2021 Environment of Care, Life Safety Code, and Emergency Management Updates

WHEA 6 Exclusive Update – April 8, 2021

The Joint Commission

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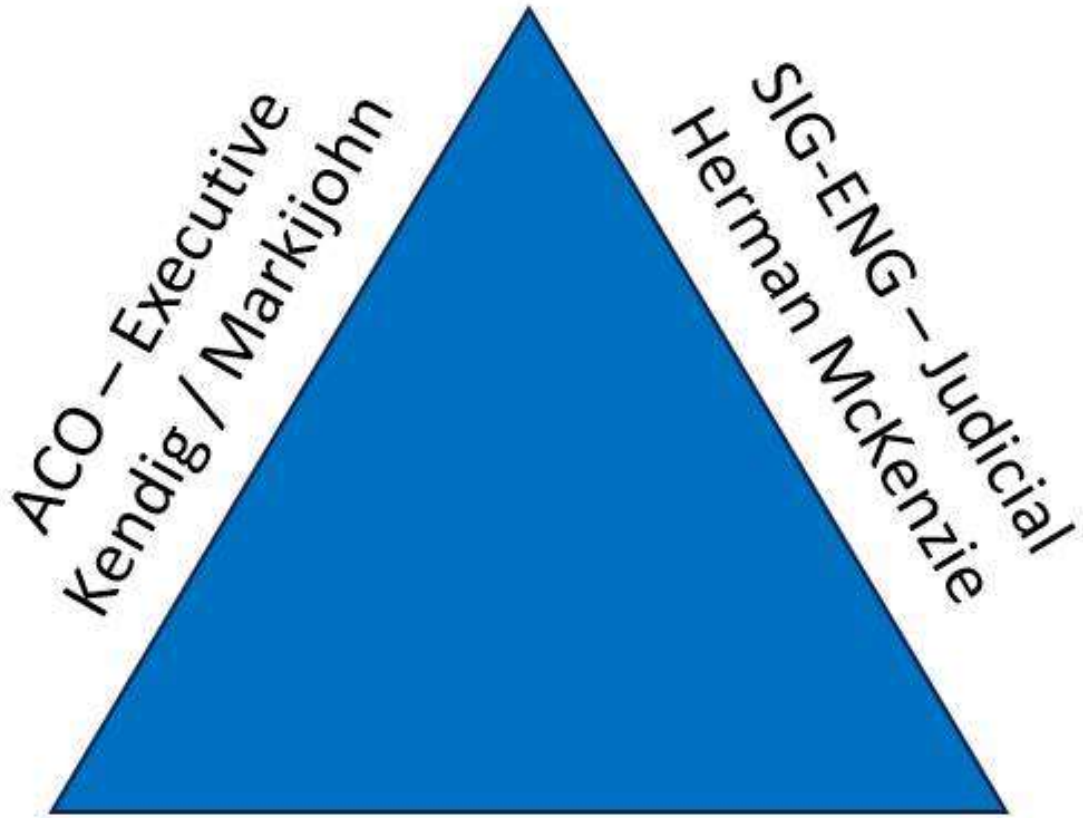

DSSM – Legislative
Herman McKenzie
Kendig / Markijohn

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Jim Kendig, MS, CHSP, HEM

Field Director – Life Safety Code Surveyors

The Joint Commission

Tim Markijohn,

MBA/MHA, CHFM, CHE

Field Director – Life Safety Code Surveyors

The Joint Commission

Herman A. McKenzie

MBA, CHSP

Director – Standards Interpretation Group

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What's New, Our Focus

New 5000A Fuses!

What's New and What We Are Working On

- Return to onsite surveys 3/15/2021
- NEW water management standard and EP
- Retirement of the Building Maintenance Program (BMP)
- New Tools
- What LSCSs want you to know
- New EC (2021) session and EM (proposed July 2021)
- New EM standards January 2022
- NEW WPV standards and Eps – July *Perspectives*
- NEW document review checklist

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What's New and What we are working on cont.

- SAFER® Dashboard: Phase 2 Launch

–SAFER® Dashboard will become available to all accredited organizations on April 6th, 2021.

–The SAFER Dashboard is a business analytics tool that provides aggregate survey finding data and Joint Commission national comparison accreditation data. Users will be able to view and filter their cumulative survey data in meaningful ways and compare their organization(s) to Joint Commission national accreditation data.

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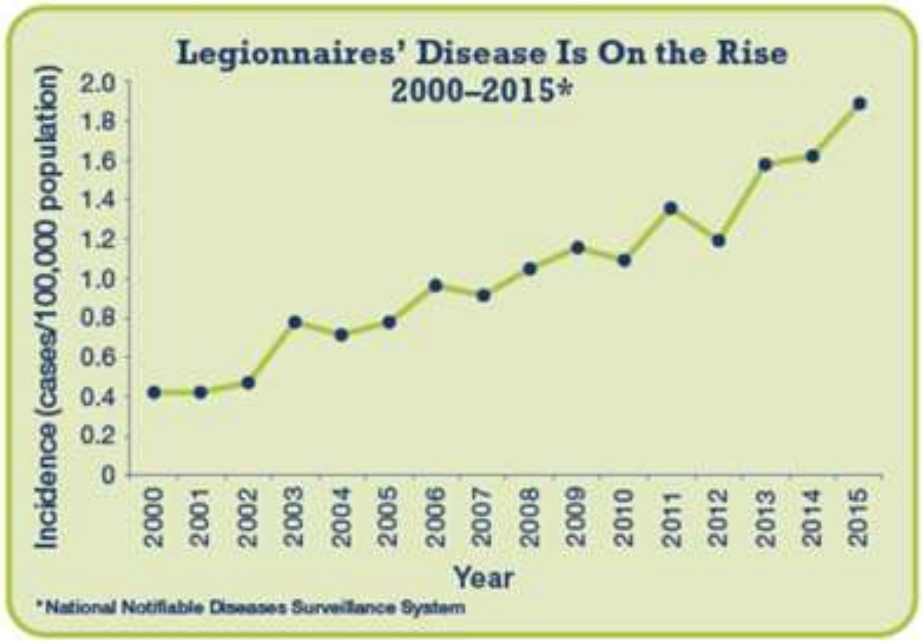
What's the Risk?

