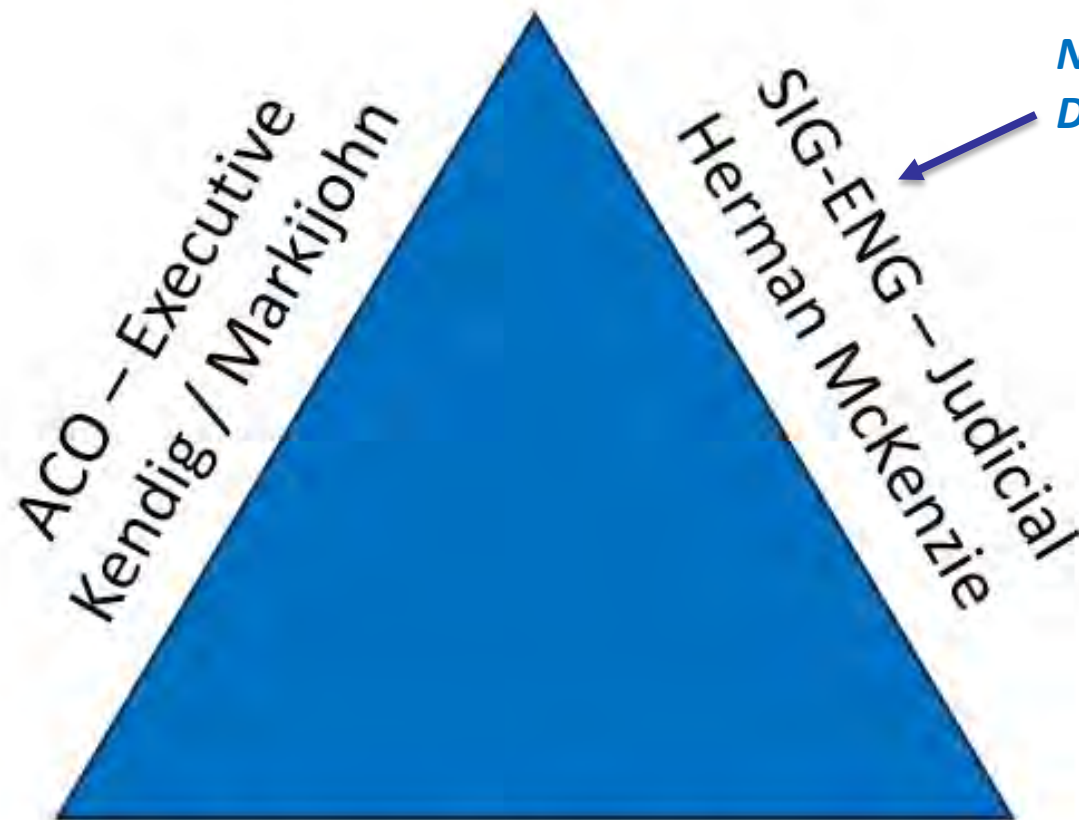

2022 Environment of Care, Life Safety Code, and Emergency Management Updates

Healthcare Facility Managers Society of New
Jersey (HFMSNJ), Iselin, NJ - June 16, 2022

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*Now The Physical Environment
Department*

Physical Environment
Specialists

DSSM – Legislative
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MHA, MPH, CHSP

Life Safety Code Surveyor





What's New, Our Focus

What's New and What We Are Working On

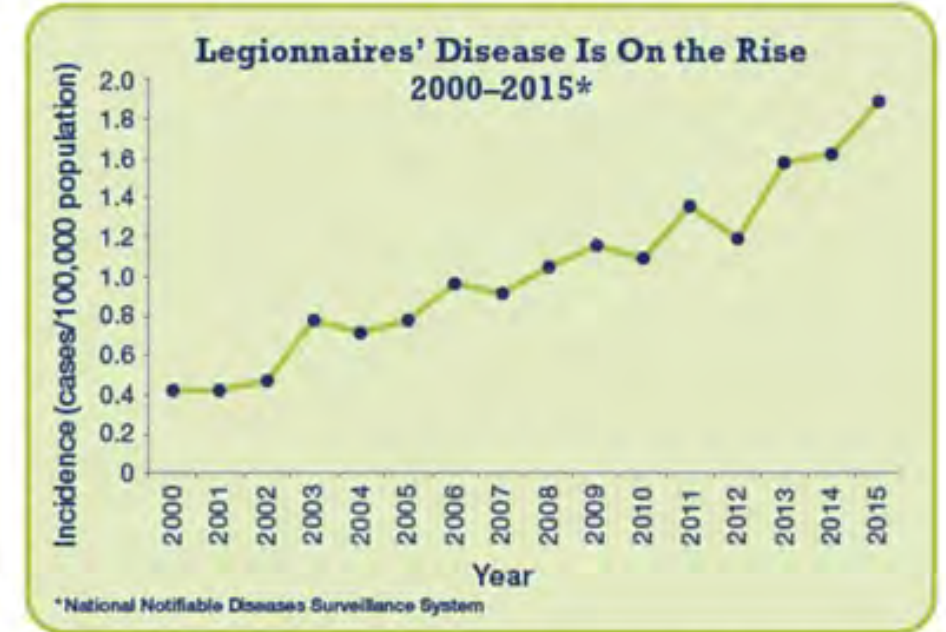
- **NEW** water management standard and EP – January 2022
- **New** Tools
- What LSCSs want you to know
- Updating eapp > BBI
- New name for SIG -**The Physical Environment Department**
- **NEW** EM Standards and Eps – July 2022 – Surveyor education May 2022 – customer education follows
- **NEW WPV**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

We need your help!

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

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>



Legionella Bacteria Found in New York City Hospital: Officials

Published at 9:35 PM EDT on Jul 28, 2018 | Updated at 2:46 PM EDT on Jul 29, 2018


'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

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.*

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

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

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.

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."

From the CDC Toolkit page 2

Identifying Buildings at Increased Risk

Survey your building (or property) to determine if you need a water management program to reduce the risk of *Legionella* growth and spread.

