

TSIG NEWS

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If you would like to contribute an article on a topical matter, or share your recent JC Survey experience with your fellow professionals, please send your emails to:
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The Joint Commission has revised language to the Emergency Management Standard

Written by: Ode Keil (guest writer)

The Joint Commission has revised language to the Emergency Management standard in the Management of the Environment of Care chapter that addresses assets and resources required to respond to emergencies. Element of Performance (EP) EC.4.11.9 states "The organization keeps a documented inventory of the assets and resources it has on site, that would be needed during an emergency (at a minimum, personal protective equipment, water, fuel, staffing, medical, (**CAH, HAP**: surgical) and pharmaceuticals resources and assets.) **Note:** The inventory is evaluated at least annually as part of EP.11)"

This requirement introduces a significant new burden on accredited hospitals. Development of a documented inventory of resources and assets requires a detailed analysis of the resources required to meet the projected demands for each type of emergency identified during the development of the Hazard Vulnerability Analysis (HVA). The HVA is a document that summarizes the likely emergencies that a hospital will become involved in the direct and indirect consequences of each emergency. The vulnerabilities related to various types of emergencies could be loss of critical patient care capability during a power outage, contamination of potable water during a flood or water main rupture, security threats during a major storm that affect community infrastructure, and much more. A complete HVA is made up of several parts. The most common portion of an HVA is a table or matrix listing various types of emergencies and ranking them based on probability and severity. The table or matrix often contains a few factors such as impact of an emergency on a community, the physical structure of a building, etc. While this approach provides a very global view of emergencies likely to affect a hospital it does not provide the information required to address the remaining elements of performance in the Joint Commission emergency preparedness standard as it relates to the development of an emergency operations plan.

Assuming that a HVA consisting of a matrix of emergency situations, a probability ranking, and some numerical assignment of the severity of the emergency has been developed the following additional work is strongly recommended to lay the foundation for development of the emergency operations plan.

1. Documented List of Consequences for Priority Emergencies

The numbers listed in most HVA's correspond to some analysis of what the likely consequences of an emergency are. The weakness of most HVA's is that the narrative of the consequences is not recorded as part of the document. For example, if a power failure occurs there are two likely scenarios that develop. First, emergency power generators come on line and provide power to some or all areas of the hospital. Second, the emergency power system fails to start, fails after a short run time, or fails when fuel is exhausted and no re-supply is possible.

CAH – Comprehensive Accreditation Manual for Hospitals; HAP – Hospital Accreditation Program

(Continued on Page2)

The Joint Commission revises language to - Emergency Management Standard

The consequences of the power failure represent a range of challenges for the hospital. If the emergency system activates the consequence is loss of functions in the areas not served by the emergency power distribution system. In the consequences document these areas and the impairments to normal operations they represent need to be listed. If the emergency power system fails to start or shuts down after some run time the consequence is complete loss of all hospital functions. The likely consequences include patient death.

As the consequences can change over time the analysis of consequences should begin at the moment of impact of an emergency and be analyzed over the first 96 hours of time. This is based on the Joint Commission requirement that hospitals now analyze what the organization can do if it cannot be supported by the community it serves for up to 96 hours.

2. Documented Immediacy of Effect

The effects of an emergency situation can be immediate or can emerge over time. The example of the electrical system is one of immediate impact. If the flow of electricity from the public utility is cut off the impact is right now. There are literally minutes between a power failure and patient deaths if no action is taken or the emergency power system activates. A slightly longer time will elapse if the public water supply is disrupted. If the supply is cut off there is generally an immediate loss of water for convenience resources such as drinking water, water for toilets and bathing, etc. There is a short time during which boilers and other industrial equipment can continue to function. In many cases the time is one to four hours. If there is a major storm that blocks highway, rail, and air travel resources in the community the development of consequences may take a day or two to become critical.

The importance of analyzing the immediacy of impact of an emergency cannot be overstated. The immediacy of impact is the most significant factor in determining whether a system, such as emergency power, can be installed to mitigate the immediate consequences or whether the hospital must immediately make arrangements for transfer of critical patients, shut down admissions and emergency services, or even conduct a full scale evacuation until services can be restored.

3. Documented Normally Available Resources

Normally available resources are the subject of the EP quoted at the beginning of the article. The available resources may be daily activity requirements alone or they may be a combination of daily activity requirements and planned emergency supply caches. In either case the new language requires that a document be developed listing the resources.

