EC.02.03.05 EP25
Door Inspections

- Annual inspection
- Knowledgeable person
- Operating components
- Both sides of the opening
- Documented
Door Inspections

- Required for all fire doors
  - Corridor doors and smoke barrier doors not required if not part of fire barrier
- Complete by January 1, 2018*
- Based on NFPA 101-2012, 7.2.1.15
  - Beneficial to ongoing reliability

* See CMS S&C Letter 17-38-LSC available at
Door Inspections

Doors to be included in the annual door inspection (based on 7.2.1.15) include:

- Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7
- Door assemblies in exit enclosures
- Electrically controlled egress doors
- Door assemblies with special locking arrangements subject to 7.2.1.6
Door Inspections

The Joint Commission does not require the following doors to be included in the annual door inspection:

- Corridor doors (i.e., patient room doors)
- Office doors (provided the room does not contain flammable or combustible materials)
Fire Doors Installed Where Not Required

NFPA 101-2012, 4.6.12.3

- Existing fire protection features obvious to the public, if not required by the Code, shall be either maintained or removed.

- Doors shall be maintained per the barrier assembly requirements

See also EC.02.03.05, EP 25 and LS.01.01.01, EP 6
Fire Doors Installed Where Not Required

- Fire-rated doors in a nonrated barrier assembly
  - Must be maintained as a fire door unless the features which identify it as a fire door have been removed in a manner that maintains the opening protective requirements applicable to the barrier into which it is installed.
EC.02.05.01 EP 14

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

- Based on risk assessment
- Cooling towers
- Air handling units
- Potable hot/cold water systems
- Other aerosolizing water systems

ASHRAE 188-2015 considered a best practice
EC.02.05.01 EP 14


- Applies to HAP, CAH, NCC
- Develop and adhere to P&Ps to inhibit microbial growth and to reduce risk of growth and spread of *legionella* and other opportunistic pathogens in water.
- Implement a water management program, including control measures
- Testing protocols & acceptable ranges specified
  - Testing and corrective actions documented when limits exceeded

Have a plan to manage pathogenic biological agents

- Bacteria, 90% of all HAIs
  - Legionella
    - Over 30 different species; legionella pneumophila most common
    - Transmission via aerosolization
    - Tolerates temperatures up to 140°F; growth up to 115°F
    - 2 to 10 days to show symptoms
  - Mycobacterium
    - Non-tuberculous mycobacteria (NTM)
    - Highly resistant to chemical disinfectants
Legionella

- Causes Legionnaire’s Disease
  - Lengthy pipe runs
  - Dead legs
  - Cooling towers
  - Fountains
  - Showers
  - Faucets
  - Ice machines
  - Water-based humidifiers
Be aware of Legionella treatment techniques

- **Copper/Silver**
  - Not as effective in hard water applications
  - Limited effectiveness for biofilm

- **Chlorine**
  - Good for Legionella; fair to poor for biofilm control
  - Corrosive and hazardous vapors
  - Excessive use corrosive to some piping

- **High temperature (> 140°F)**
  - Scalding
  - Not effective for cold water systems
  - Impact to corrosion, seals, and gaskets
In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature and humidity.
Categorical Waiver

ASHRAE 170 included with NFPA 99-2012 adoption

- Ventilation Table
- >20% relative humidity (RH) permitted in seven affected areas of the Surgical Environment, and one in Diagnostic & Treatment per S&C 13-25 (ASHRAE 170-2008, Addendum D)
- The established 60% upper range however should be maintained for issues such as mold growth
- Be aware of S&C 15-27: Potential Adverse Impact of Lower Relative Humidity (RH) in Operating Rooms (ORs)
CMS EMERGENCY MANAGEMENT FINAL RULE AND THE JOINT COMMISSION’S EMERGENCY MANAGEMENT STANDARDS
CMS Emergency Management: Final Rule

- CMS Final Rule September 16, 2016
  - Effective Date: November 15, 2016
  - Implementation Date: November 15, 2017

- Emergency Management standards released in e-dition
  - Deemed status only

- CMS sponsored portal:
Joint Commission Emergency Management

Six Functional Areas:

- Communication
- Resources & Assets
- Staffing
- Utilities
- Safety & Security
- Patient Care

Exercises
CMS Emergency Management: Final Rule

CMS Structure

- Emergency Plan
- Policies & Procedures
- Communication Plan
- Training and Testing
- Integrated Healthcare Systems (option)
- Transplant Hospitals

Annual Review and Update of the functional areas of the Emergency Management program
Emergency Plan

- Annual review and update of Emergency Plan
- Risk Analysis of Community-based risks
- Document collaboration with Emergency Management community officials
  - local, tribal, regional, state, & federal
Emergency Plan

Succession plans

- Succession plan of key leaders
- A succession plan that lists who replaces key leaders during an emergency if a leader is not available to carry out his or her duties
- A delegation of authority plan that describes the decisions and policies that can be implemented by authorized successors during an emergency and criteria or triggers that initiate this delegation
Emergency Plan

