- Ensure e-SOC™ & BBI are current
- List all LSC deficiencies to be addressed for entire bldg.
- Complete FSES worksheets for entire bldg. (all zones)
- Provide floor plans (11"x 17" max) for each zone
- Drwgs., SOC & LSC deficiencies must support point values
- Actions & features of fire protection to be installed must be delineated in PFI
- Remaining LSC deficiencies "equivalized" must be listed
- Survey or evaluation info more than 1-yr old not acceptable (except current drwgs & BBI) [Re. Jan. 2011 EC News]

Equivalencies

- Submit to The Joint Commission a.s.a.p. -the earlier the better!
- Maintain a copy of The Joint Commission approval letter in multiple locations
- Note: Equivalencies or variances approved by other AHJs are not automatically accepted by The Joint Commission nor are The Joint Commission equivalencies accepted by other AHJs.

Equivalencies

Mail to: The Joint Commission
Standards Interpretation Group, Engineers
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

or

e-mail to: engineer@jointcommission.org

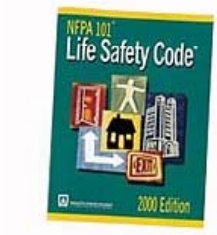
and complete: Online Standards Submission Form
http://jcwebnoc.jcaho.org/newsigsub/sigonlineform.aspx

NFPA 101 Life Safety Code® (Basis for SOC)

2000 NFPA 101 Life Safety Code®

(Ref. by TJC, CMS, DNV, AOA, Local & State Fire Marshals)

Note: CMS & TJC may adopt 2012 LSC in 2013 or 2014.



TJC's Code Effective Date

- TJC's LS chapter addresses both existing and new occupancies. Buildings are considered existing occupancies if final plans for buildings, additions, renovations, or changes in occupancy were approved by the local authority having jurisdiction (AHJ) prior to March 1, 2003. Buildings with final plans approved after March 1, 2003 are considered new occupancies and will be surveyed as such.

CMS's Code Effective Date

- If the facility's building plans were approved **or** a building permit was issued **or** construction started after the effective date (March 13, 2003), of the final regulation, the building or addition must be surveyed under the 2000 LSC's new occupancy chapter.
- If the facility's building plans were approved by a State Agency **or** building permit issued **or** construction started prior to the effective date (March 13, 2003), of the final regulation, the building must be surveyed under the 2000 LSC's existing occupancy chapter.

CMS Major/Minor Modifications

- CMS has defined the terms "major" and "minor" for alterations, modernization or renovation of buildings as follows: If the building has undergone a modification **(**usually more than 50 percent **or** more than 4,500 square feet, of the smoke compartment involved**)** it is considered "major." If the building has undergone a modification **(**usually less than 50 percent **or** less than 4,500 square feet, of the smoke compartment involved**)** it is considered "minor" regardless of the size of the area involved.

CMS Major/Minor Modifications (cont.)

If a building undergoes a "major" modification after March 13, 2003 then the building would be surveyed under 2000 LSC new occupancy chapter. The replacement of a system such as a fire alarm system would be considered "major" for that system only. Thus, that system only would have to meet the LSC new occup. chapter requirements, not the entire building.

Note**:** Cosmetic changes such as painting and wallpapering by themselves would not constitute a "major" modification.

New EP 1 for TJC Standard EC.02.06.05

- Std: The hospital manages its environment during demolition, renovation, or new construction to reduce risk to those in the organization.
- EP 1: When planning for new, altered, or renovated space, the hospital uses one of the following design criteria:

  1) State rules and regulations or

  2) *Guidelines for Design and Construction of Health Care Facilities*, 2010 edition* (Effective Jan.1, 2011)

*Note: Applies to new construction or renovations only!