It is not sufficient to simply list on hand quantities of equipment and supplies. Each emergency situation should be analyzed separately to determine, based on the projected consequences and the immediacy of the impact of the emergency, what supplies and equipment are available to manage the emergency.

The new requirement fits with the context of the HVA requirement in the current standard. The change simply results in a more appropriate set of documents for the HVA that can be used as the foundation for designing an emergency operations plan. An example of the documents described in the article is available from the Ode Keil Consulting Group, Inc. through TSIG. Please direct requests for the documents to: **TSIG CONSULTING Inc. at 212-420-8724 Ext. 111 or 234. or email your request to templea@tsigconsulting.com.**

WHAT'S NEW AT TSIG

Written by: **Ralph Heiman**

Welcome our Newest Member



We at TSIG are proud to welcome the newest addition to our professional consultation team, Mr. Ed Snider. Ed has extensive experience in healthcare consultation and compliance validation related to the Joint Commission, Center for Medicare and Medicaid Services, and multiple State Department of Health agencies. Mr. Snider has provided consultative services nationwide, working closely with Facility Directors, Safety Officers and other healthcare Managers and Directors, with an extensive record of professional competence and expertise in NFPA code interpretation and application & implementation of Environment of Care standards. As one of the leading experts in fire science engineering and all aspects of the Life Safety Code, he has successfully prepared hundreds of Statement of Conditions (SOC's) for some of the largest and most respected health care organizations throughout the country. I am confident that he will bring his talent and experience to TSIG by providing the highest quality of service we currently afford all our clients. Ed acquired his Bachelor of Science degree in Mechanical Engineering from Florida Atlantic University. Ed is also an active member in the NFPA and ASHE.

TSIG Goes International

As we continue to expand our services nationally, we are soon to extend our EC professional expertise to organizations on a global scale. George A. Rivas, Vice president of Consultation will soon be undertaking responsibility for providing consultation to several hospitals in the mid east, currently participating in the Joint Commission International accreditation process. For those of you who have had the past pleasure of working with Mr. Rivas (a.k.a. "the Safety Geek"), I am sure that you would agree that he will prove equally successful in providing his own special style of "Tough Love", when it comes to assuring organizations maintain the highest standards for safety, while effectively developing processes and tools to illustrate continuous readiness compliance. Mr. Rivas will begin his journey shortly to several hospitals in Jordan. For those of you who maintain regular contact with Mr. Rivas, there's no need to worry- thanks to modern technology and the internet, Mr. Rivas will be in constant communication via cell phone and email. For those of you interested in getting some first hand insight as to how healthcare professionals manage regulatory compliance half way around the world, please feel free to email George anytime at rivasg@tsigconsulting. I'm sure he would welcome any questions you might have. Safe travels George.

Reducing the Risk of Patient Suicide (Part 3)

As stated in our last issue, the risk factors associated with the physical environment for inpatient psychiatric units are cited as the most common root cause of inpatient suicide. It is for this reason that we have included a special insert within this issue, that contains a comprehensive and detailed checklist that can be used for verifying those conditions that could minimize the potential risk of suicide within your facility. Be advised that Joint Commission does not require that all of these safeguard measures be verified or be in place, but the list contains many of the requirements that state and local mental health departments often times require in the design of new construction or be present in existing facilities. Furthermore, it should be noted that the use of this tool should not be considered as a template to survey each patient room or occupied space within a behavioral setting, for in fact, there may be special rooms dedicated for the placement of those expressing suicide ideation and where you may wish to focus your attention on when applying it's use.

We would like to express our sincere gratitude to Ode Kiel and Michelle Evans DPH, Safety Officer, NIH Clinical Research Center for their dedicated effort in creating and sharing this outstanding tool that they developed for the National Institutes of Health.