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



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

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

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

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

DATE: **June 02, 2017**

TO: State Survey Agency Directors

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

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

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

Memorandum Summary

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

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

- *EC News*
  - 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

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Legionella DRAFT 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.

EC.02.05.02, EP 2

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

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DRAFT 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.”

WPV Draft Standards and Eps (field review version EC, HR, and LD)

17. The hospital conducts an annual work-site analysis related to its workplace violence program. The hospital takes action on findings from the analysis.
Note: A work-site analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence events, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect current practices and conform to applicable laws and regulations.

1. The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
- Injuries to patients or others within the hospital's facilities
- Occupational illnesses and staff injuries
- Incidents of damage to its property or the property of others
- 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

Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.
Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process.

6. Based on its process(es), the hospital reports and investigates the following: Security incidents involving patients, staff, or others within its facilities.

6. Based on its process(es), the hospital reports and investigates the following: Security incidents involving patients, staff, or others within its facilities, including those related to workplace violence.

29. As part of its workplace violence prevention program, the hospital provides training, education, and resources for the prevention of workplace violence to leadership, staff, and licensed practitioners as appropriate to their roles and responsibilities. These are provided within 90 days of hire, annually, and ongoing and include the following:
- 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 codes
- The reporting process

(See also LD.03.01.01, EP 9)

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 events and trends
- A process for follow up and support to victims and witnesses by workplace violence, including trauma and psychological counseling, if necessary
- Reporting of workplace violence incidents to the governing body

(See also HR.01.05.03, EP 29)

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New tools…from LSCSs!

New tools…

Hospital Name: Score at EC.02.03.03 EP3

Quarterly Hospital Fire Drills (NFPA 101-2012 18/19 19.7.1)

Day = M, Tu, W, Th, F, Sa, Su
Time: 24 hour formatted

			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												
		Time												
	ILSM	**Location/Building**												
		Day												
		Date												
		Time												
2nd Shift	Normal	**Location/Building**												
		Day												
		Date												
		Time												
	ILSM	**Location/Building**												
		Day												
		Date												
		Time												
3rd Shift	Normal	**Location/Building**												
		Day												
		Date												
		Time												
	ILSM	**Location/Building**												
		Day												
		Date												
		Time												

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

		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4
1st Shift	**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 Buliding**		**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