Building Occupancy Types

- For TJC purposes there are four major building types, with subsets as well, determined by occupancy:

-Healthcare (Hospital, Psych Hosp, LTC, Critical Access Hospital)

-Ambulatory Health Care

-Business (Outpatient) (No LSC – Local AHJ)

-Residential (RTC) (Overnight stay)

-Mixed (Multiple occupancies with rated separations)

Life Safety Code® Occupancy Chapters (Used by TJC)

-Health Care (Ch.18-new/19-existing):

1) Hospitals
2) Nursing Homes
3) Limited Care Facilities

-Ambulatory Health Care (Ch.20-new/21-existing)

-Residential (Ch.26 or 28-new/29-existing)

1) Lodging or Rooming Houses (Ch.26)
2) Hotels and Dormitories (Ch.28-new/29-existing)

Ambulatory Health Care Occupancy Definition

- A building or portion thereof used to provide services or treatment simultaneously to four or more patients that:

- (1) provides, on an outpatient basis, treatment for patients that renders the patients incapable of taking action for self-preservation under emergency conditions without the assistance of others; or
- (2) provides, on an outpatient basis, anesthesia that renders the patients incapable of taking action for self-preservation under emergency conditions without the assistance of others.

Standard LS.01.01.01 (eSOC)

- EP 2. The hospital maintains a current electronic SOC™ 3 [DIR]
- Note: The e-SOC is available to each hospital through The Joint Commission Connect™ extranet site.
- EP 3. When the hospital plans to resolve a deficiency through a Plan for Improvement (PFI), the hospital meets the time frames identified in the PFI accepted by TJC. (See also LS.01.02.01, EPs 1-14 for Interim Life Safety Measures) 2 [SDR]

ILSM

ILSM

Standard LS.01.02.01 (ILSM)

- The organization protects occupants during periods when the Life Safety Code® (LSC) is not met or during periods of construction. (See EPs 1-14)
- 1. The hospital notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm or sprinkler system is out of service more than 4 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. 3

ILSM EPs 2-3

- 2. The hospital posts signage identifying the location of alt. exits to everyone affected. 3
- 3. The hospital has a written interim life safety measure (ILSM) policy that covers situations when Life Safety Code deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent the hospital follows special measures to compensate for increased life safety risk. 2 [SDR]

ILSM EPs 4-6

- 4. When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Inspects exits in affected areas on a daily basis. 3
- 5. Provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired. 3
- 6. Provides additional fire-fighting equipment. 3

ILSM EPs 7-10

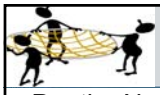
- 7. Uses temporary construction partitions that are smoke-tight, or made of noncombustible material or made of limited combustible material that will not contribute to the development or spread of fire.
- 8. Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices.
- 9. Enforces storage, housekeeping, and debris-removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level.
- 10. Provides additional training to those who work in the hospital on the use of fire-fighting equipment.

ILSM EPs 11-14

- 11. Conducts one additional fire drill per shift per quarter.
- 12. Inspects and tests temporary systems monthly. The completion date of the tests is documented.
- 13. The hospital conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety. 3
- 14. The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features. 3

Immediate Threat to Health or Safety (ITHS)

- Definition: Any condition identified during survey that poses a serious threat to public or patient health or safety.
- Examples:
- 1) Inoperable fire alarm or pump w/o fire watch or ILSM;
- 2) Emergency generator down for extended period w/o backup;
- 3) Lack of master alarms for med gas systems



Immediate Threat to Health or Safety (ITHS)

- Per the November 2010 EC News, failure to maintain the following four critical facilities systems may trigger an Immediate Threat to Health or Safety condition:

An "unaddressed issue" with the

1) Fire alarm system
2) Sprinkler system
3) Emergency power system
4) Medical gas master panel

Note: Also compromised exits

Immediate Threat to Health or Safety (ITHS) (cont.)

- Result: TJC President issues an expedited Preliminary Denial of Accreditation decision which remains in effect until the implementation of corrective action is validated thru an on-site survey. Once resolved, org. status would change to Accreditation w/ Follow-up Survey until a follow-up survey is conducted in 4 to 6 mo. to assess org's sustained implementation of appropriate corrective actions.
- Note: Org has 72-hours to either eliminate the situation entirely or implement emergency interventions to abate risks (or max of 23 days!)