For an electronic copy of the Suicide Risk Assessment Design & Environment Checklist, please send your request to info@tsigconsulting.com

Behavioral Health Risk Assessment

Area	Risk	Yes	No	Controls
Patient Sleeping Rooms	Glazing is break resistant safety glass or protected by unbreakable material			
	Exterior windows are fixed glazing, protected by security screens, or have stops that limit opening to a degree appropriate for the population of patients served			
	Cords on mini-blinds or other window treatments are not looped and are not capable of supporting a load greater than 50 pounds			
	All loose cords are breakaway			
	Hardware on furniture does not provide an attachment point for suicide by strangulation			
	Hardware on furniture is non-removable or of a design that is not likely to be an effective weapon			
	Wardrobes, counters, and shelving are arranged to prevent use as a jumping platform			
	Mirrors are made of non-distorting, unbreakable materials			
	Curtain rods and clothes rods are break away or weakened to a point that they will not support a load greater than 50 pounds			
	Electrical outlets are listed safety wiring devices			
	All cover plates and removable hardware on walls and ceilings are attached using tamper resistant fasteners or are riveted			
Patient Sleeping Rooms	Glazing is break resistant safety glass or protected by unbreakable material			
	Exterior windows are fixed glazing, protected by security screens, or have stops that limit opening to a degree appropriate for the population of patients served			
	Cords on mini-blinds or other window treatments are not looped and are not capable of supporting a load greater than 50 pounds			
	All loose cords are breakaway			
	Hardware on furniture does not provide an attachment point for suicide by strangulation			
	Hardware on furniture is non-removable or of a design that is not likely to be an effective weapon			
	Wardrobes, counters, and shelving are arranged to prevent use as a jumping platform			
	Mirrors are made of non-distorting, unbreakable materials			
	Curtain rods and clothes rods are break away or weakened to a point that they will not support a load greater than 50 pounds			
	Electrical outlets are listed safety wiring devices			
	All cover plates and removable hardware on walls and ceilings are attached using tamper resistant fasteners or are riveted			

SAMPLE

SAMPLE

Behavioral Health Risk Assessment

Area	Risk	Yes	No	Controls
	Ceilings are solid			
	Sprinkler heads are listed institutional devices			
	Exposed plumbing is boxed			
	Handrails and grab bars are pocketed to prevent use as an attachment point for suicide by strangulation			
	Door hardware is designed to prevent jamming			
	Artwork is permanently attached to the wall and protected by Lexan™ or a similar material			
Patient Toilet and Bathing Areas	All shower controls are listed institutional hardware designed to prevent use as an attachment point for suicide by strangulation			
	Hoses in handicapped showers are designed to break away			
	All shower curtains are tear away or supported by rods that will not support a load greater than 50 pounds			
	Mirrors are made of non-distorting, unbreakable materials			
	Benches are not removable			
	Exposed plumbing is boxed			
	Cords on mini-blinds or other window treatments are not looped and are not capable of supporting a load greater than 50 pounds			
	Handrails and grab bars are pocketed to prevent use as an attachment point for suicide by strangulation			
	Flooring is a slip resistant material			
	Emergency call cords will not support a load greater than 50 pounds			
	Toilet stall and other dividers are attached with tamper resistant hardware			
	All cover plates and removable hardware on walls and ceilings are attached using tamper resistant fasteners or are riveted			
	Door hardware is designed to prevent jamming			
Corridors and lobbies	Glazing is unbreakable material			
	Exterior windows are fixed glazing, protected by security screens.			
	Hardware on furniture does not provide an attachment point for suicide by strangulation			
	Hardware on furniture is non-removable or of a design that is not likely to be an effective weapon			
	Chairs, couches and other furniture is attached to the floor or of substantial construction that minimizes the potential that it can be thrown			
	Mirrors are made of non-distorting, unbreakable materials			
	Electrical outlets are listed safety wiring devices			

