

2014

THE HEALTHCARE ENVIRONMENT

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RISK ICON



Risk


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

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

Standard/NPSG	2012 Non Compliance	2013 Non Compliance
RC.01.01.01	61%	55%
LS.02.01.20	51%	54%
IC.02.02.01	42%	47%
EC.02.05.01	34%	46%
LS.02.01.10	46%	46%
EC.02.03.05	40%	44%
LS.02.01.30	39%	43%
LS.02.01.35	34%	38%
EC.02.06.01	35%	36%
MM.03.01.01	35%	33%

Standard/NPSG	2012 Non Compliance	2013 Non Compliance
EC.02.02.01	30%	33%
PC.01.03.01	25%	26%
MM.04.01.01	26%	24%
EC.02.05.07	22%	23%
EC.02.05.09	23%	22%
HR.01.02.05	16%	22%
PC.01.02.03	25%	21%
EC.02.03.01	19%	19%
MS.01.01.01	21%	18%
PC.03.01.03	19%	18%

NOTE: THIS JUST IN



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

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

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

No change to bronchoscopy procedure rooms.

GUIDELINES VENTILATION TABLE: ENDOSCOPY & BRONCHOSCOPY



Edition	ENDOSCOPY				BRONCHOSCOPY	
	PROCEDURE		PROCESSING (CLEANING)		PROCEDURE	
	PRESSURE	DIRECT EXHAUST	PRESSURE	DIRECT EXHAUST	PRESSURE	DIRECT EXHAUST
2014 (pending)	N/A	N/A	Negative (-)	YES	Negative (-)	YES
2010	Positive (+)	N/A	Negative (-)	YES	Negative (-)	YES
2006	Neutral	N/A	Negative (-)	YES	Negative (-)	YES
2001	Negative (-)	N/A	N/A	N/A	Negative (-)	YES
1996/1997	N/A	N/A	N/A	N/A	Negative (-)	YES
1992/1993	N/A	N/A	N/A	N/A	N/A	N/A
1987	N/A	N/A	N/A	N/A	N/A	N/A
1979	N/A	N/A	N/A	N/A	N/A	N/A

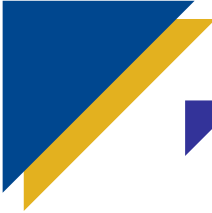


2012 LIFE SAFETY CODE UPDATE

THE FOLLOWING ARE AVAILABLE
WITH CERTAIN PROVISIONS.

THESE ARE BASED ON
CMS S&C 13-58-LSC

BACKGROUND

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

PROCESS



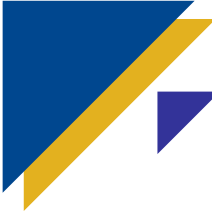
If the organization decides to adopt these categorical waivers they must

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

RH 20 – 60% RANGE

- ▶ CMS first issued a *Categorical Waiver* in S&C 13-25-LSC & ASC to align with the 2010 FGI *Guidelines for Design & Construction of Health Care Facilities* use of ASHRAE 170-2008
 - ❑ Reduced the relative humidity (RH) in certain areas to a range of 20 – 60%
 - ❑ *This 2013 CMS action matched the Joint Commission's 1/2011 adoption* of the 2010 Guidelines and the 20 – 60% RH range provided
- ▶ The S&C had two criteria
 1. Document the decision
 2. Declare at the beginning of a survey the decision

MEANS OF EGRESS 18/19.2.1

- 
- 18/19.2.1 which allow, under certain circumstances, **existing openings** to exit enclosures to **mechanical room spaces** as provided at section 7.1.3.2 Exits and more specifically the requirements at 7.1.3.2(9)(c)

EXISTING OPENINGS TO MECHANICAL SPACES



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

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

18/19.2.5.7 SUITES

- ▶ 18/19.2.5.7.2.1(B) which allow, under certain circumstances, one of the exit access doors in a sleeping suite be permitted to be **directly to an exit stair, exit passageway or exit to the exterior**;
- ▶ 18/19.2.5.7.3.1(B) which allow, under certain circumstances, one of the exit access doors in a **non**-sleeping suite be permitted to be **directly to an exit stair, exit passageway or exit to the exterior**;
- ▶ 18/19.2.5.7.1.2 which allow, under certain circumstances, suites to be **separated by corridor wall requirements**;