If you answer **YES** to any of questions 1 through 4, you should have a water management program for *that building's* hot and cold water distribution system.

Healthcare Facilities

- Yes ____ No ____ 1. Is your building a healthcare facility where patients stay overnight or does your building house or treat people who have chronic and acute medical problems[†] or weakened immune systems?
- Yes ____ No ____ 2. Does your building primarily house people older than 65 years (like a retirement home or assisted-living facility)?
- Yes ____ No ____ 3. Does your building have multiple housing units and a centralized hot water system (like a hotel or high-rise apartment complex)?
- Yes ____ No ____ 4. Does your building have more than 10 stories (including basement levels)?

Devices in buildings that can spread contaminated water droplets should have a water management program even if the building itself does not. If you answer **NO** to all of questions 1 through 4 but **YES** to any of questions 5 through 8, you should have a water management program for *that device*.

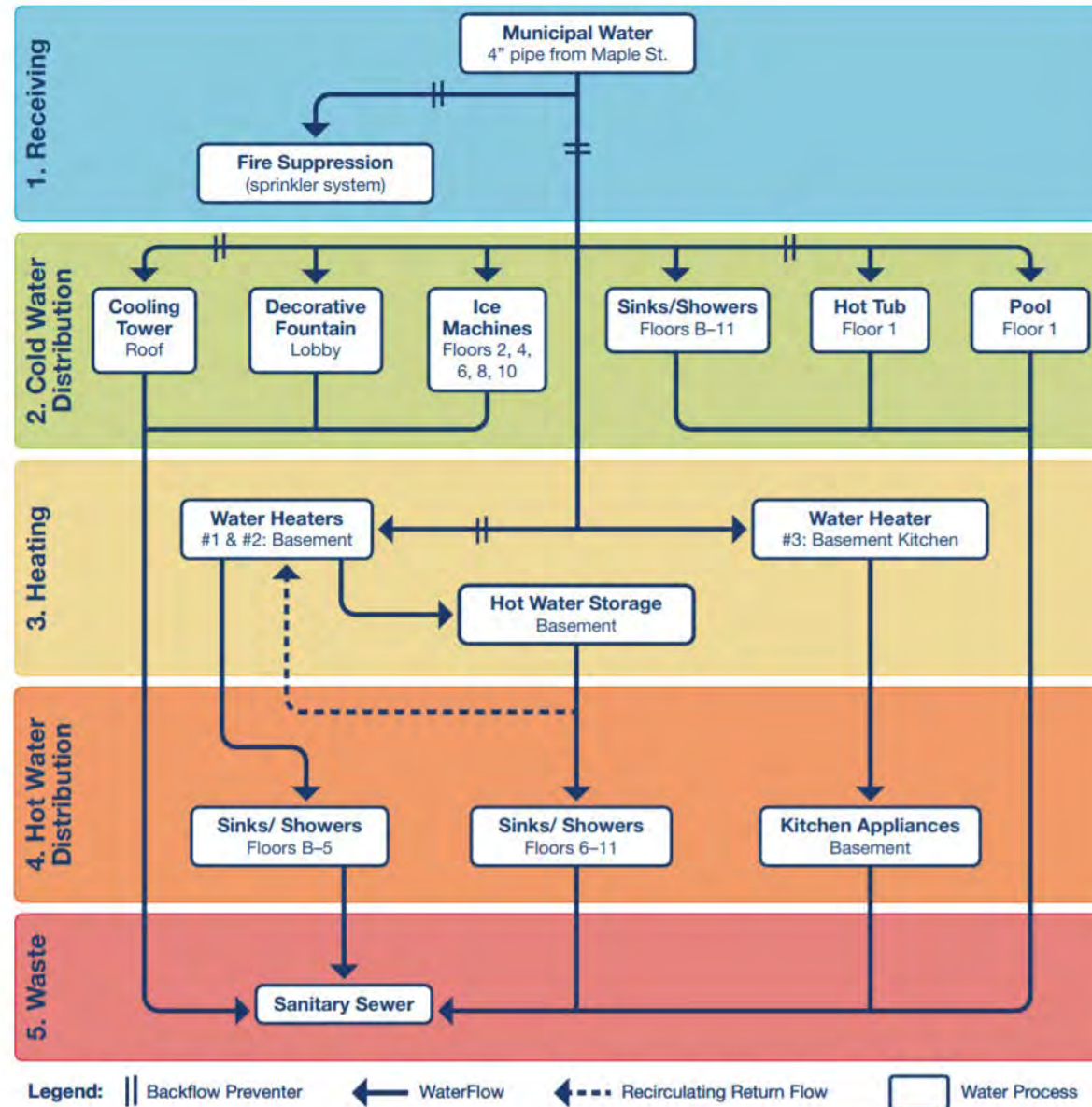
- Yes ____ No ____ 5. Does your building have a cooling tower*?
- Yes ____ No ____ 6. Does your building have a hot tub (also known as a spa) that is not drained between each use?
- Yes ____ No ____ 7. Does your building have a decorative fountain?
- Yes ____ No ____ 8. Does your building have a centrally-installed mister, atomizer, air washer, or humidifier?

If you answer **NO** to questions 1 through 8, you should still maintain water systems according to manufacturer recommendations. On properties with multiple buildings, prioritize buildings that house or treat people who are at increased risk for Legionnaires' disease (see Appendix A to learn who is at increased risk).

The building standards discussed in this toolkit do not apply to single-family or small multiple-family residences (e.g., duplexes), even those with the devices in questions 6 through 8, but residents do need to take steps to protect themselves from waterborne diseases.

Homeowners should follow local and state guidelines for household water use, and owners of the devices in questions 6 through 8 should follow the manufacturer's instructions regarding cleaning, disinfecting, and maintenance.

Flow Diagram – CDC Toolkit page 10



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: **R**
 - 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.