THE GOOD, THE BAD & THE UGLY

INTERIM LIFE SAFETY MEASURES



By George A. Rivas, CHSP

The true beauty behind the Joint Commissions standard, EC.5.30 is; that it allows organizations to create (and live with) any life safety code violation imaginable, provided that it be evaluated, and a preplanned, determined “interim” measure(s) be assessed, implemented and monitored to compensate for said deficiency. This is truly a **good** thing, especially since seldom are healthcare facilities completely void of life safety code deficiencies at any given time (I will get to the various causes of violations/ deficiencies later in this article). But the way I see it is, that it’s almost like tossing a bad piece of meat on the scale at the butchers shop, and weighing how heavy the mass is, to determine how the butcher will ultimately compensate for the lack of beef stock in order to meet the public demand. *(Stand easy, all you vegetarians and life safety code purists out there- I am in no way comparing the lack of beef at your local butcher with the lack of fire safety integrity in a healthcare facility).* The point I’m making (with this analogy) is that for any life safety deficiency that one creates, one must also compensate with an interim measure(s) as equal to, or as close as equal to compensate for the lack of life safety one creates. For example, the butcher may very well cut up some additional hog meat and post a sale sign to promote the sale price of pork to divert the public’s attention for beef, while still satisfying his clientele. The problem that I have witnessed over the years is that many organizations only place the bad meat caused by one reason- “construction” on their scales, totally neglecting the myriad of other causes and problems that could create life safety code problems / deficiencies. This is **bad!** Because there are more than a few reasons why meat can turn rancid- just like there are a number of reasons, other than construction, that an organization can create life safety code deficiencies, it is important to recognize the value of assessing any deficient life safety issue one creates. Furthermore, not only have I seen this problem perpetuate, but the Joint Commission Life Safety Surveyors now actually target these commonly neglected areas during survey and frequently cite RFI’s to those organizations who see ILSM as only a “construction related” result. This is now reaching the point of truly being **ugly**. Don’t get me wrong, I have no argument for their decisions. Overall, these surveyors are accurately identifying problematic processes with organization’s ILSM protocols, but it is important to recognize that construction activity alone is not the sole cause of life safety issues and ILSM needs to be assessed whenever one creates a life safety deficiency. This might include failures of fire alarm / suppression devices discovered in your periodic testing, or even more apparent issues such as assessing the impact of numerous violations (PFI’s) related to your SOC. Therefore, in order to assure you play it “safe”, not only for regulatory purposes, but also to assure your effectiveness in maintaining a true safe environment I recommend that you take the time to evaluate each individual life safety deficiency you create, and assess the necessary impact for determining what measures (if any) are necessary. Don’t stop there just yet folks, you also want to maintain vigilance in monitoring the effectiveness of those measures determined necessary and modify your assessment at various stages when (and if) you feel it’s necessary to make changes. Let’s put an end to the ugliness and help keep our facilities fire safe.



FREQUENTLY ASKED QUESTIONS



By popular demand, we are providing our readers with some of the most frequently asked questions that continue to raise concern time and time again. It is our sincere hope that you will find value with this information which will be an ongoing series of Q&A's in each of our future newsletters. Should you have your own questions related to regulatory issues, please feel free to email them to us at: info@tsigconsulting.com Our team of EC experts will be glad to provide you with an answer promptly, and we will share our response top all our readers within each next newsletter.

Storing Items Under Sinks

Q: Does the Joint Commission prohibit the storage of all items under sinks?

A: No. There are no specific standards that address this issue nor prohibit storage. However, organizations should evaluate the risks (via conducting risk assessments) to consider what items can be kept under-sink cabinets for storage. The risk assessment should consider the impact on infection control for sterile supplies or patient items, hazardous materials for chemical storage, or paper records. You would have to also confirm whether there are any prohibitions for said storage per State and local requirements.

It is also important to note that TJC has published previous guidance regarding said storage, indicating that storage of reagents and chemicals in under-sink cabinets, in quantities allowed by both OSHA and the fire protection Authorities Having Jurisdiction (AHJs), would be permissible per Joint Commission standards as long as the reagents and chemicals couldn't react with each other or with moisture.

Infant Abduction Drills

Q: Are we required by Joint Commission to conduct infant abduction drills annually?

A: Although there is no specific requirement for an organization to conduct infant abduction drills each year, TJC recommends that your prevention plan be tested to the extent and with the frequency necessary to ensure that the plan is effective, just the same as you would with other emergency or disaster events. It is recommended that you evaluate the risk factors based on your Hazard Vulnerability Analysis and/or Security Risk Assessment to determine if the risk, probability and impact lend credence to performing said exercises. Although not a formal requirement by TJC, it is important to remember that these drills (even if performed periodically) can serve as an effective means of assuring staff knowledge and identifying opportunities for improvement for developing mitigation and preparation processes.

Generator Testing

Q: Recognizing that monthly generator tests must be performed ≥ 20 and ≤ 40 days apart; if I have three generators and they were tested during one month at 45 days apart from their last test, will Joint Commission score that as a single non compliant event or will they count each generator as a separate event?

A: Unfortunately TJC will recognize each generator test as a separate occurrence and will thus be scored individually as three separate occurrences. Seeing how this Element of Performance is scored as a Category C score, where three or more occurrences can result in an automatic Recommendation for Improvement (RFI), you will want to ensure that the interval requirements are strictly maintained.