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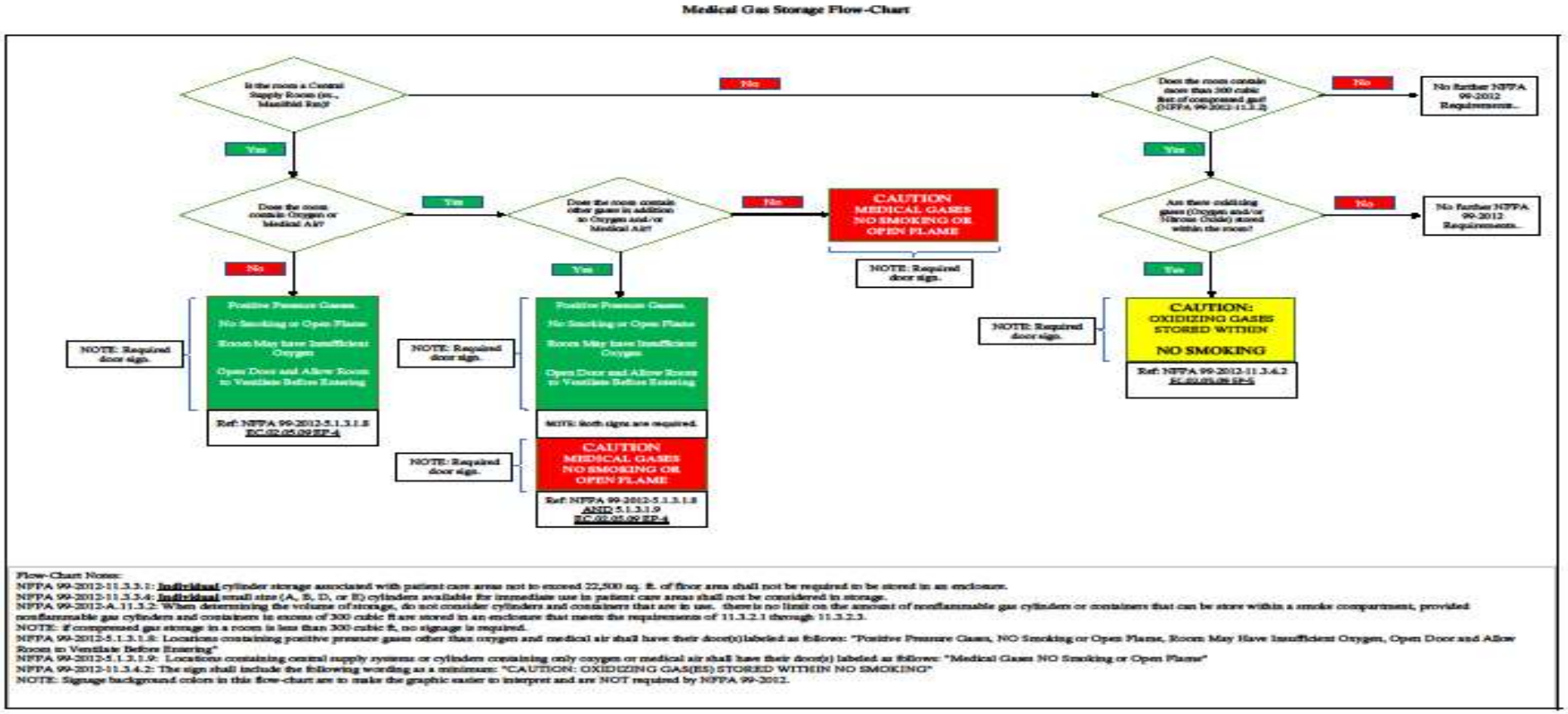
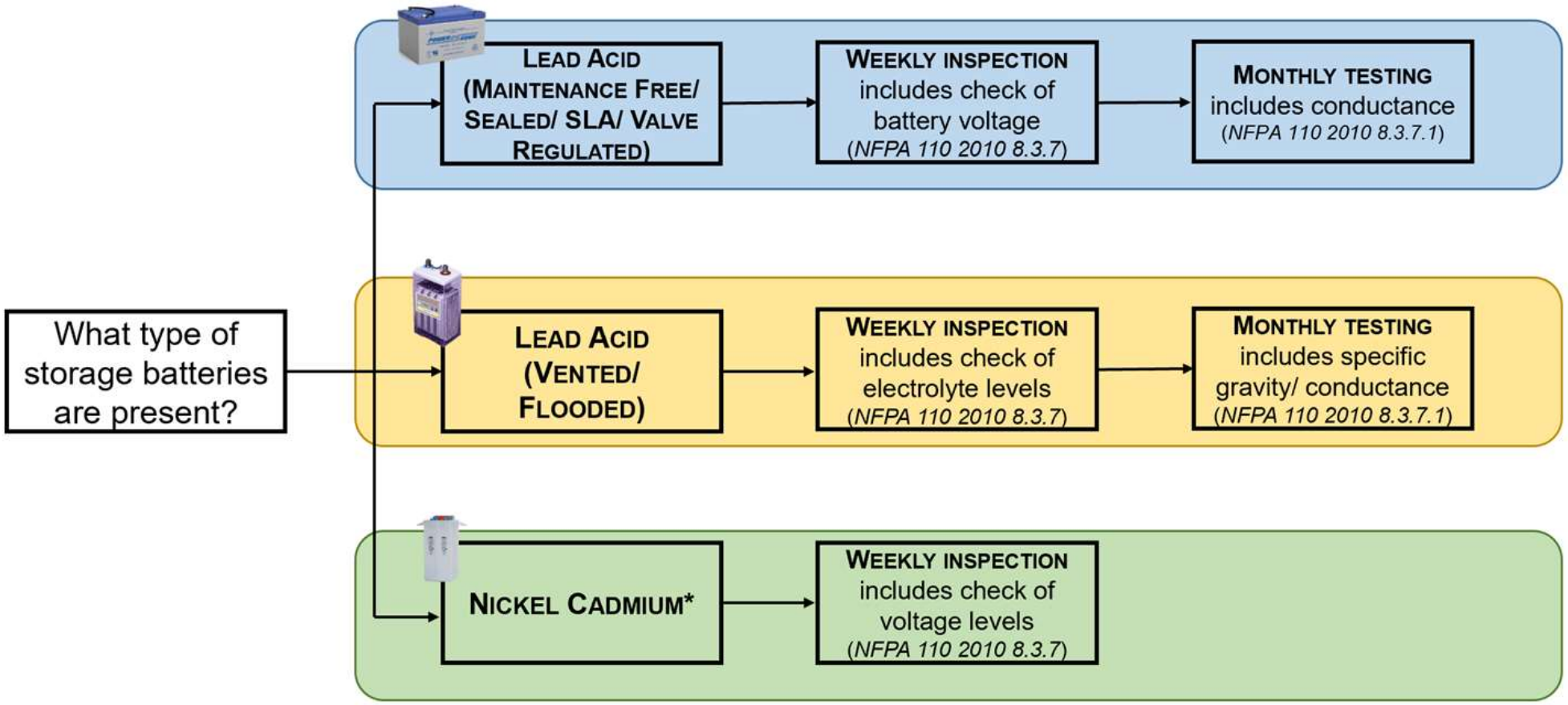
New tools cont. (draft only future *EC News* article).



New tools cont.