2 Situational Decision Rules (SDR)

- Definition: Situations in which an accreditation decision of PDA, Contingent Accreditation, or Accreditation with Follow-up Survey is triggered
- Examples:
- 1) Failure to implement corrective action in response to identified Life Safety deficiencies;
- 2) Lack of written interim life safety measure (ILSM) policy.
- 3) Failure to make sufficient progress toward the corrective actions described in a previously accepted SOC/PFI.

New "Accreditation with Follow-Up Survey" Rule AFS13 to Replace CON04

- Conditional Accreditation Rule CON04 replaced with Accreditation with Follow-Up Survey Rule AFS13 effective January 1, 2011
- "The hospital has failed to implement or make sufficient progress toward the corrective actions described in a Statement of Conditions™, Part 4, Plan for Improvement, which was previously accepted by The Joint Commission, or has failed to implement or enforce applicable interim life safety measures."

New Survey Window

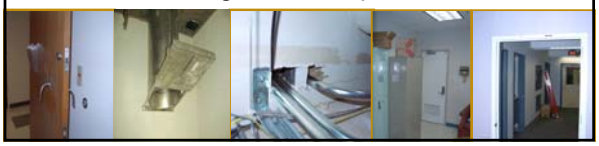
- Effective January 1, 2011, unannounced TJC surveys will be scheduled any time between 18 and 36 months from the previous full survey. The previous window was 18 to 39 months.
- Note: This change was made to maintain consistency in the timing of the survey window with CMS.

New Life Safety Code Specialist Surveyor Schedule

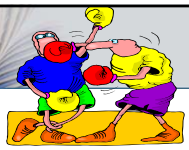
- Effective January 1, 2011, all hospitals and critical access hospitals will have a LSC Specialist Surveyor for:
- - At least 2 days
- - 3 days for hospitals > 1.5 million sq. ft.
- Note: 1 additional day will be added for every 3 buildings classified as a health care occupancy.

Typical TJC Survey Findings

- LSC Building Maintenance Issues (Also CMS)
- Lack of Sufficient Progress on SOC/PFI
- Failure to Implement ILSM
- Not Complying with EC/LS/EM Standards/EPs
- Not Complying w/ Your Own P&Ps
- Not Documenting Your Compliance Efforts



Disputed Survey Findings During Survey



Whenever you feel a surveyor has "mistakenly" cited you for a LS, EC, EM, or any standards issue:

1) At your earliest opportunity, get out the LSC or your accreditation standards manual and, together with the surveyor, review and discuss the applicable section(s) and specific requirements. It may also be necessary to call TJC SIG unit (with the surveyor) to obtain further clarification. Surveyors have 800 #

Disputed Survey Findings During Survey

2) The 2011 HAS manual's The Accreditation Process (ACC) chapter section "Daily Briefings" states, "…surveyors will communicate to organization staff their observations on the previous day's survey findings…, if requested to do. If the org. has additional information that would demonstrate compliance with a standard that a surveyor has indicated may be an RFI, the org. should supply that information to the surveyor(s) a.s.a.p!"

Sage Advice to Organizations

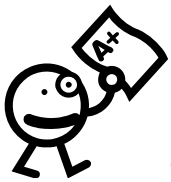
Note: Be prepared to prove that you do what you say you do via:

Minutes of Meetings (e.g. Safety Committee, EM Committee, Infection Control Committee, etc.)
Documented Risk Assessments
Records, Logs, Manifests
Performance Indicators

Being Prepared for Survey

- Obtain Most Current TJC Accreditation Manual
- Review Chapters You are Responsible For
- Highlight Situational Decision Rule EPs 2
- Highlight Direct Impact Requirement EPs 3
- Ensure Policies & Procedures are In Place
- Ensure Management Plans are In Place
- Ensure P&Ps and Mgt. Plans are Implemented and Enforced
- Ensure Applicable Staff Training is Provided

Questions?



Thank You!

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