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)

WPV Resources

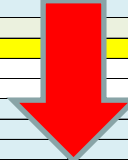
- Prepublication Report: <https://www.jointcommission.org/standards/prepublication-standards/new-and-revised-workplace-violence-prevention-requirements/>
- R3: <https://www.jointcommission.org/standards/r3-report/r3-report-issue-30-workplace-violence-prevention-standards/>
- Compendium of Resources: <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=



New tools...from LSCSs!

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

Hospital Name:										Score at EC.02.03.03 EP3											
Day = M, Tu, W, Th, F, Sa, Su Time: 24 hour formatted										Quarterly Hospital Fire Drills (NFPA 101-2012 18/19 19.7.1)											
										Q1			Q2			Q3			Q4		
										Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
1st Shift	Normal	Location/Building	flr/Main																		
		Day																			
		Date																			
	ILSM	Location/Building																			
		Day																			
		Date																			
2nd Shift	Normal	Location/Building																			
		Day																			
		Date																			
	ILSM	Location/Building																			
		Day																			
		Date																			
3rd Shift	Normal	Location/Building																			
		Day																			
		Date																			
	ILSM	Location/Building																			
		Day																			
		Date																			
Required Annual Fire Drills (NFPA 99-2012 15.13.3.10.3 & 14.3.1.4.5 - if applicable)																					
Location:		Previous	Current	Location:		Previous	Current														
OR				Hyperbaric																	
Day				Day																	
Date				Date																	
Time				Time																	
Quarterly Ambulatory Fire Drills																					
1st Shift			Q1	Q2	Q3	Q4			Q1	Q2	Q3	Q4									
	Location/Building						Location/Building														
	Day						Day														
	Date						Date														
	Time						Time														
Annual Business Occupancy Fire Drills (2 Years of drills)																					
Previous		Current		Previous		Current		Previous		Current		Previous		Current		Previous		Current			
Building		Medical Office Building		Building		Building		Building		Building		Building		Building		Building		Building			
Day				Day				Day				Day				Day					
Date				Date				Date				Date				Date					
Time				Time				Time				Time				Time					
Definitions of Shifts: Provide timeframes for shift hours below (e.g. 1st shift: 0700-1600, 2nd shift: 1600-2400, 3rd shift: 2400-0700)																					
1st																					
2nd																					
3rd																					
NA		Not applicable for no shift, building, location or ILSM.																			
NC		Not completed or missed																			



Hyperbaric Facilities & fire drills

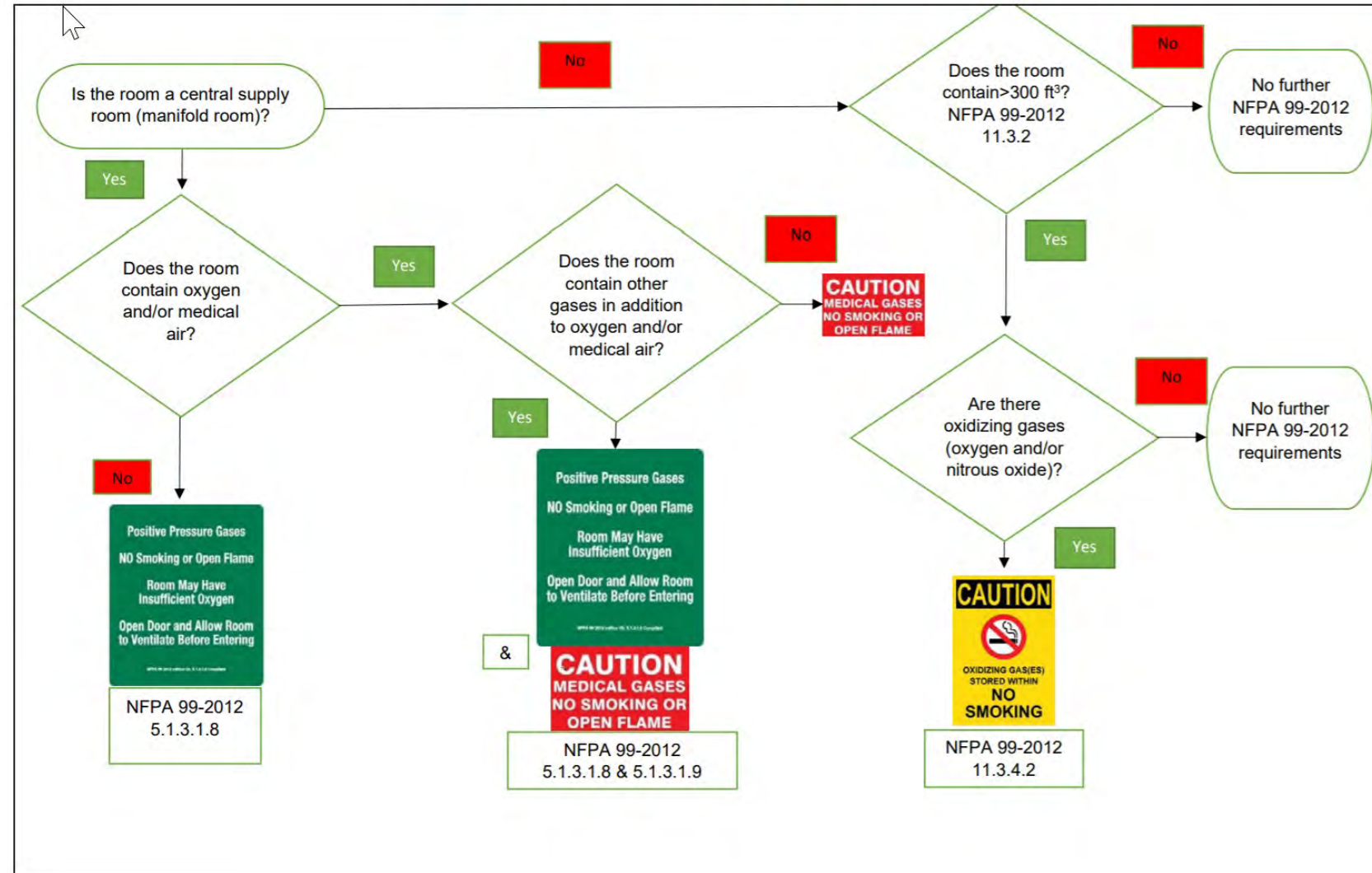
— For July 2022

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.