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

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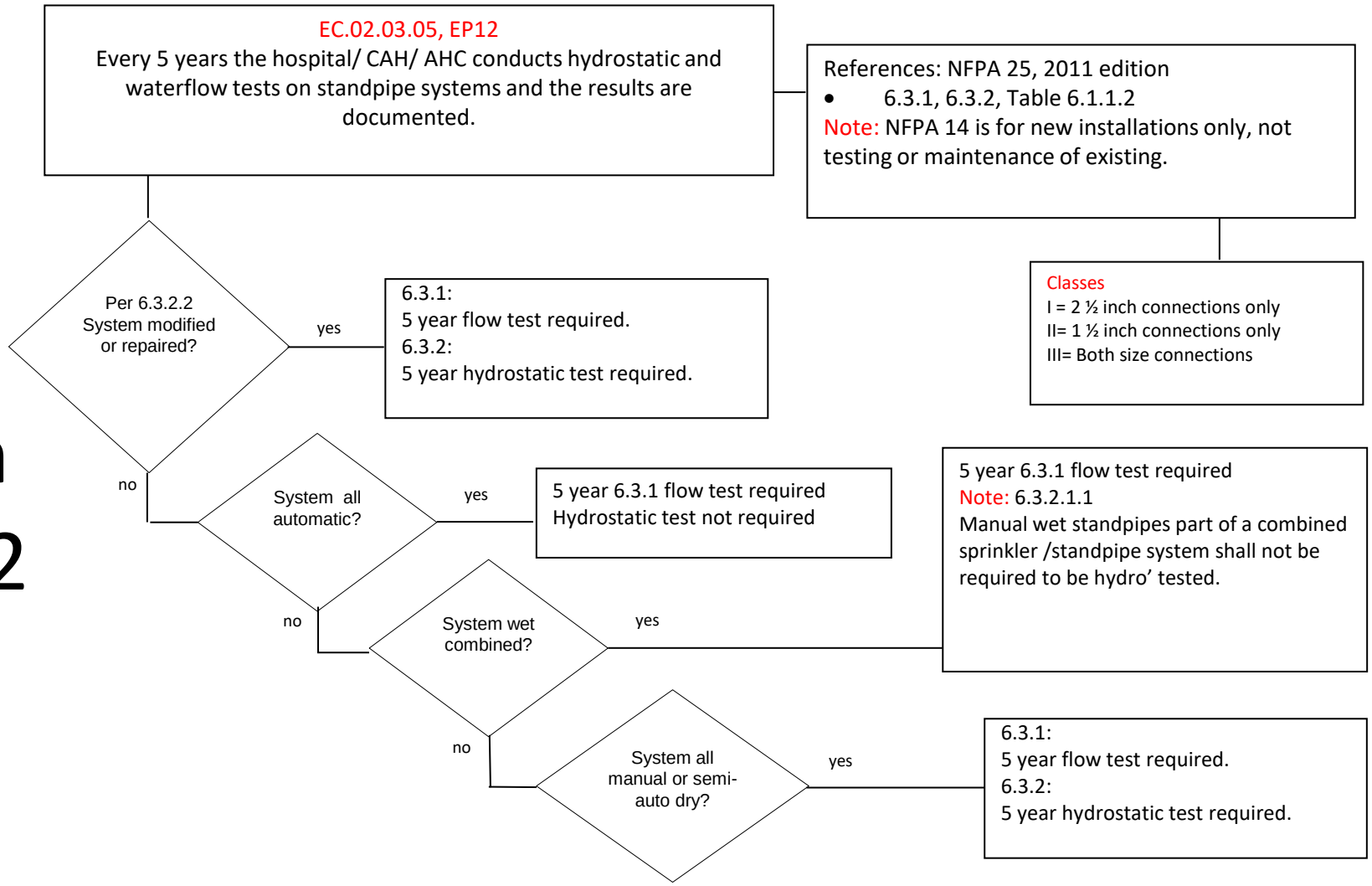
EC.02.03.05, EP 12
&
NFPA 25, 2011



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What Life Safety Code Surveyors want you to Know…

Retirement of BMP

- We are retiring the BMP in July 2021
  - Page LS – 3
  - Not adopted by CMS
  - Allows organizations flexibility in addressing deficiencies via there own methodology

Life Safety Code Surveyor Days July 2020

- **REMINDER:** LSCS added one day for each free-standing emergency department and ambulatory surgery center.
  - **NOTE: Additional time for the Life Safety Code Surveyor will not be added to Department of Defense hospital organizations length of survey, but all areas identified are in scope of survey and will be addressed by the assigned clinical surveyors. This decision was made based on current contract language and is subject to change in the future.*

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What LSCSs want you to know!

- Power strips not installed/used per NFPA 99: 10.2.3.6 (more later)
- Double doors in suite boundaries with meeting edge gaps in excess of 1/8 inch.
- Fire drills – one hour apart (looking at 4 quarters)
- New fire drill matrix!
- New 05 LS standards and eps
- Don’t forget about the ‘kitchen checklist!’
- SCAB patches! (see *EC News* Sept 2020)

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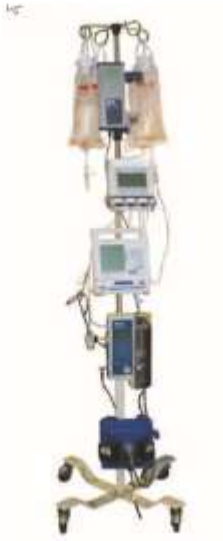
Requirements Life Safety Code Surveyors Want You to Know About...