MEANS OF EGRESS 18/19.2.2.2

- ▶ 18/19.2.2.2.5.1 which allow, under certain circumstances, door locking arrangements where clinical needs of patients require specialized security measures or where **patients pose a security threat**
- ▶ 18/19.2.2.2.5.2 which allow, under certain circumstances, door locking arrangements based on the patient special needs requiring **specialized security measures for their safety**

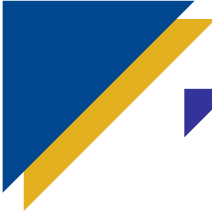
MEANS OF EGRESS 18/19.2.2.2

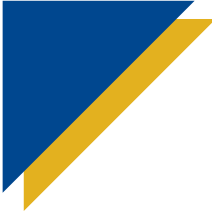
- ▶ 18/19.2.2.2.4 which allow, under certain circumstances, **more than one delayed egress** in the egress path
- ▶ 18/19.2.2.2.6 which allow, under certain circumstances, **remote control of locks** for the rapid removal of occupants

SUITES

- ▶ 18/19.2.5.7.2.3(B) and 18/19.2.5.7.2.3(C) which allow, under certain circumstances, patient sleeping suites **up to 10,000square feet**
- ▶ 18/19.2.5.7.2.2(C) which allow, under certain circumstances, one of the two required exits in a sleeping **suite to exit into another suite**
- ▶ 18/19.2.5.7.3.2(C) which allow, under certain circumstances, one of the two required exits in a ***non*-sleeping suite to exit into another suite;**

96 GALLON CONTAINERS

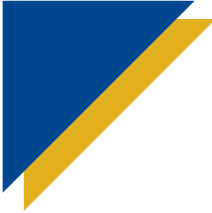
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- ▶ 18/19.7.5.1 which allow, under certain circumstances container used
 - solely for recycling clean waste or
 - patient records awaiting destruction
 - up to 96 gallons are not required to be stored in a room identified as hazardous storage.
 - ▶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



MODIFIED S&C 12-21-LSC

CATEGORICAL WAIVER NOW APPLIES: WHEELED EQUIPMENT EXPANDED


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



MODIFIED S&C 12-21-LSC

CATEGORICAL WAIVER NOW APPLIES: FIXED SEATING ALLOWED

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



MODIFIED S&C 12-21-LSC

CATEGORICAL WAIVER NOW APPLIES: CORRIDOR COOKING ALLOWED

- ▶ 18/19.3.2.5 Cooking Facilities, more specifically the requirements at 18/19.3.2.5.2 - 18/19.3.2.5.5 which allow certain types of alternative kitchen cooking arrangements
 - One cooking area may be open to the egress corridor per smoke compartment
 - Any additional cooking areas must be in protected room similar to hazardous areas
 - Provisions:
 - No deep fat fryers
 - Safety equipment to de-activate fuel supply
 - Grease baffles installed
 - No solid fuel (i.e. charcoal)



MODIFIED S&C 12-21-LSC

CATEGORICAL WAIVER NOW APPLIES: FIREPLACES PLACEMENT MODIFIED

- ▶ 18/19.5.2 Heating, Ventilating, and Air Conditioning more specifically the requirements at 18/19.5.2.3(2), (3) and (4) which allow
 - ❑ the installation of direct vent gas fireplaces in smoke compartments containing patient sleeping rooms and
 - ❑ the installation of solid fuel burning fireplaces in areas other than patient sleeping areas

MODIFIED S&C 12-21-LSC

CATEGORICAL WAIVER NOW APPLIES: COMBUSTIBLE DECORATIONS ADJUSTED

- ▶ 18/19.7.5 Furnishings, Mattresses, and Decorations including sections 18/19.7.5.6 which allow the installation of combustible decorations on walls, doors and ceilings.
 1. On non-fire rated doors and do not interfere with latching or area limits at 18/19.7.5.6(b), (c), (d)
 2. $\leq 20\%$ of wall, ceiling and door, inside a room or space of a smoke compartment that is not protected throughout with approved automatic sprinkler system