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 ft² 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.

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

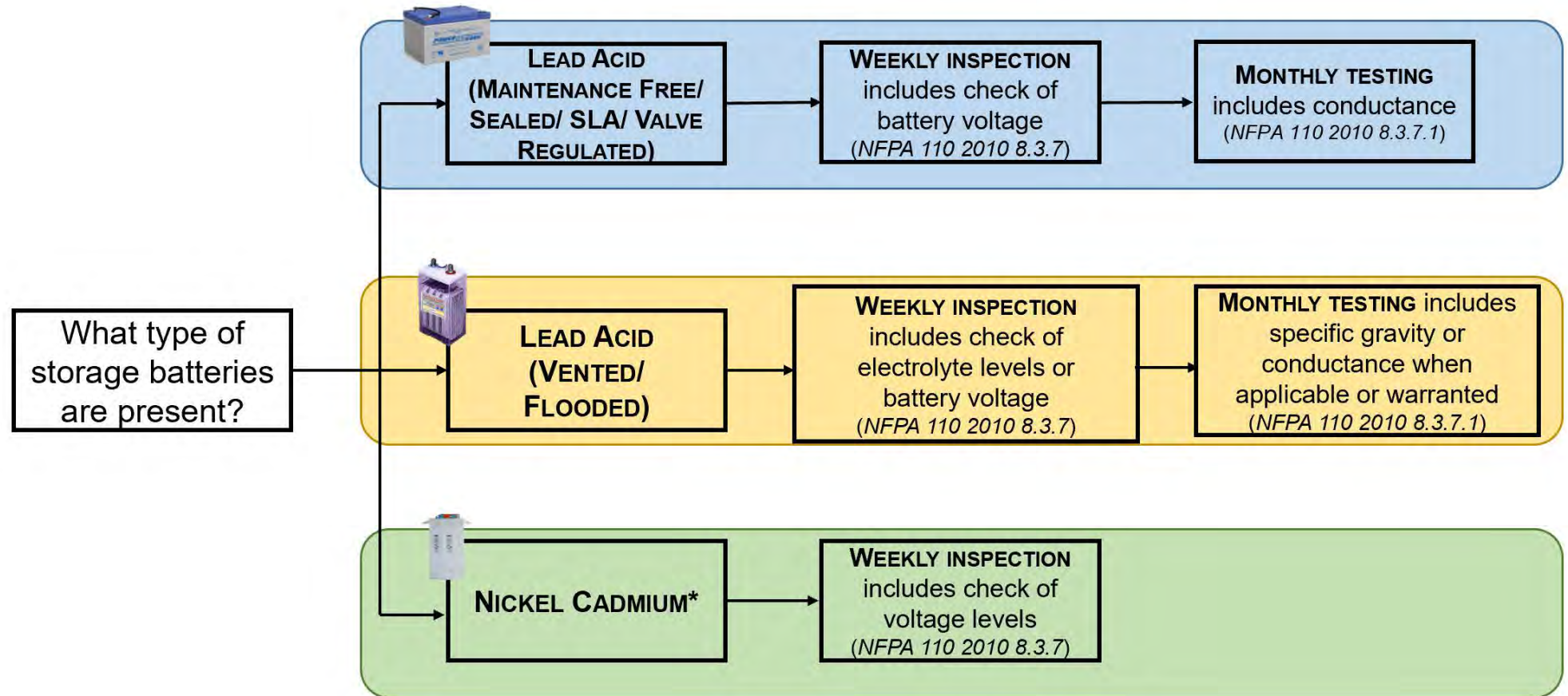
- EC.02.05.07 EP4
 - Every week, the hospital inspects the EPSS, including all associated components and batteries.
 - ATS's
 - Generator Batteries (maintenance free)
 - Monthly Specific Gravity – or – Monthly Conductance

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.