- RPTs Assure compliance with all requirements in NFPA 99-2012, 10.2.3.6
  - Not an 'assembly'
    - RPT on a 'stick'

  - An 'assembly'



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

Requirements Life Safety Code Surveyors want you to know about...

- Example of a substitute for fixed

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.

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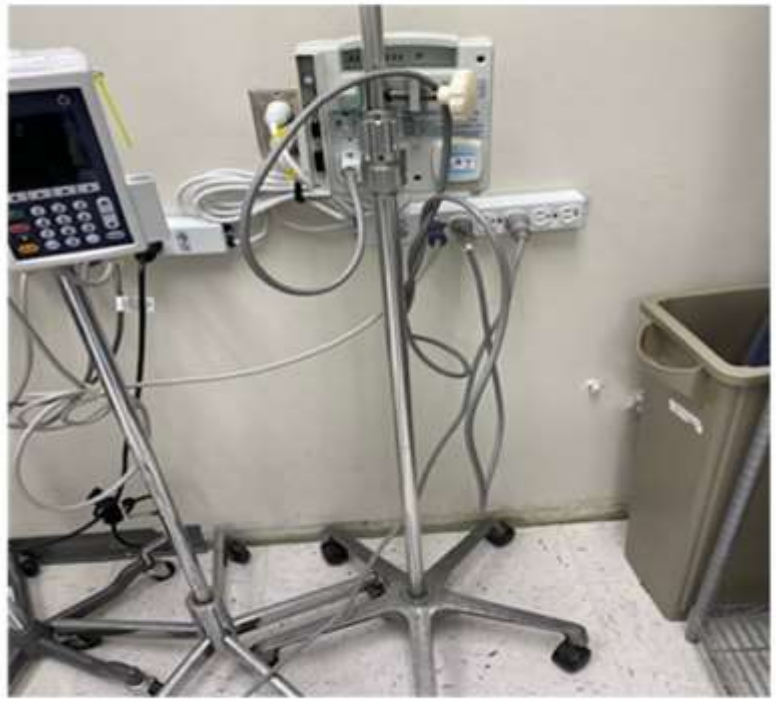

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Requirements Life Safety Code Surveyors Want You to Know About (cont.) Yes…but…

- What about wheeled carts in the corridor (LSC NFPA 101-2018 19.2.3.4)?

with the requirements of 19.2.3 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.

Condition-Level Deficiency Data – NEED TO UPDATE SLIDE

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

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

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Condition-Level Deficiency Data – NEED TO UPDATE slide

% 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
01/01/2020 – 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%**
01/01/2016 – 12/31/2016	113 of 203	**55.67%**

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

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

COVID SAFER & "See it / Cite it" "C" Category & OFI's

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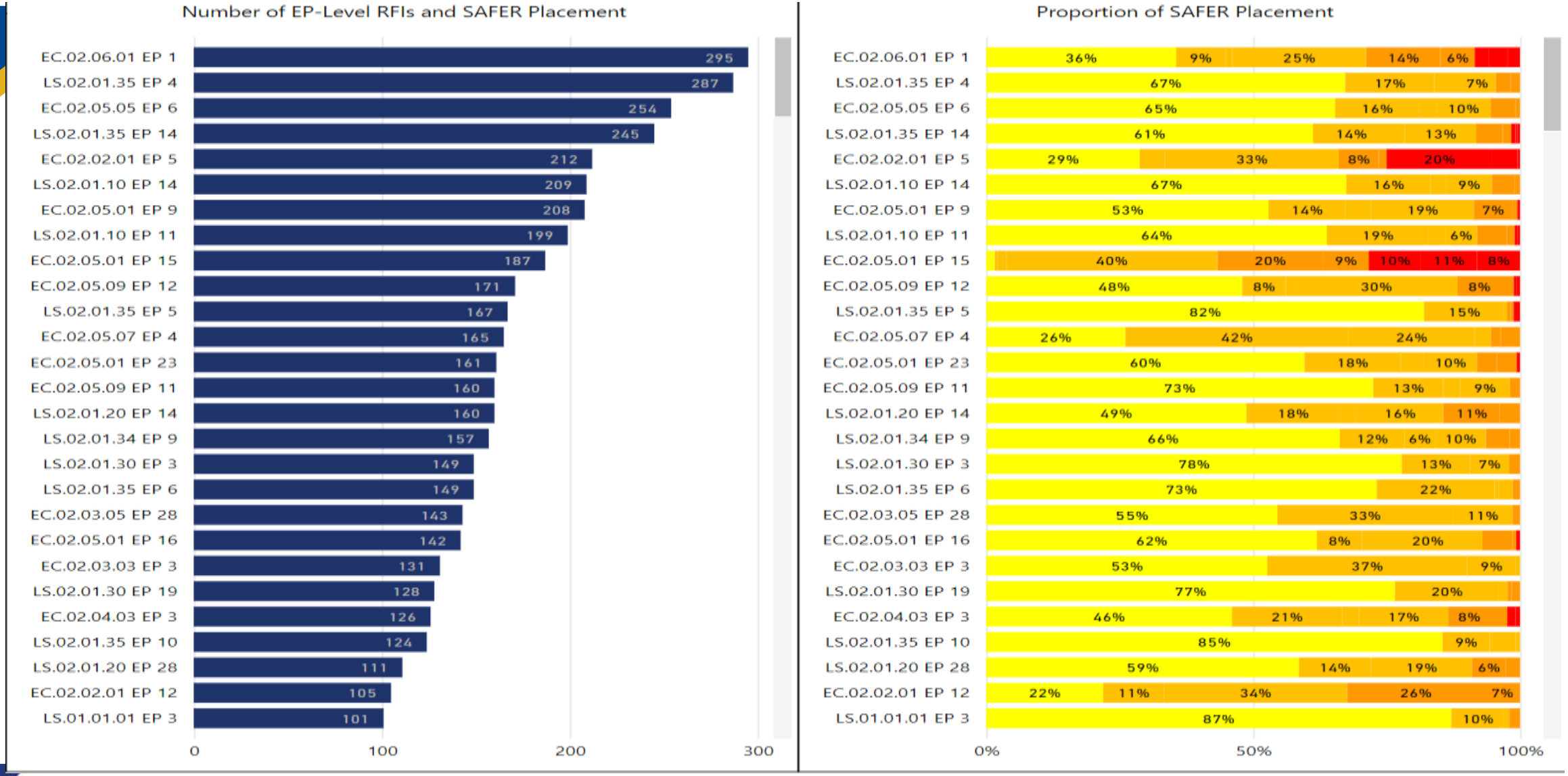
U.S. Most scored during surveys…1/1/20 to present