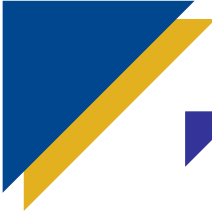
MODIFIED S&C 12-21-LSC

CATEGORICAL WAIVER NOW APPLIES: COMBUSTIBLE DECORATIONS ADJUSTED

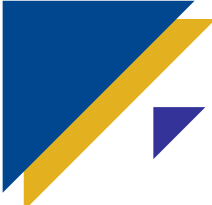
Continued:

3. $\leq 30\%$ of wall, ceiling and door inside a room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system
4. $\leq 50\%$ of wall, ceiling and door, inside a patient sleeping room with capacity of ≤ 4 persons in a smoke compartment that is protected throughout with approved, supervised automatic sprinkler system

CENTRALIZED COMPUTER SYSTEM FOR MEDICAL GAS MASTER ALARM

- 
- 101-2012 Section 2.2 refers to the 2012 edition of the Health Care Facilities Code, and more specifically 5.1.9.2.2 which allows a **centralized computer system** to be permitted to be substituted for one of the medical gas master alarms required at 5.1.9.2.1 if the computer system complies with 5.1.9.4.

ANNUAL LOAD BANK TEST REDUCED 25% SAVINGS



18/19.2.9 Emergency Lighting, more specifically the requirements at 18/19.2.9.1 which refers to 7.9, which refers to NFPA 110-2010 which includes requirements for **annual load bank tests** as follows:


- ❑ 30 minutes at 50% of nameplate, and
- ❑ 60 minutes at 75% of nameplate
 - see NFPA 110-2010 8.4.2.3

▶ **Cost savings of 25%** based on reduction of two hour test by 25%


WEEKLY CHURN NOW MONTHLY: ELECTRIC MOTOR DRIVEN FIRE PUMP

- ▶ LSC sections 18/19.3.5 Extinguishment Requirements, and more specifically the requirements at 9.7.5 Maintenance and Testing which refers to NFPA 25-2011. This edition of NFPA 25, the *Standard for the Inspection, Testing & Maintaining of Water-Based Fire Protection Systems* section 8.3.1.2. which requires the **electric motor driven fire pump exercise to be monthly;**
- ▶ Cost savings of reducing a weekly test to monthly is a **77% cost savings**

WATER FLOW ALARM TEST SEMI-ANNUALLY

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

PRA EC.02.06.05 EPs 2 & 3



Preconstruction Risk Assessment (PRA)
Construction or renovation in occupied
healthcare facilities can result in environmental
problems such as:

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

INTERIM LIFE SAFETY MEASURES



Order of Standards (LS.01.02.01)

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

RELOCATABLE POWER TAPS (RPTs)



CMS:

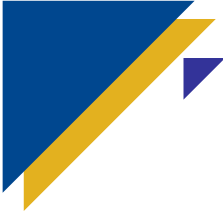
- ❑ “RPT’s are not to be used with medical equipment in patient care areas.

- This includes critical areas such as operating rooms, recovery areas, intensive care areas, and non-critical patient care areas such as patient rooms, diagnostic areas, exam areas, etc.”

- ▶ Healthcare Interpretation Task Force (12/2007) stated

- ❑ NFPA 70, NFPA 99 and NFPA 101 all have regulations that control the electrical components and equipment in a patient room. *It appears that it is the intent of these documents to restrict RPT use so that it is not used in conjunction with medical equipment*

RELOCATABLE POWER TAPS

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



THE HEALTHCARE ENVIRONMENT

SURVEY REPORT CHANGES

2014

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The Joint Commission



WHAT PROMPTED THE CHANGES?

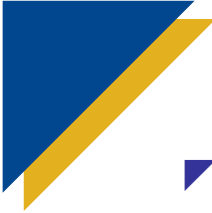
- ▶ The Centers for Medicare and Medicaid Services (CMS) has approved The Joint Commission to use its accreditation programs to deem certain providers in compliance with federal requirements.
- ▶ Recently, our Hospital and Home Care accreditation programs went through the application process to renew CMS's approval. During that review, CMS identified areas we need to change to align with their requirements for continued deeming.
- ▶ On May 23rd we received a response from CMS in which they approved our responses/action plans for the “category 3” items, **which include LSC waivers, PFI follow-up processes, and citation of all deficiencies (i.e., single observation C EPs and PFIs.)**
 - ❑ These changes will be effective as of **July 1, 2014.**
- ▶ **Please note:** We are still awaiting response from CMS related to our standards crosswalk and survey process components before a final determination is made on renewal of our deeming authority.