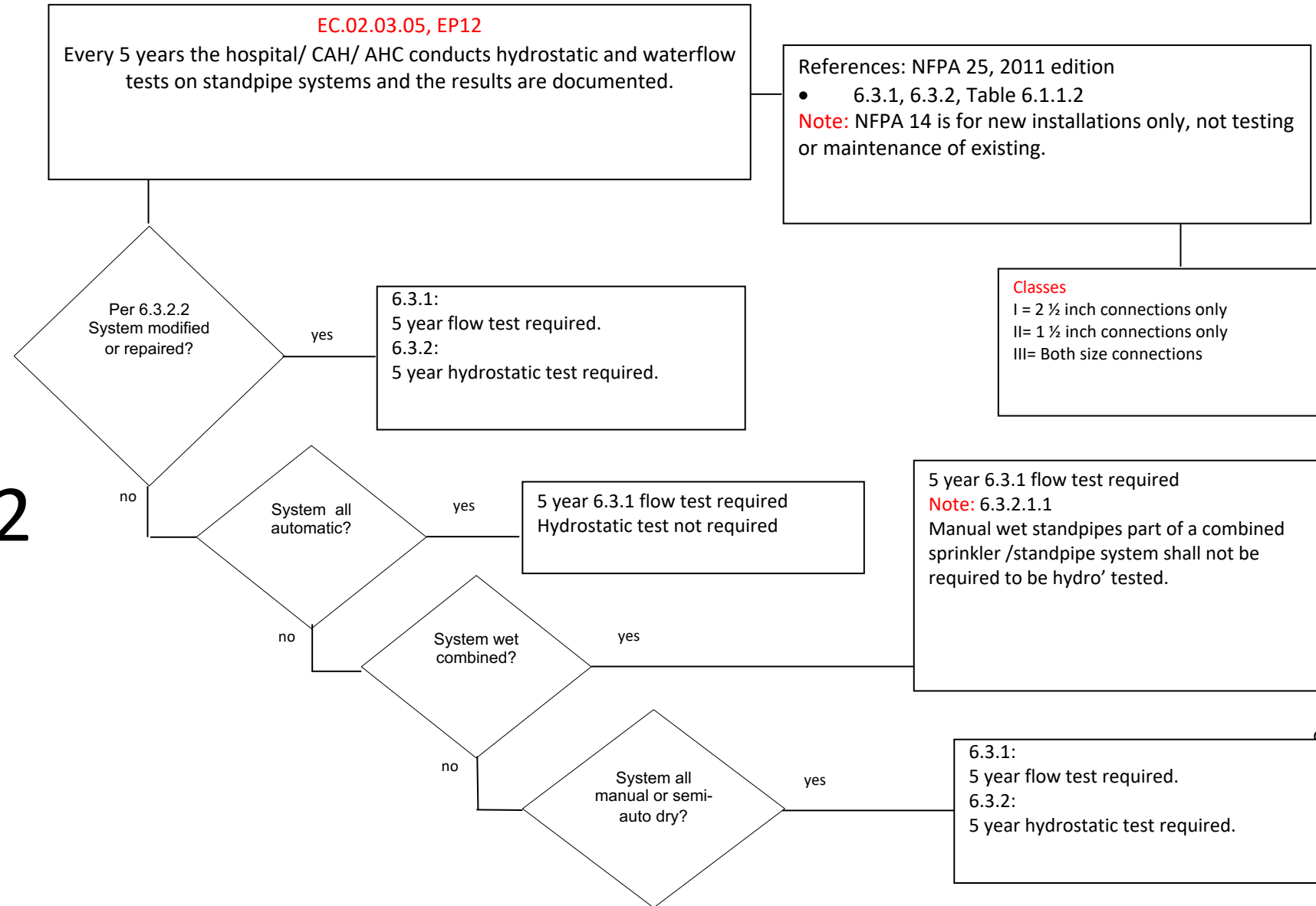
New tools cont. Generator Battery Testing

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.

EC.02.03.05, EP 12 & NFPA 25-2011





What Life Safety Code Surveyors want you to Know...

ABHR



From a life safety standpoint, what should I consider to make sure our alcohol-based hand rub (ABHR) dispensers are properly located and mounted throughout my facility?

Life Safety Code** (NFPA 101-2012) Alcohol-Based Hand Rub (ABHR) Dispensers

- ABHR dispensers are protected in accordance with Section 8.7.3.1 unless all the following conditions are met:
- Corridor is at least 6 feet wide.
- An ABHR dispenser must be installed so that the bottom of the dispenser is at least 42 inches but not more than 48 inches above the finished floor.
- Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols.
- Dispensers have at least 4 feet of horizontal spacing between them.
- Not more than an aggregate 10 gallons of fluid or 1,135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room.
- Storage of more than 5 gallons in a single smoke compartment complies with NFPA 30: *Flammable and Combustible Liquids Code*.
- Dispensers are not installed within 1 inch of an electrical receptacle, switch, device, appliance, or other ignition source.
- Dispensers are not installed directly above an electrical outlet.
- Dispensers above carpeted floors are in sprinklered smoke compartments.
- ABHR does not exceed 95% alcohol.
- Operation of the dispenser complies with Section 18/19.3.2.6(11).
- ABHR is protected against inappropriate access per Section 18/19.3.2.6; and 42 CFR Parts 403, 418, 460, 482, 483, and 485.

*Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.

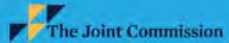
Dispensers are routinely mounted so that the bottom of the dispenser is not less than 42 inches (1067 mm) and not more than 48 inches (1219 mm) above the finished floor.



Must be at least 1" apart



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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.

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

LSCSs want you to know cont.....

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



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.

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

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

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 rack-, table-, pedestal-, 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.

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

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



- Example of an 'assembly'



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)



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)?

- with the requirements of 19.2.3.4 shall be permitted.
- (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.

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 2 3 1 eps 1 & 4).
- Please note: For the BHC program, these standards only apply to buildings that are business occupancies where individuals receive services.

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.

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.

Spare Sprinkler Heads Effective January 1, 2022

AHC

- **LS.03.01.35 EP 7**
- 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.

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)