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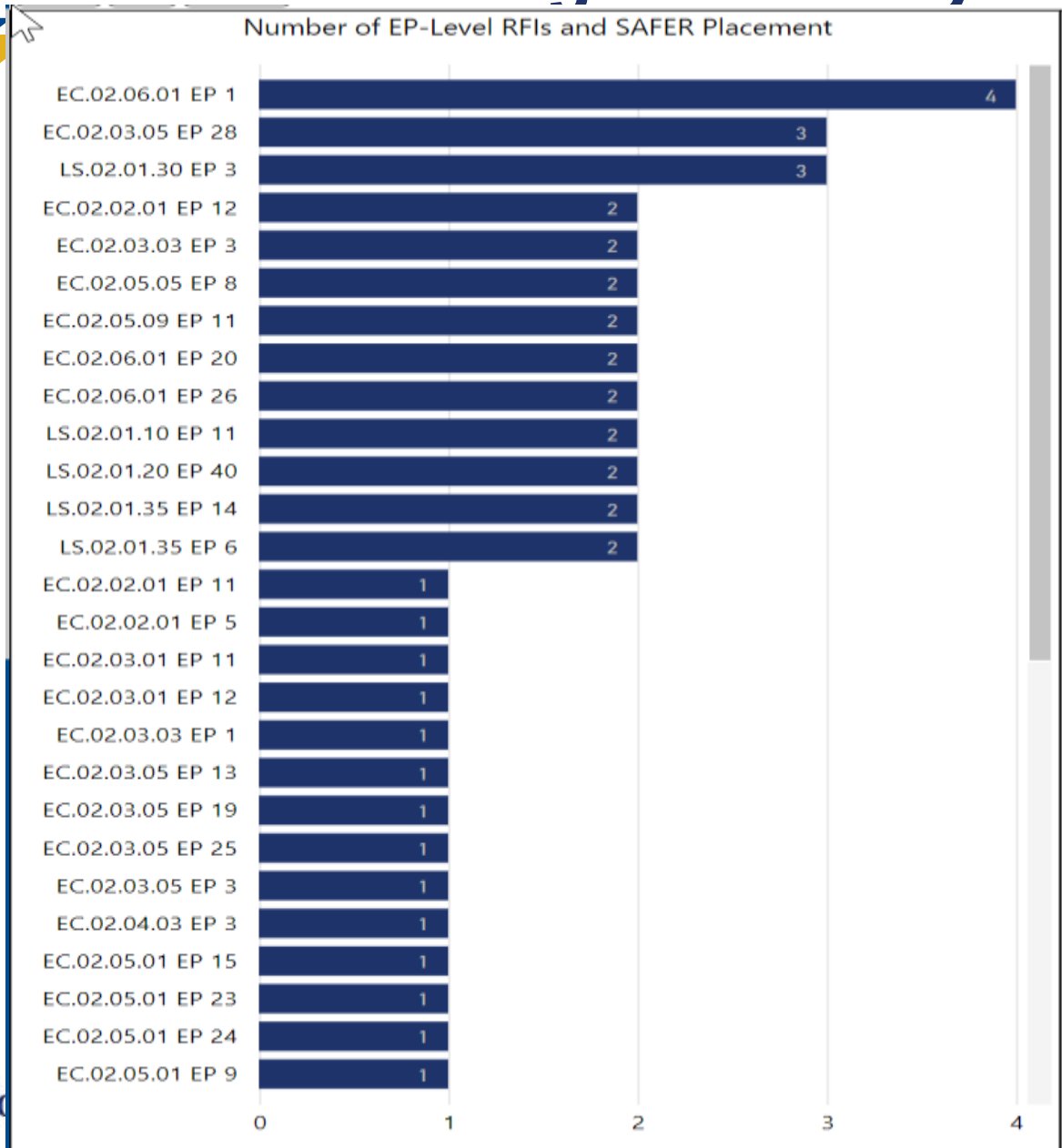