Med Gas Valve Signage

Q: Are we required to post signage above each med gas shut-off valve indicating who is authorized to shut off in case of an emergency?

A: No. However, although there is no requirement for said signage, your fire plan should indicate who (or whom) is responsible, and authorized, to shut off these valves in case of an emergency. Furthermore shut off valves must have signage indicating the locations served in the event that those authorized know exactly what areas will be affected should they need to be shut off. NFPA 999 states that shut off valves shall be labeled to reflect the rooms that are controlled by such valves and that labeling be kept current. Valves shall be labeled in substance as follows:

**CAUTION: (NAME OF MEDICAL GAS) VALVE
DO NOT CLOSE EXCEPT IN EMERGENCY THIS VALVE CONTROLS**

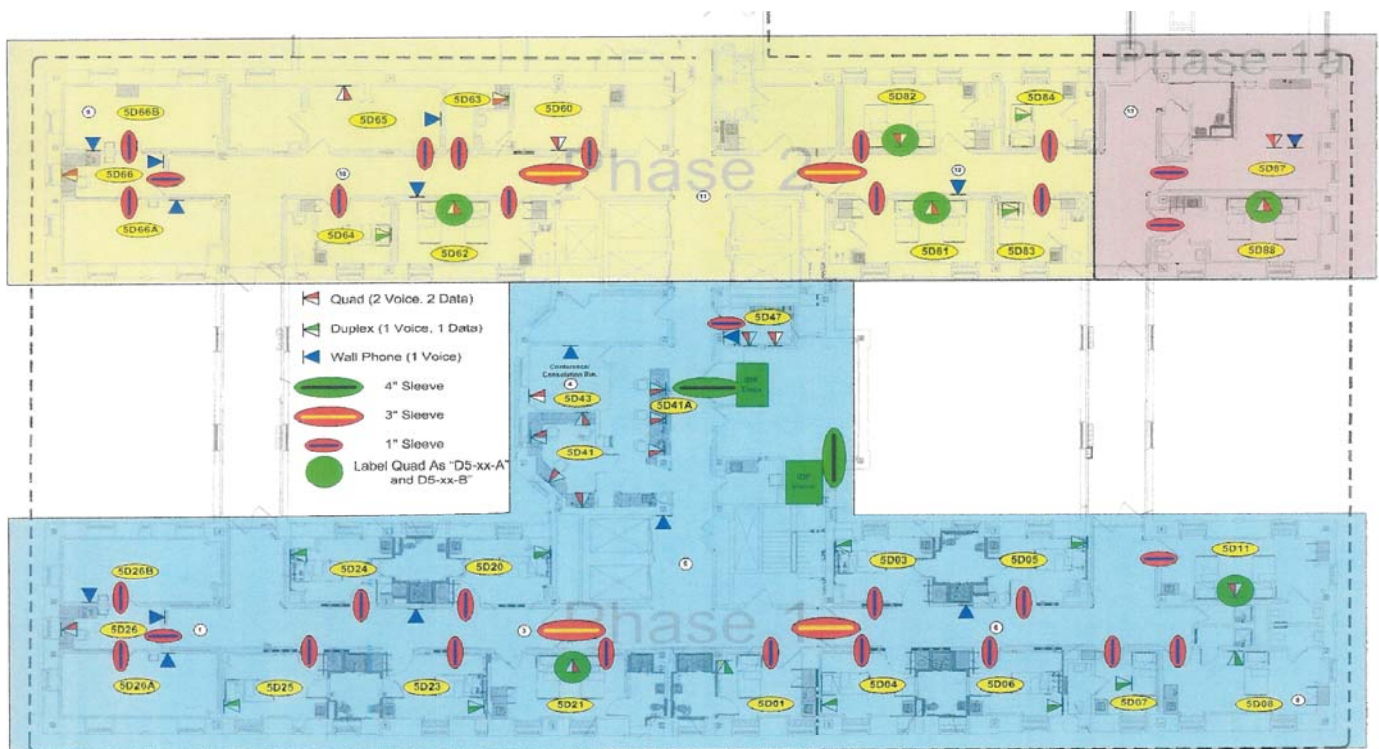
MINIMIZING SMOKE & FIRE WALL PENETRATIONS

One of the biggest frustrations shared among Facilities and Safety alike is answering the big question: “How do we minimize the number of penetrations to our smoke and fire barriers and corridor walls?” And although installation of data exchange network cables and wiring is not the sole cause for these headaches, it sure has a historical past for being among the most frequently observed- particularly with the ever-changing technologies installed in healthcare facilities today.