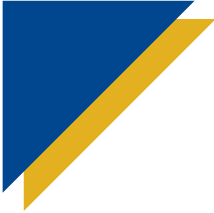
OUR NUMBER ONE PRIORITY — PATIENT SAFETY!

- ▶ As we strive to help all health care organizations achieve “zero harm”, we believe that these changes will help us all focus on the highest level of patient safety.
- ▶ These changes will offer our customers a more complete picture of their risk areas.

THE FOLLOWING WILL BE IMPLEMENTED FOR ALL ACCREDITATION AND CERTIFICATION PROGRAMS BEGINNING **JULY 1, 2014:**

- 
- ▶ Single observations at C category EPs will be included in a new, separate section of the accreditation and certification decision reports, titled **Opportunities for Improvement (OFIs)**.
 - ❑ OFIs will *not* require official follow-up through the Evidence of Standards Compliance (ESC) process.
 - ❑ Organizations will not be able to use the clarification process on OFIs.
 - ▶ All open and accepted Plans for Improvement (PFIs) from the organization's Statement of Conditions (SOC) will be included in a new, separate section of the accreditation and certification decision reports, titled **Equivalencies/Plans for Improvement**
 - ❑ PFIs will *not* require official follow-up through the Evidence of Standards Compliance (ESC) process, however, the organization will still need to complete the scope of work self-identified in the PFI.
 - ❑ All previously granted Life Safety Code Equivalencies will be reviewed during the full survey and affirmed that they are consistent with what was previously submitted.
 - ❑ New Life Safety Code Equivalency requests will be reviewed and processed by the Joint Commission SIG Engineers, and those with a recommendation for approval will be sent to the CMS Regional Office for final decision.

NEW REPORT CONTENTS



Report Contents

Executive Summary

Requirements for Improvement

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

Opportunities for Improvement

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

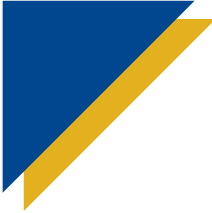
Equivalencies/Plan for Improvement

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

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

New page describing the 3 sections of the report

NEW REPORT CONTENTS

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

OPPORTUNITIES FOR IMPROVEMENT



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

REPORT SCREENSHOTS



Description of Section

Opportunities for Improvement

Opportunities for Improvement – Summary

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

Program:	Hospital Accreditation Program	
Standards	EC.02.01.01	EP5

Summary of observations that are OFIs

REPORT SCREENSHOTS



Opportunities for Improvement – Detail

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.01.01
Standard Text: The hospital manages safety and security risks.

OFI Standard

Primary Priority Focus Area: Physical Environment

OFI EP

Element(s) of Performance:
5. The hospital maintains all grounds and equipment



Scoring Category: C

OFI Observation

Observation:
**Observed in Tracer Activities at Demo Healthcare Provider (1 Renaissance Blvd, Oakbrook, IL) site for the Hospital deemed service.
The key was left in the trash compactor while unattended.**

****Please note: Corresponding CoPs will not be displayed in the "Opportunities for Improvement" section since the observation does not require follow-up**

ONE MORE CHANGE: BOLDING THE OBSERVATION TEXT

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.02.01

ESC 45 days

Standard Text: The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance:

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



Scoring

Category :

A

Score :

Insufficient Compliance

Observation(s):

EP 6

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

Radioactive materials must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice.

This Standard is NOT MET as evidenced by:

Observed in Tracer Activities at Demo Healthcare Provider (1 Renaissance Blvd, Oakbrook, IL) site for the Hospital deemed service.

During a tour of the Radiation Therapy department of the Cancer Center, the Hot Lab door was found unsecured. The Hot Lab was identified in the Hospital Security Plan as a risk area.

