COMPLIANCE news

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NOTIFYING TJC ABOUT ORGANIZATION CHANGES

By Dean Samet, CHSP *dsamet@ssr-Inc.com*

If and when significant changes occur within a hospital, the hospital must notify The Joint Commission in writing or through its Joint Commission Connect site not more than 30 calendar days after such a change is made. The hospital must also notify TJC in writing or in its electronic application (e-APP) if it opens or closes any units or services.

There are three change categories addressed in the 2011 Hospital Accreditation Standards manual's The Accreditation Process (ACC) chapter:

- Changes affecting e-APP Information
- Changes to the Site of Care, Treatment, or Services
- Mergers, Consolidations, and Acquisitions

An accredited hospital might undergo a change that modifies the information reported in its e-APP. The hospital must update its e-APP within 30 calendar days after such a change is made in:

- Ownership
- Location
- A significant increase/decrease in the volume of services or individuals served
- The addition or deletion of a new type of health service, program or site of care
- The acquisition of a new component
- The deletion of an existing component

The accuracy and veracity of relevant information reported in the e-APP is subject to The Joint Commission's Information Accuracy and Truthfulness Policy and must be accurate and truthful. Falsification, which applies to both commissions and omissions in sharing information with TJC, will lead to a Preliminary Denial of Accreditation decision.

When a hospital offers at least 25% of its services/programs at a new location or in a significantly altered physical plant, the hospital must also fill out and submit a TJC Basic Building Information (BBI) within the electronic Statement of Conditions™ (e-SOC), which is available on the hospital's secure Joint Commission Connect site, and Plan for Improvement (PFI), should there be any Life Safety Code® deficiencies. Failure to provide timely notification to TJC of these changes could result in the hospital's loss of accreditation.

In case of a merger, consolidation, or acquisition, TJC may decide that the hospital responsible for services must have a survey. Barring any exceptional circumstances, TJC continues the accreditation of the hospital undergoing the changes described herein until it determines whether or not an extension survey is necessary.

See also Accreditation Participation Requirements Standard APR.01.03.01: The hospital reports any changes in the information provided in the application for accreditation and any changes made between surveys. EP.1: The hospital notifies The Joint Commission in writing within 30 days of a change in ownership, control, capacity, or services offered. Note: When the hospital changes ownership, control, location, capacity, or services offered, it may be necessary for The Joint Commission to survey the hospital again. If the hospital does not provide written notification to The Joint Commission within 30 days of these changes, the hospital could lose its accreditation.

The Joint Commission accreditation is neither automatically transferred nor is it automatically continued if significant changes (as described above) occur within an accredited hospital. When such changes occur, it is imperative to notify The Joint Commission within 30 calendar days or less after any such changes are made.

Should you have any questions or need further clarification, you may review the aforementioned chapters of the accreditation manual or contact your TJC account executive, Standards Interpretation Group, or TJC Customer Service.

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UNSEALED SPACES 1/8 INCH OR LESS IN CORRIDOR PARTITIONS TO BE SEALED

By Dean Samet, CHSP *dsamet@ssr-Inc.com*

Effective February 1, 2011, unsealed penetrations above the ceiling in existing corridor partitions of 1/8-inch wide or less around pipes, conduits, ducts, and wires will no longer be permitted by The Joint Commission according to the April 2011 edition of The Joint Commission's Environment of Care News. Note #1 of Standard LS.02.01.30, Element of Performance No. 6, has been deleted.

Standard LS.02.01.30 states, "The [hospital/critical access hospital] provides and maintains building features to protect individuals from the hazards of fire and smoke." EP 6 states, "Existing corridor partitions are fire rated for ½-hour, are continuous from the floor slab to the floor or roof slab above, extended through any concealed spaces (such as those above suspended ceilings and interstitial spaces), are properly sealed, and are constructed to limit the transfer of smoke." Note 1 had stated, "Unsealed spaces 1/8-inch wide or less around pipes, conduits, ducts, and wires above the ceiling are permitted." Again, unsealed penetrations with a 1/8-inch gap or less above the ceiling will no longer be permitted.