Condition-Level Deficiency Data

% 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%

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%



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

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

LSCS Survey Process

Standardized agenda

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

Three Questions

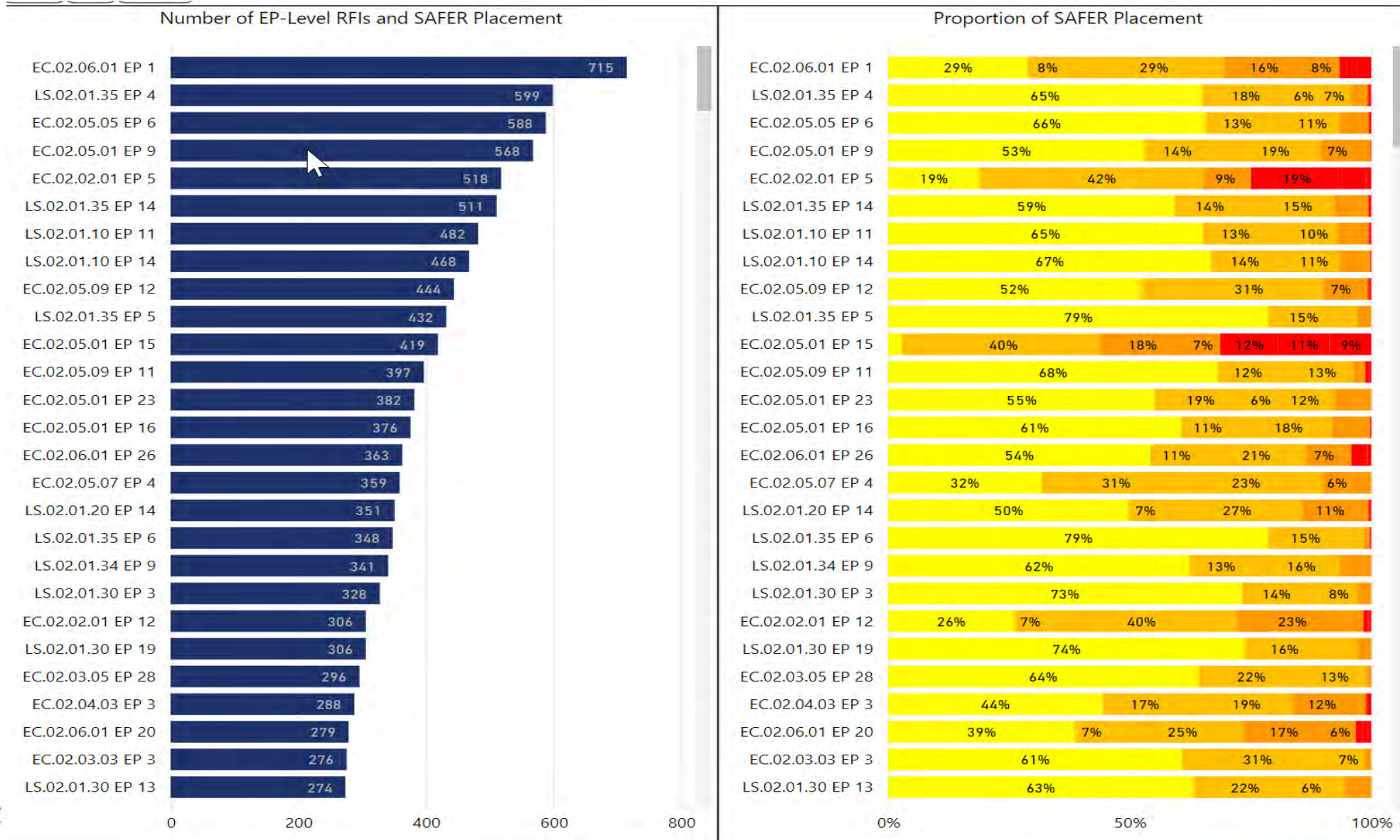
- Fire Stop...
- Above ceiling...
- HLD...

LSCS Survey Process

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

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

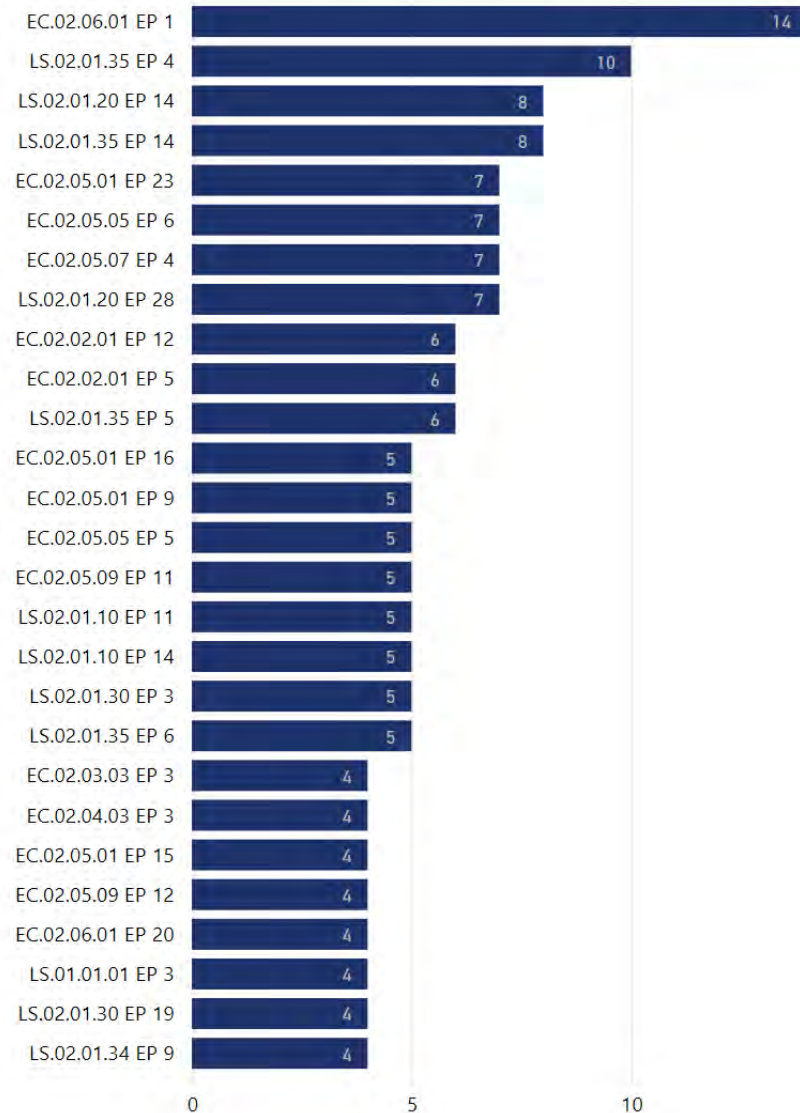
U.S. Most scored during surveys...1/1/21 to 12/31/21