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



PLAN FOR IMPROVEMENT MODIFICATIONS


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BACKGROUND

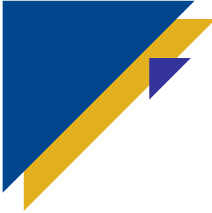


- ▶ Many organizations conduct routine building inspections
 - ❑ During inspections deficiencies are discovered
 - ❑ Resolution of deficiencies occurs either
 - Immediately
 - Scheduled activity (i.e. corrective maintenance)
 - Scheduled activity (i.e. Plan For Improvement)

BACKGROUND

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

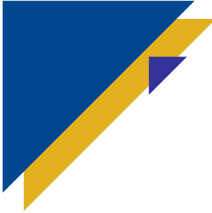
PLAN FOR IMPROVEMENT



All PFIs may be edited by the organization until they are *accepted* during survey

- ❑ On the first day of survey the surveyor will review all open PFIs by entering the Statement of Conditions, selecting the **PFI** button and then the **PFI Menu**, and then **View All**
- ❑ The Surveyor will evaluate each PFI for validity
- ❑ The Surveyor will “**accept**” the Open PFI which locks the PFI
 - The Surveyor may select all PFIs on the displayed page or individually
 - Once selected click on the PFI Accept button
 - Go to the next screen and repeat
 - Finalize by entering status update into the History Audit Trail

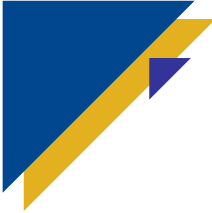
PLAN FOR IMPROVEMENT



Once the Joint Commission accepts the PFI we are acknowledging the organization has identified deficiencies in the Plan For Improvement

- ❑ The Joint Commission expects the organization to resolve the deficiency within six months of the Projected Completion Date
- ❑ Failure to meet the Projected Completion Date within six months may result in an adverse decision (AFS10)
- ▶ A monitoring feature has been built into the PFI that is based on the Projected Completion Date (PCD) and actual calendar date
 - ❑ Once a PFI exceeds the PCD by more than 4 months the PFI turns yellow
 - ❑ Once a PFI exceeds the PCD by more than 6 months the PFI turns red
 - At this point a email is sent to the Central Office Department of Engineering


PLAN FOR IMPROVEMENT



A monitoring feature is built into the PFI that is based on the Projected Completion Date (PCD) and actual calendar date

- ❑ Once a PFI exceeds the PCD by more than 4 months the PFI turns yellow
- ❑ Once a PFI exceeds the PCD by more than 6 months the PFI turns red
 - At this point a email is sent to the Central Office Department of Engineering
 - An engineer will contact the organization with a first time coaching call
 - If a second PFI exceeds the PCD by more than 6 months an onsite survey may be scheduled
 - This could result in an adverse decision (AFS10)

PFI SCREEN SHOTS

- 
- ▶ First two PFIs are not overdue:
 - ❑ First one is unaccepted: The organization has full edit capability
 - ❑ The second one was accepted: Not overdue, compliant
 - ▶ Second set of two PFIs: ≥ 4 months past PCD [YELLOW]
 - ❑ First one is unaccepted: The organization has full edit capability
 - ❑ The second one was accepted, if the organization does not anticipate completion on time the need to submit extension request
 - ▶ Third set of two PFIs: ≥ 6 months past PCD [RED]
 - ❑ First one was accepted: the organization must either complete the PFI or request an extension from the Joint Commission Central Office Engineers
 - ❑ The second one is unaccepted: the organization has full edit capability
 - The organization should evaluate process

BBI

PFI

Mock Test
 Test Login
 (555)555-5555

PFI

- Search
- Open
- Closed
- ViewAll
- Convert Excel PFI
- Import PFI
- View Errors
- Create New
- History / Audit Trail
- PFI Pie Chart
- Request for Extension and Equivalencies

PFI View All

All Sites/Buildings
 Specific Site/Building
 Filter: All Open Items

Proj Comp Date > 4 Months
Proj Comp Date > 6 Months
Actual Comp > 6 Months of Proj Comp Date