Many hospitals have initiated proactive measures such as establishing a well written “Penetration Permit Policy” but no matter how well written one’s plan is, it all comes down to how well the process is executed and specifically; how diligent the organization’s follow-up is to verify their own procedure. In fact, TSIG has performed hundreds of Statement of Conditions for a variety of healthcare facilities nationally, and it has been our experience that only a few of those claiming to have a ‘Penetration Permit Policy’, truly provide evidence of an effective program. This leaves our clients baffled as to how they could have in place an accountable system to minimize penetrations, when in fact the number of penetrations continues to rise.

Therefore, we were most impressed when we discovered how A Larger New York City Medical Center established a process to minimize their penetrations directly caused by data exchange (computer and telephone) installations and upgrades. The process, as defined by Joe Cuccurullo, Nortel Resident Engineer at A Larger New York City Medical Center is really quite simple. The Information Systems department designs the project plan and scope, drafts a layout of each floor affected and then plots a location of where each penetration will occur as a result of the installation / cable run. The prints are then provided to the contractor tasked to perform the installation, as well as copies provided to the Facilities, Safety Department and TSIG (who perform the regular updates for their SOC). By sharing this illustrative tool, the contractors know only the areas they are limited to create the penetrations while Facilities and Safety personnel can perform periodic spot checks / inspections of work being performed and we can assure the organization of verification of all penetrations being appropriately sealed once the job is complete.

Since this is a new process, it is obviously impossible to provide any data on the effectiveness of said process however; it appears to lend optimism for all involved at A Larger New York City Medical Center and represents how effective communication among various departments and contractors and a regular verification process could very well serve as a model to consider for the future- especially if you are one those tired of these headaches at your own facility.



Example courtesy of A Larger New York City Medical Center

Red Stripe Rules Can Give You the Blues

Written by: Ed Snider



Don't be so quick to put up a red stripe around your storage rooms or any other rooms for that matter. Often times organizations use a painted red stripe around their perimeter walls within a room to indicate the 18 inch limit to the sprinkler heads. However, there is a little known exception within NFPA 13 that allows the practice of storing items along perimeter walls. The exception to the 18 inch rule can be found within the Appendix of NFPA 13 (A-5-6.6) and reads as follows:

The 18-in. (457-mm) dimension is not intended to limit the height of shelving on a wall or shelving against a wall in accordance with 5-6.6. Where shelving is installed on a wall and is not directly below sprinklers, the shelves, including storage thereon, can extend above the level of a plane located 18 in. (457 mm) below ceiling sprinkler deflectors. Shelving, and any storage thereon, directly below the sprinklers cannot extend above a plane located 18 in. (457 mm) below the ceiling sprinkler deflectors.

Most times sprinkler head coverage does not get blocked within storage rooms but if you provide a red stripe around a room to keep staff from storing items within 18 inches you could be setting yourself up for something you can't control and ultimately getting cited for your own policy. Most sprinkler layouts in rooms provide enough spacing from the wall to allow for storage to be stacked to the ceiling. It gets tricky when an in house remodel has occurred where a partition gets put up near a sprinkler head. Then a head could be obstructed by storage along a wall. Based on our observations these occurrences happen less than five percent of the overall hospital rooms surveyed. Most rooms outside of materials management, sterile supply, and record storage do not have obstruction issues. Unit managers still try to be cautious of the possibility of coverage obstruction by providing a red stripe around a room to keep staff from violating the 18 inches rule. An assessment should be done throughout the facility to determine what areas could be considered possible trouble spots. Then if a red stripe is going to be placed in a room it should be accurately measured from the deflector to 18 inches below. So that means for concealed type heads the measurement from the ceiling down should be 19 inches and standard pendant heads should be measured 22 inches down from the ceiling. Environmental tours are a great opportunity to perform this assessment. If the team finds an area that could be a potential problem they should then notify the unit manager as to whether a red stripe should be put up or be taken down. Remember the problem is not only violating sprinkler coverage obstruction but also your own red stripe policy.