This appears to be another move by The Joint Commission to demonstrate that its standards and elements of performance (EPs) are equivalent to the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (COPs). This action allows TJC to maintain CMS deeming authority and to better reflect the intent of CMS's COPs.

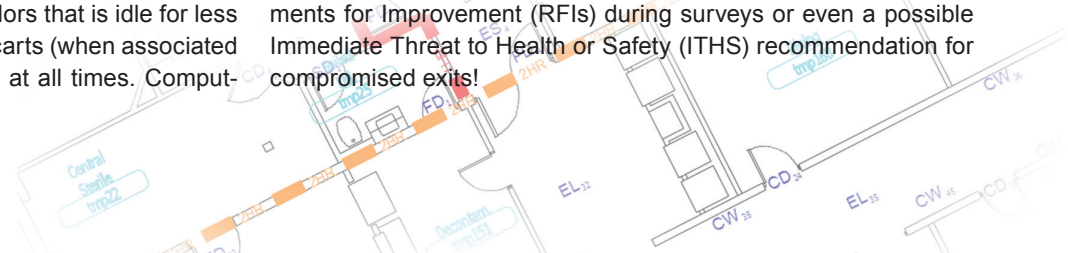
CARTS IN CORRIDOR: 30 MINUTE "IN USE" RULE

By Dean Samet, CHSP *dsamet@ssr-Inc.com*

In a Q & A segment of The Joint Commission's Environment of Care® News, June 2009, Volume 12, Issue 6, TJC's Standards Interpretation Group (SIG) answers questions on how long computer on wheels and other wheeled carts may be in corridors, provided that they are "in use." This issue continues to be a common finding during The Joint Commission surveys and Centers for Medicare & Medicaid Services inspections.

TJC explains, "Computers on wheels and other wheeled carts may be in the corridors, provided that they are "in use" and addressed in a fire plan (for example, moved from the corridor in an emergency situation). "In use" refers to anything in the corridors that is idle for less than 30 minutes. Crash carts and isolation carts (when associated with a patient) are considered to be in use at all times. Computers on wheels are allowed to charge in the corridors while in use and may be stored in alcoves, provided that the corridor width is not compromised at any time. Keep in mind that the batteries in the computers on wheels are to be the sealed lead-acid type of either absorbed glass mat design or sealed case. Finally, battery systems (li-ion or li-ion polymer) are to utilize a smart charging system with overcharge and shorted cell protection."

Surveyors will be looking closely during survey to see if your organization is complying with the 30-minute "in use" rule. Occasional reminders to staff about this issue may help alleviate unwanted Requirements for Improvement (RFIs) during surveys or even a possible Immediate Threat to Health or Safety (ITHS) recommendation for compromised exits!



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RISK ASSESSMENTS: PROACTIVE PROCESS FOR MANAGING EOC SAFETY RISKS

By Dean Samet, CHSP *dsamet@ssr-Inc.com*

Performing a risk assessment is an accepted approach to identifying and minimizing safety hazards associated with the health care physical environment and services.

Per The Joint Commission's 2011 Hospital Accreditation Standards manual, standard EC.01.01.01: The hospital plans activities to minimize risks in the environment of care.

The Rationale for EC.01.01.01 provides the background and further explanatory information: "*Risks are inherent in the environment because of the types of care provided and the equipment and materials that are necessary to provide that care. The best way to manage these risks is through a systematic approach that involves the proactive evaluation of the harm that could occur. By identifying one or more individuals to coordinate and manage risk assessment and reduction activities—and to intervene when conditions immediately threaten life and health—organizations can be more confident that they have minimized the potential for harm.*

"Risks in the environment include safety and security for people, equipment, and other material; the handling of hazardous materials and waste; the potential for fire; the use of medical equipment; and utility systems. High-level written management plans help the hospital manage risks. These plans are not the same as operational plans, but they do provide a framework for managing the environment of care. These plans should also address the scope and objectives of risk assessment and management, describe the responsibilities of individuals or groups, and give time frames for specific activities identified in the plan." See also:

EC.02.01.01: The hospital manages safety and security risks.

EC.02.02.01: The hospital manages risks related to hazardous \ materials and waste.

EC.02.03.01: The hospital manages fire risks.