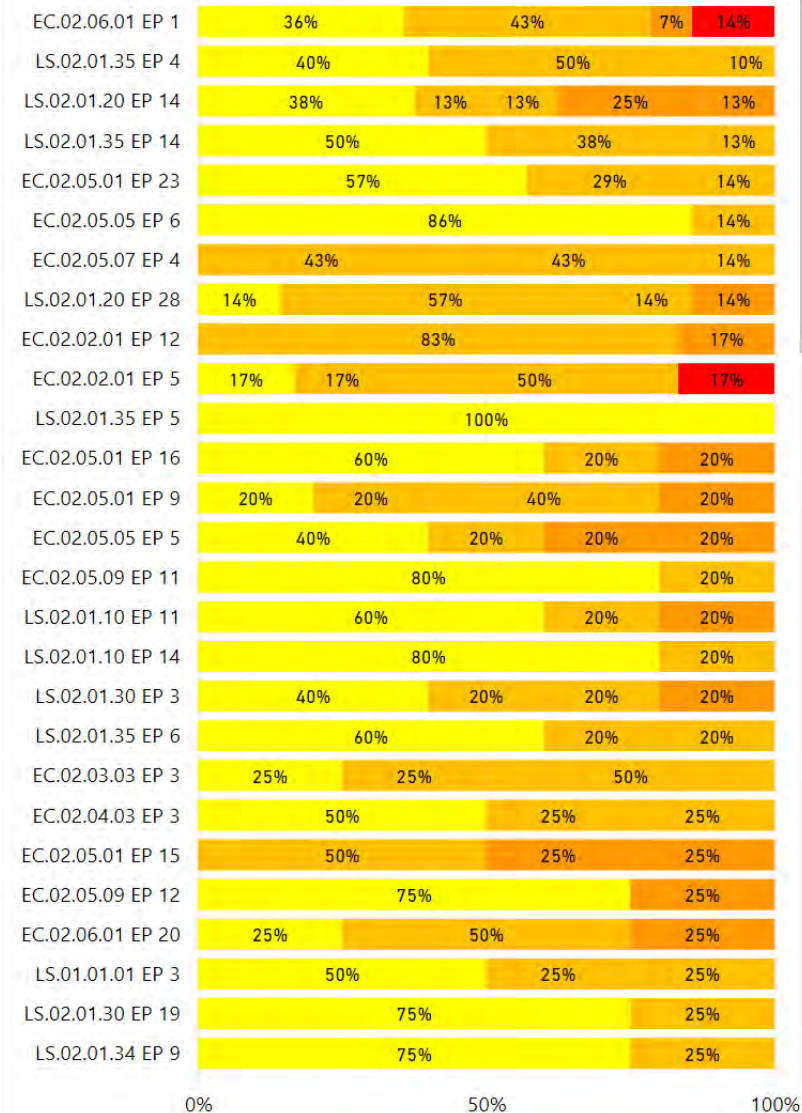
New Jersey



Number of EP-Level RFIs and SAFER Placement



Proportion of SAFER Placement



Reminder – SAFER definition *(Perspectives Jan 2017)*

REMINDER: SAFER™ Matrix Effective January 1, 2017 (continued)
Continued from page 1

		Immediate Threat to Life (a threat that represents immediate risk or may potentially have serious adverse effects on the health of the patient, resident, or individual served)		
Likelihood to Harm a Patient/Staff/Visitor	HIGH			
	MODERATE			
	LOW			
		LIMITED	PATTERN	WIDESPREAD

Scope

Figure 1. SAFER Matrix

- **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.

SAFER National

SAFER Matrix Scoring				
Likelihood to Harm	Immediate Threat to Health or Safety -			0.0%
High	1.9%	0.9%	0.6%	3.4%
Moderate	18.3%	6.1%	2.3%	26.7%
Low	54.7%	11.5%	3.7%	69.8%
	Limited	Pattern	Widespread	
	74.9%	18.5%	6.5%	
	Scope			



SAFER Matrix Scoring

Likelihood
to Harm

Immediate Threat to
Health or Safety -

0.0%

High

1.7%

0.0%

0.0%

1.7%

Moderate

21.6%

7.3%

1.7%

30.6%

Low

49.6%

12.9%

5.2%

67.7%

Limited

72.8%

Pattern

20.3%

Widespread

6.9%

Scope

Some conclusions...

SAFER

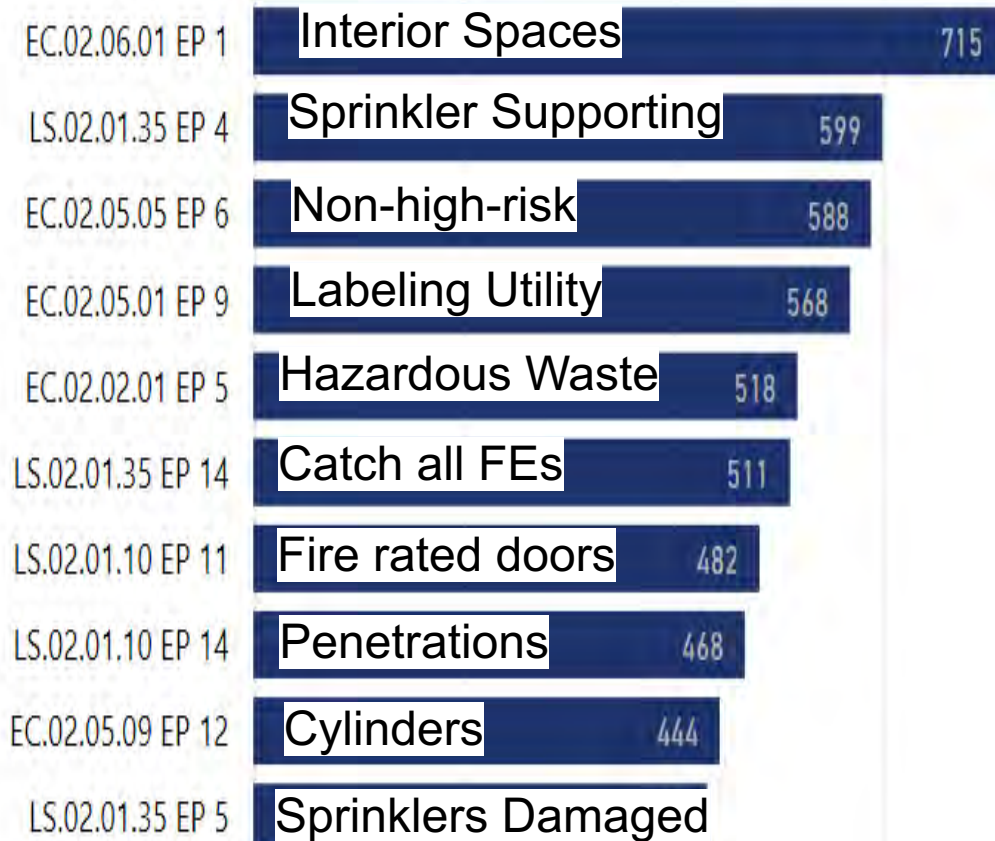
- ❑ Nothing in ITH – congrats!
- ❑ Consistent in placement!
- ❑ Combination of LS and EC standards and elements of performance!