Listing of PFI items for this HCO:

view	ILSM Assess	Site	Building	PFI ID	Description	Proj. Comp Date	Accept Date	Accept?/Modify?	Status
view	N	Rush North Shore Medical Center	HAP - BK: 7/19/13_HAP	7/29/13 at 3	New PFI: 7/29/13 at 3:52pm.	07/16/14		<input type="checkbox"/>	Modified
view	N	Rush North Shore Medical Center	HAP - BK: 7/19/13_HAP	11/25 test	11/25 test	06/11/14	5/28/2014	<input checked="" type="checkbox"/>	Accepted
view	N	Rush North Shore Medical Center	HAP - BK: 7/19/13_HAP	7/29/13 at 3	New PFI: 7/29/13 at 3:52pm.	01/16/14		<input type="checkbox"/>	Modified
view	N	Rush North Shore Medical Center	HAP - BK: 7/19/13_HAP	13.20.091	BK: 9/12/13	01/14/14	5/28/2014	<input checked="" type="checkbox"/>	Accepted
view	N	Rush North Shore Medical Center	HAP - BK: 7/19/13_HAP	7/29/13 at 3	New PFI: 7/29/13 at 3:52pm.	08/08/13	7/31/2013	<input checked="" type="checkbox"/>	Accepted
view	N	Rush North Shore Medical Center	HAP - BK: 7/19/13_HAP	55	m	08/01/13			New

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Help Tab



PLAN FOR IMPROVEMENT

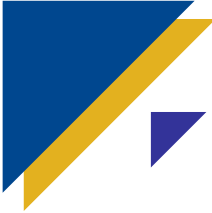
IMPORTED INTO THE FULL SURVEY REPORT

Anne M. Guglielmo, Engineer
Engineering Department
The Joint Commission

PFI UPDATE

- ▶ When a Life Safety Code deficiency is found during survey it results in an RFI
 - ❑ If the organization has a PFI already identifying the deficiency, the finding is not written
 - ❑ If the organization does not have a PFI identifying the deficiency, then a finding is written
- ▶ Effective July 1, 2014 all open, accepted PFIs will be imported into the final survey report
 - ❑ At close of survey only a summary page of open accepted PFIs will be in the preliminary exit report

PFI UPDATE

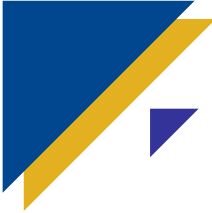
- 
- If the organization wants to see their open, accepted PFIs at the exit conference, they can print them out by opening their SOC, clicking on PFI, selecting PFI Menu, selecting View All, and then select Print
 - The final, full survey report following the clarification period will have all open, accepted PFIs listed in the PFI Section
 - The final report is a pdf, and print ranges may be used by the organization to print sections



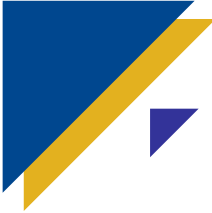
EQUIVALENCIES

Anne M. Guglielmo, Engineer
Engineering Department
The Joint Commission

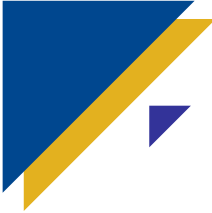
EQUIVALENCIES

- 
- ▶ CMS grants waivers, which are when Life Safety Code (LSC) non-compliance is identified and have corrective actions that would pose a hardship but the deficiency does not present a risk to patient or staff safety
 - ▶ The Joint Commission manages equivalencies, which are based on the LSC (NFPA 101-2000, 1.5)
 - An equivalency is when alternative methods, systems or devices off set the risk associated with the LSC non-compliance condition

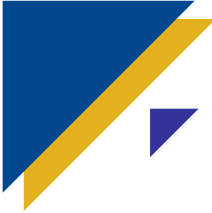
EQUIVALENCIES

- 
- ▶ When Joint Commission granted an equivalency they entered a summary in the Statement of Conditions™ Plan For Improvement under the History Audit Trail Section
 - ▶ Effective 7/1/2014 surveyors will be reviewing the History Audit Trail for evidence of equivalencies that have been granted
 - During building tour the surveyor will field verify the conditions align with the information sent during the request process