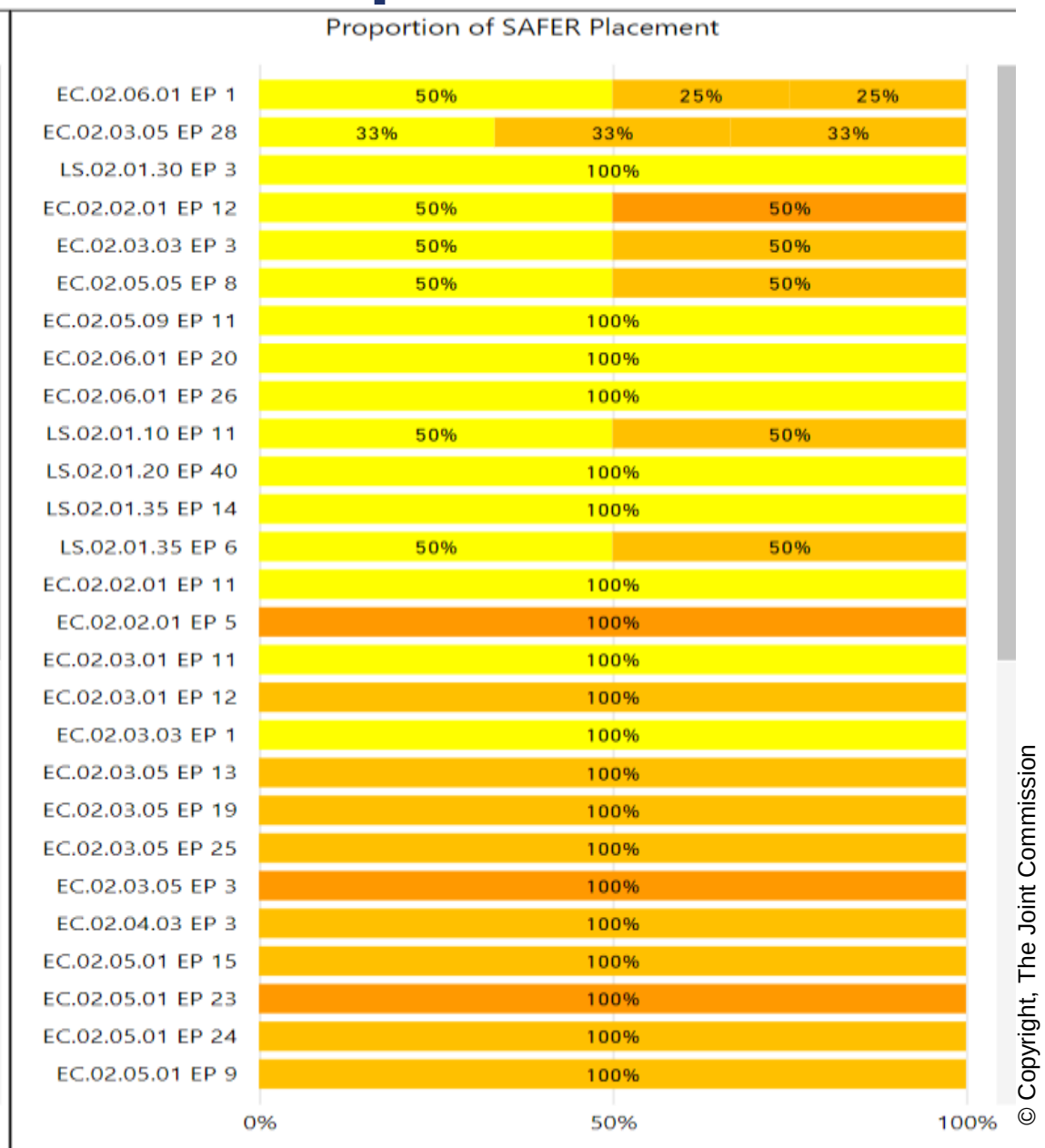
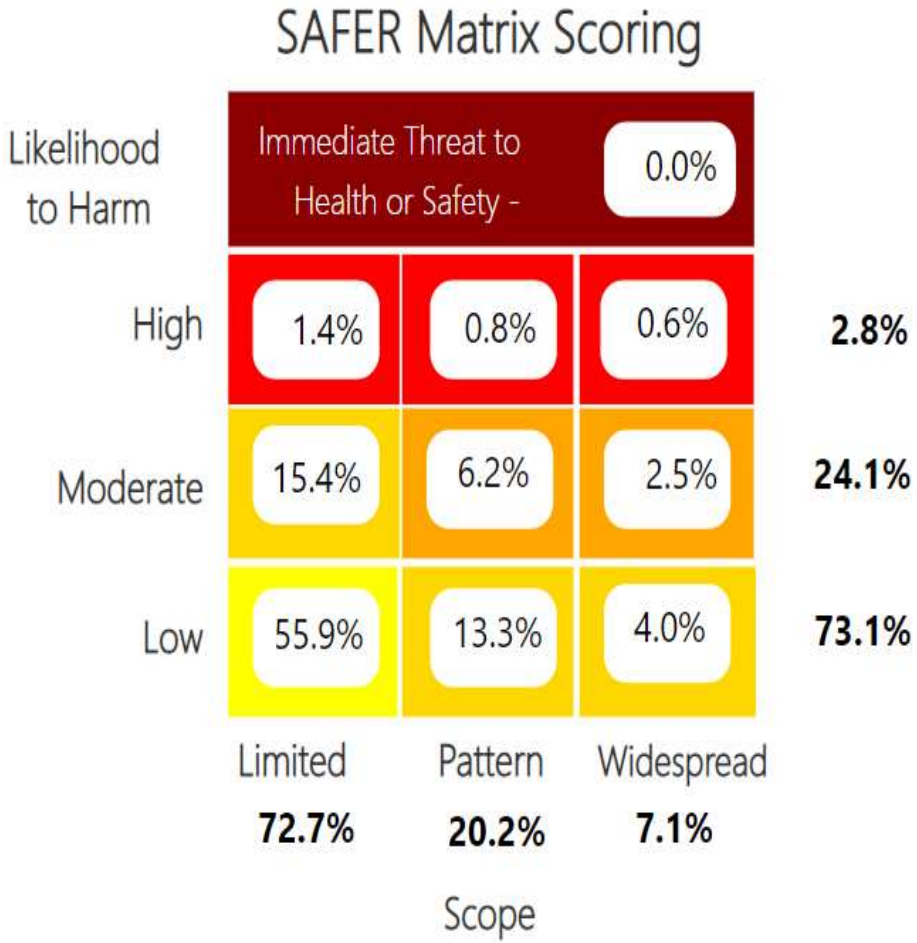
Most scored during WI surveys...1/1/20 to present