Continuity of operations

- A continuity of operations strategy focuses on the organization.
- Goal to protect the physical plant, information technology systems, business and financial operations, and other infrastructure from direct disruption or damage so that it can continue to function throughout or shortly after an emergency.
- When the organization itself becomes, or is at risk of becoming, a victim of an emergency (power failure, fire, flood, bomb threat, and so forth), it is the continuity of operations strategy that provides the resilience to respond and recover.
Policies & Procedures

- Annual update of Policies & Procedures related to Emergency Management program
- Scope of responsibilities for evacuated patients
- Communication with external sources of assistance for emergency response
- Role of volunteers and integration of federal health care workers
- Subsistence needs of sheltered/evacuated patients & staff
- Inform state/local officials of on-duty staff & patients that can’t be located
Communication Plan

- Annual review and update

- Contact information on
  - Volunteers, Sub-contractors and Physicians
  - Tribal groups
  - Specify primary/secondary means of communicating w/external authorities

- How information is provided on condition or location of patients to community & local ICS
Training & Testing

- Annual documented training of all new and existing staff, contractors, volunteers in
  - emergency procedures
  - specific to their expected role in emergency management functions

- Two exercises per year
  - Facility/Community
  - Functional/Tabletop
    - **NOT ALLOWED BY THE JOINT COMMISSION AS AN EXERCISE**
Integrated Healthcare Systems

- Participate in community-based assessment activities with the system
- Establish coordinated system communication
- Coordinate site and system emergency plans
- Participate in site and system joint training
- Participate in site and system joint exercises
Transplant Hospitals

- If a hospital has one or more transplant centers
  - A representative from each transplant center must be included in the development and maintenance of the hospital's emergency preparedness program
If a hospital has one or more transplant centers

- The hospital must develop and maintain mutually agreed upon protocols addressing the duties and responsibilities of the
  - Hospital
  - each transplant center
  - the organ procurement organization (OPO)
    - unless the hospital has been granted a waiver to work with another OPO, during an emergency
LIGATURE RISKS
Ligature Risks

Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment and services provided.

- Ligature/self harm risks (i.e. BHC)
  - Current Risk Assessment
  - Best Practice Guidelines
    - Design Guide for the Built Environment of Behavioral Health Facilities
Ligature Risks – Psychiatric Settings

- Inpatient and Designated Non-behavioral settings for treatment
  - Ligature and self-harm risks identified and eliminated
  - No additional time beyond 60 days from last day of survey

See also November 2017 Perspectives and Joint Commission Online, May 24, 2017
www.jointcommission.org/issues
Ordinarily a provider or supplier is expected to take the steps needed to achieve compliance within 60-days of being notified of the deficiencies, but the State survey agency may recommend that additional time be granted by the Secretary in individual situations, if in its judgment, it is not reasonable to expect compliance within 60-days, for example, a facility must obtain the approval of its governing body, or engage in competitive bidding.
Ligature Risks – Psychiatric Settings

Process: self-harm risks identified

- Determination if previously identified
- Evaluate existing plans for removing the risks
- Evaluate the environmental risk assessment process

See also November 2017 Perspectives and Joint Commission Online, May 24, 2017
www.jointcommission.org/issues
Ligature Risks – Psychiatric Settings

Further evaluation

- Plans and policies on mitigation of harm posed by risks while removal occurs
- Adequacy of staffing patterns to the mitigation plans
- The patient suicide risk assessment process

See also November 2017 Perspectives and Joint Commission Online, May 24, 2017
www.jointcommission.org/issues
Further evaluation

- Policies and practices related to actions needed for patients identified at risk
- Policies and processes of ensuring staff awareness of a patient’s level of risk
- The organization’s internal processes for improvement, including:
  - The history of patient safety events and the process for root cause analysis of these events
Ligature Risks – Psychiatric Settings

Further evaluation

- The organization’s internal processes for improvement, including:

  [continued]

  - The organization’s process for monitoring its compliance with its policies
  - Actions taken when noncompliance was identified
Ligature Risks – Psychiatric Settings

- Not designated
  - Temporary location for psychiatric patient
    - Ligature/self-harm issues must be identified
    - Remove physical risks not required for treatment
      - If able
        - Implement surveillance if risks remain
    - P&Ps adequately guide staff in assessment
    - Implement measures based on patient needs

See also November 2017 Perspectives and Joint Commission Online, May 24, 2017
www.jointcommission.org/issues
# Most Cited Standards

## 1st 6 Months Comparison

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<td>Manage systems for extinguishing fires including the integrity (nothing supported by sprinkler piping, missing escutcheons)</td>
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<td>Sprinkler heads are not damaged. They are free of corrosion, foreign materials, paint, and have necessary escutcheon plates installed</td>
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<td>Other issues, including:</td>
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Engineering Department 2017-38
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<td>In critical areas the organization manages risk associated with Utility Systems, including Pressure relationships, Filtration, Air Exchanges (ach), and Temperature and Humidity</td>
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Department of Engineering

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Acting Director

Andrea Browne, PhD., DABR
Medical Physicist

Kathy Tolomeo, CHEM, CHSP
Engineer

Herman McKenzie, MBA, CHSP
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Engineer

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Technical Coordinator
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