EQUIVALENCIES

- 
- ▶ Once the survey is completed, in **WST** will be a question as follows:
 - Does the organization have previously granted equivalencies? YES NO
 - ▶ If NO, then no further action is needed, and nothing will appear in the final survey report related to equivalencies
 - ▶ If YES, then two more questions will be asked:
 1. Were the conditions associated with the equivalency met? YES NO
 2. Was there evidence corrective actions would create a hardship for the organization? YES NO

EQUIVALENCIES

- 
- ▶ If both questions are answered **YES**, then in the final survey report a section titled Equivalencies / PFI Summary will be created
 - ▶ Under the Equivalencies paragraph will be:
 - ❑ **Status:** During survey your existing, approved Equivalencies were evaluated and affirmed consistent with what was submitted previously. It was confirmed that corrective actions may present an ongoing hardship but conditions remain safe for patient staff and visitors.

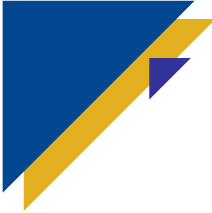
EQUIVALENCIES



If either or both questions are answered **NO**, then in the final survey report a section titled Equivalencies / PFI Summary will be created

- ▶ Under the Equivalencies paragraph will be:
 - ❑ **Status:** During survey your existing, approved Equivalencies were evaluated and found to be non-compliant. An observation(s) was documented and is contained within this report.
- ▶ Clearly annotate the History Audit Trail with this information about the failed equivalency
- ▶ Write the appropriate RFI in the Life Safety Chapter

CMS & EQUIVALENCIES



Organizations that use Joint Commission accreditation for deemed status purposes equivalencies will continue to be submitted to our offices

- ❑ The Engineering staff will work with the organizations until the request is acceptable
- ❑ Once the equivalency is considered acceptable the Joint Commission will forward the entire request to the CMS Regional Office (RO) for final decision
- ❑ The CMS RO will send a response to both the organization and Joint Commission
 - If approved the History Audit Trail will be updated
 - If denied, the organization will need to either correct the deficiency or re-submit a corrected equivalency



EQUIPMENT MANAGEMENT

MEDICAL EQUIPMENT: EC.02.04.01, EC.02.04.03

UTILITY SYSTEMS: EC.02.05.01, EC.02.05.05

ONLY APPLIES TO HOSPITAL PROGRAMS

Anne M. Guglielmo, Engineer
Engineering Department
The Joint Commission

EC.02.05.01



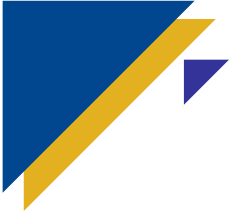
Standard EC.02.05.01

The hospital manages risks associated with its utility systems.

EC.02.05.01 EP 1


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

EC.02.05.01 EP 2



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


EC.02.05.01 EP 3



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

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

EC.02.05.01 EP 4




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

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

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

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

EC.02.05.01 EP 5



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

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


EC.02.05.01 EP 5 (CONTINUED)



▶ Note: Maintenance history includes any of the following documented evidence:

- ❑ Records provided by the hospital's contractors
- ❑ Information made public by nationally recognized sources
- ❑ Records of the hospital's experience over time

EC.02.05.01 EP 6



For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified individual(s) uses written criteria to support the determination whether it is safe to permit operating components of utility systems to be maintained in an alternate manner that includes the following:

- How the equipment is used, including the seriousness and prevalence of harm during normal use
- Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm
- Availability of alternative or back-up equipment in the event the equipment fails or malfunctions
- Incident history of identical or similar equipment
- Maintenance requirements of the equipment

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

EC.02.05.01 EP 7




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

EC.02.05.01 EP 8



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

EC.02.05.01 EP 9



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

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

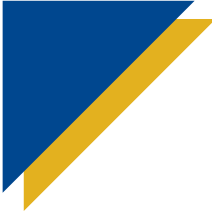
- operating rooms
- special procedure rooms
- delivery rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis)
- patients in "protective environment" rooms (for example, those receiving bone marrow transplants), laboratories,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