EC.02.04.01: The hospital manages medical equipment risks.

EC.02.05.01: The hospital manages risks associated with its utility systems.

The Joint Commission has certain expectations regarding risk assessments if risks are identified during a survey. The surveyor may ask about:

- What sources of information is the organization reviewing to keep abreast of risks?
- What internal data does it use to identify risks?
- How often does it assess risk?
- Who has input into the process?

EC.01.01.01 is the standard that the surveyors often use when there are safety-related matters not covered by the other EC standards. Therefore, it is imperative to be proactive while addressing these safety matters.

It is further recommended to: avoid combining issues; create a list of questions for both advantages and disadvantages regarding patient care delivery, staff, visitors/volunteers, work environment, public safety, financial considerations, building and grounds, equipment, and internal physical systems, etc.; conduct an impartial comparison of advantages and disadvantages; submit conclusion to safety, risk, or environment of care committee; document the process; incorporate a monitoring strategy within the risk assessment document including dates for reassessing the conclusions; perform reassessments and procedure if necessary.

Be aware that the surveyor(s) will be looking for a proactive approach as opposed to a reactive approach.

Consider using the Joint Commission "Seven-Step Risk Assessments" process which was delineated back in their July 2006 Joint Commission Perspectives on Patient Safety™ as follows:

1) Identify the issue(s).
2) Develop arguments in support of an issue.
3) Develop arguments against that issue.
4) Objectively evaluate both arguments.
5) Reach a conclusion.
6) Document the process.
7) Monitor and reassess the conclusion to ensure that it is the best decision.

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GUARDS IN THE MEANS OF EGRESS

By Robert Trotter, CBO, CFM, MCP *rtrotter@ssr-Inc.com*

While the guard pictured in the example is aesthetically pleasing it may not provide for the greatest level of protection for life safety. In fact, NFPA 101®, Life Safety Code® specifically addresses guards in the means of egress. Means of egress components that might require protection with guards include stairs, landings, balconies, corridors, passageways, floor or roof openings, ramps, aisles, porches, and mezzanines. To understand the Life Safety Code® provisions for guards consult the adopted edition for your jurisdiction.

The fundamental requirements for guards in the means of egress that are more than 30 inches above the floor or grade below include the following:

- Guards are to be provided with guards to prevent falls over the open side.
- The height of guards is measured vertically to the top of the guard from the surface adjacent thereto.
- Guards should not be less than 42 inches high.
- Open guards, other than approved, existing open guards, must have intermediate rails or an ornamental pattern such that a sphere four inch in diameter cannot not pass through any opening up to a height of 34 inches. Relative to the example pictured, vertical intermediate rails are preferred to reduce climbability.

Handrails are often incorporated into guards as part of a protection package for the means of egress components described above.

PUBLICATIONS AND SEMINARS

Publications

"Continuous Compliance - Maintaining a constant state of regulatory readiness," *Health Facilities Management*, May 2011
"Plenum Requirements for Egress Corridors in Healthcare Environments," *Engineered Systems,* July 2011

Seminars

July 18-20	ASHE Annual Conference, Seattle, WA, "NFPA 110/111 Update," and "ASHE Codes & Standards Plenary Panel - The Saga Continues"
August 11	St. John's Health System, Springfield, MO, "Life Safety Accreditation Challenges"
August 25	Healthcare Facilities Management Society of New Jersey All-Day Seminar, Union, NJ, "Life Safety Accreditation Challenges," "Transitioning from Construction to Operations and Regulatory Compliance," "Preparing for Surveys and Continuous Compliance," and "NFPA 110/111 Update"
September 15	2011 Energy & Power Distribution Conference, Schaumberg, IL, "NFPA 110 & 111 Update - Proposals for the 2013 Editions"
September 27	27th Annual AHCA Seminar, Orlando, FL, "NFPA 110/111 Updates"
September 28	Florida Healthcare Engineering Association Annual Meeting, Orlando, FL, "Life Safety Accreditation and EC Hot Spots"
October 24	Decision Health EC Summit, Las Vegas, NV, "Overcoming Environment of Care and Life Safety Accreditation Challenges"

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