Scoring

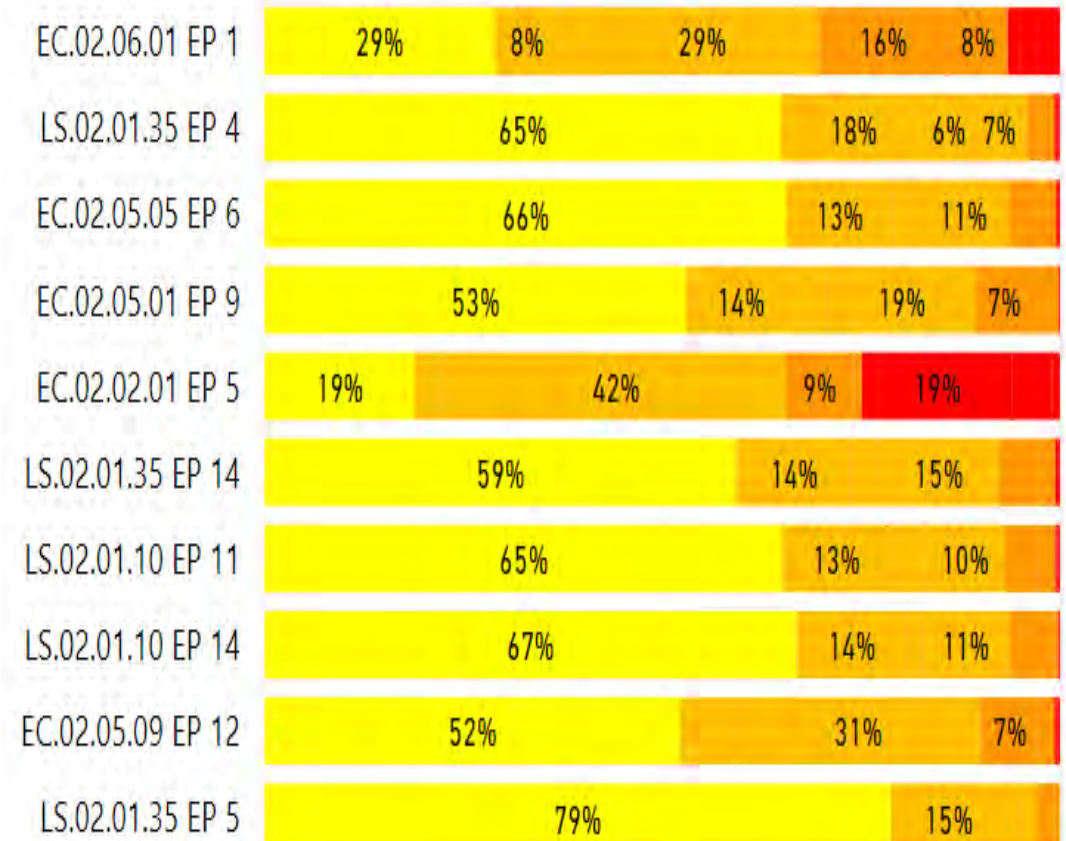
- ❑ Let's take a deeper dive...

Top 10 National

Number of EP-Level RFIs and SAFER Placement



Proportion of SAFER Placement



Top Ten New Jersey



Number of EP-Level RFI and SAFER Placement

EC.02.06.01 EP 1	Interior spaces	14
LS.02.01.35 EP 4	Sprinklers supporting	10
LS.02.01.20 EP 14	Exits blocked	8
LS.02.01.35 EP 14	FE catch all	8
EC.02.05.01 EP 23	Power strips	7
EC.02.05.05 EP 6	Non-high risk 100%	
EC.02.05.07 EP 4	Weekly inspections	7
LS.02.01.20 EP 28	Suite separation	7
EC.02.02.01 EP 12	Labeling haz	6
EC.02.02.01 EP 5	Haz waste	6

Proportion of SAFER Placement

EC.02.06.01 EP 1	36%	43%	7%	14%
LS.02.01.35 EP 4	40%	50%	10%	
LS.02.01.20 EP 14	38%	13%	13%	25%
LS.02.01.35 EP 14	50%	38%	13%	
EC.02.05.01 EP 23	57%	29%	14%	
EC.02.05.05 EP 6	86%		14%	
EC.02.05.07 EP 4	43%	43%	14%	
LS.02.01.20 EP 28	14%	57%	14%	14%
EC.02.02.01 EP 12	83%		17%	
EC.02.02.01 EP 5	17%	17%	50%	17%



Common Compliance Questions

Regarding the Public Health Emergency (PHE)

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 then be postponed

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.

PHE Compliance Issues



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

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 periodic air balance testing to verify that all spaces are compliant.

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?

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.

PHE Compliance Issues



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

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



Risk Assessments

Where, When, How




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

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

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

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.

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)

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)

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

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.

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.

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.

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

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

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).

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.

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).

Interim Life Safety Measures (ILSM)

- Policy reviewed during facility orientation
 - LSCS to provide copy of ILSM reference guide morning of day 1
 - For LS findings, either corrected on-site
- OR
- Surveyor required to document in the report what ILSM is put in place until corrected

Tip for Success: Know your ILSM policy - education can be limited to specific staff such as plant ops and security - be careful how you write your ILSM policy. TJC will hold you to your policy!



ANY QUESTIONS?



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