EC.02.05.05 EP 1



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

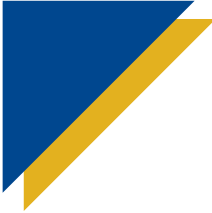
EC.02.05.05 EP 3



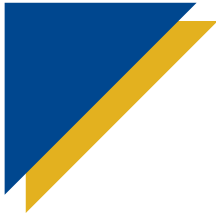
The hospital inspects, tests, and maintains the following: ~~life-support~~ High-risk utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2 and 4)

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

EC.02.05.05 EP 4


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

EC.02.05.05 EP 5



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

EQUIPMENT SURVEY PROCESS



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

❑ Accuracy of Inventory

- All High-risk and Life Support equipment must be on the inventory and identified
- Preventive maintenance frequencies must be clearly defined in writing

❑ Confirm work done as per scheduled activities

- Ensure appropriate work is scheduled based on maintenance strategies
- Evaluate equipment failure and scheduled actions

SURVEY PROCESS: STAFF INTERVIEWS



Department Leader

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

SURVEY PROCESS: STAFF INTERVIEWS



Equipment Maintainers

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

SURVEY PROCESS: STAFF INTERVIEW




Users of the Equipment

- Evaluate equipment reliability
- Evaluate response time when equipment fails
 - Evaluate emergency response process
- Evaluate “Culture of Safety”
 - Appropriate training of staff related to equipment use
- Customer satisfaction with department

Contract Services

- Evaluate the process used to ensure contractors use qualified personnel
- Evaluate reliability of equipment serviced
- Evaluate integration of the process

EVALUATING PROGRAM EFFECTIVENESS

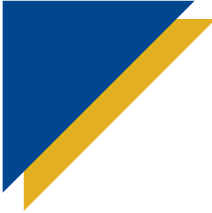


The equipment management programs must have written policies & procedures

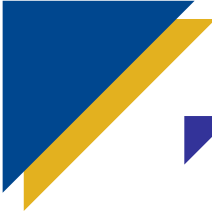
▶ Evaluating the program:

- ❑ How is equipment evaluated to ensure no degradation of performance?
 - Consider mis-calibration of equipment
 - Consider test equipment calibration confirmation
- ❑ How are equipment-related incidents investigated?
 - Could the malfunction have been avoided?
 - Did the alternative maintenance strategy contribute to the malfunction?
 - How to sequester equipment deemed unsafe?

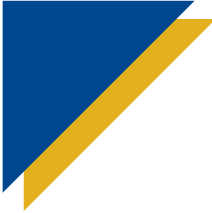
EVALUATING PROGRAM EFFECTIVENESS

- 
- ▶ Is there a performance process to evaluate if modifications to the maintenance strategy are needed?
 - ▶ Evaluate the accuracy of the inventory
 - ❑ High-risk equipment segregated in the inventory?
 - ❑ Equipment in an alternative maintenance program segregated?
 - ❑ Grouping of like equipment is acceptable
 - ❑ Are imaging/radiologic equipment and medical laser devices exempt from the alternative maintenance program?

EVALUATING PROGRAM EFFECTIVENESS: MISCELLANEOUS TOPICS

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

HIGH-RISK MEDICAL EQUIPMENT

- 
- High-risk equipment
 - Includes Life Support
 - Heart/lung bypass machine
 - Anesthesia equipment
 - Circulatory Assist Equipment
 - IABP
 - LVAD
 - Ventilations
 - Adult; Infant; MRI-Compatible
 - Other High-risk equipment
 - Defibrillators
 - Robotic surgery devices

HIGH-RISK UTILITY SYSTEMS



- High-risk equipment
 - Includes Life Support
 - Isolation room air handlers
 - Operating room air handlers
 - Egress components
 - Other High-risk equipment
 - Emergency Generators
 - Medical Gas System
 - Fire Alarm System
 - Sprinkler System

DEPARTMENT OF ENGINEERING
630 792 5900



George Mills, MBA, FASHE, CEM, CHFM, CHSP, Green Belt
Director

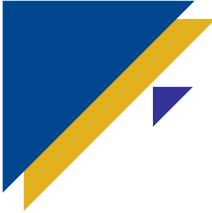
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Kathy Tolomeo, CHEM
Engineer

James Woodson, P.E., CHFM
Engineer

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