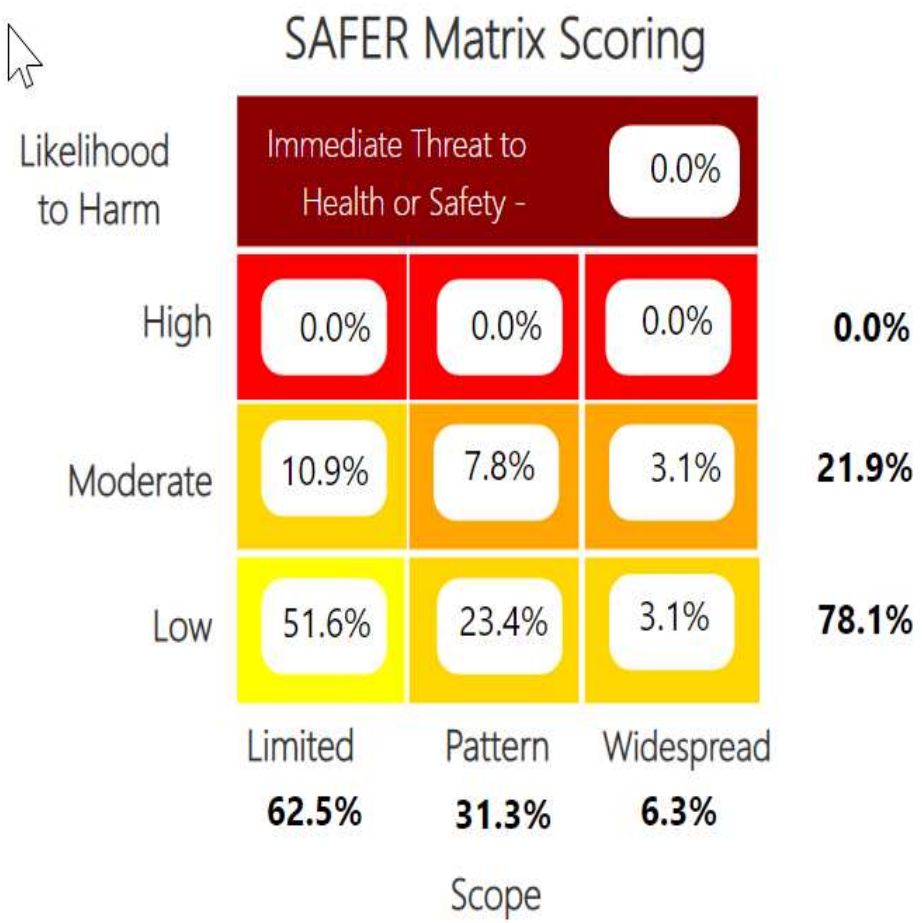


SAFER comparison

USA



WI



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Some conclusions…

- SAFER
  - Nothing in HIGH or ITH – congrats!
  - Consistent in placement!
- Scoring
  - Let’s take a deeper dive…

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US v WI

- Top 5 – US
  - EC 2 6 1 – 1 (catch all…)
  - LS 2 1 35 – 4 (stuff on/affixed)
  - EC 2 5 5 - 6 (non high-risk utilities)
  - LS 2 1 35 – 14 (catch all)
  - EC 2 2 1 – 5 (haz matls)
- Top 5 – WI
  - EC 2 6 1 – 1 (catch all…)
  - EC 2 3 5 - 28 (NFPA/Year)
  - LS 2 1 30 – 3 (haz doors)
  - EC 2 2 1 – 12 (labeling haz waste)
  - EC 2 3 3 - 3 (fire drills – 1 hour)

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 than be postponed

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PHE Compliance Issues

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

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 period 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?

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PHE Compliance Issues

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

PHE Compliance Issues

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

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PHE Compliance Issues

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

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Jim Kendig, MS, CHSP, HEM
Field Director
jkendig@jointcommission.org
(630) 792-5819

Tim Markijohn, MBA\MHA, CHFM, CHE
Field Director
tmarkijohn@jointcommission.org
(630) 792-5148

Herman A. McKenzie, MBA, CHSP
Director – Standards Interpretation Group
hmckenzie@jointcommission.org
(630) 792-5718

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