DON'T GET CAUGHT UNPREPARED FOR REQUIRED EC DOCUMENTS

TSIG CAN HELP YOU BE CONTINUOUSLY PREPARED FOR ALL YOUR EC RECORDS

Only TSIG Consulting offers the revolutionary, Environment of Care Tracker (ECT) that allows immediate access to all your valuable EC related documents. Safety, Engineering, Security & Leadership healthcare professionals today cannot afford to be without this amazing computer aid. This web-based instrument not only provides your organization an efficient means to upload & download all your required EC documents, but it also has a unique feature that affords your organization the opportunity to schedule all required tasks, track and manage compliance programs and even has a built-in automatic email reminder message system that alerts you a schedule diligence warning as you approach required due dates. Never again will you need to frantically search for missing documents or forget to complete a required task on time. Whether you need a Management Plan, Risk Assessment, Completed Fire Drill form or any testing and maintenance related documents, you can always be confident that your records will be available at moments notice.

For more information on ECT, contact us at: info@tsigconsulting.com

TJC Releases the Proposed 2009 EC Standards for Review

As part of Joint Commission's continuous effort to improve their current standards, they have launched a Standards Improvement Initiative to:

- Clarify standards language
- Ensure that standards are program-specific
- Delete redundant or non-essential standards
- Consolidate similar standards

According to the Joint Commission website, the revised manuals will be reorganized and the scoring and decision process will be refined. For now, they are currently seeking organization's feedback which can be submitted via online survey, email or regular mail.

We at TSIG encourage our readers to review these new changes and provide your input directly to the Joint Commission. For a copy of our matrix with current - 2009 revised standards, please email your request to info@tsigconsulting.com

In order to provide your feedback to the Joint Commission, you can find their online survey at: <http://www.surveyconsole.com/console/TakeSurvey?id=389927>

When reviewing these materials, it is important to remember the fact that these changes and enhancements in both format and language edits **are expected to go into effect January 2009** for ambulatory, critical access hospital, home care, hospital, and office-based surgery programs. The Joint Commission will seek feedback on standards for the behavioral health care, laboratory and long term care accreditation programs throughout 2008.

Here is a brief summary and overview of these revisions, and some of the things to consider when evaluating these changes.

What is the General Focus of the Revised EC Standards?

The Joint Commission has stated these revised Environment of Care standards focus on how all personnel within the organization should participate in those activities that comprise of a safe environment. The new standards require organizations to assure the following:

- establish plans
- identify key individuals for managing the environment of care
- identify physical risks to which the organization is susceptible
- establish activities to minimize these risks
- train staff to implement these activities
- monitor the effectiveness of these activities and implement improvements.

New Standard: EC.1.10.0

Although this standard is new, all the elements of performance in this standard currently appear in other EC standards as existing planning activities. It is anticipated that by consolidating these planning requirements under one standard, organizations now have a comprehensive list of what needs to be considered when planning for environment of care issues, and can be creative in establishing their management plans to avoid unnecessary duplication of their planning efforts.

Current standards: EC.1.10 and 2.10

Current EC.2.10 (managing security risks) has been consolidated with current EC.1.10 (managing safety risks) into revised EC.2.01.0 (managing safety and security risks). The field has indicated that because the safety and security requirements are closely related, it would be appropriate to consolidate both sets of requirements under one standard.

Current standard EC.3.10

Current EC.3.10 EP 3 (managing infectious materials and wastes) has been moved to the revised IC.2.10 EP 6. Requirements related to chemotherapy materials and wastes have been moved to the revised Medication Management (MM) chapter and are currently posted for comment. The purpose for relocating these requirements is to improve integration of these functions throughout other areas of the organization.

Gone are current standards EC.4.10 & EC.4.20

For hospitals and critical access hospitals, new emergency management standards have already been approved for January 2008. These new standards, as well as current EC.4.10 and EC.4.20 for ambulatory health care, office-based surgery, and home care, will be moved into a new chapter specifically on emergency management. This new chapter will be open for review at a later date.

Current standard: EC.5.20

Current EC.5.20 (Life Safety Code®) is moving into a new chapter created specifically for the Life Safety Code® requirements; this new chapter will be open for review at a later date.

New standard: EC.8.01.0

Revised EC.8.01.0 is the current HR.2.20 (individuals can describe or demonstrate their role in minimizing risk in the environment and reporting incidents). Prior to 2005, these requirements were located in the EC chapter. The requirements were subsequently moved into the HR chapter under the current standard HR.2.20, in proximity with other human resource training requirements. Organizations have since indicated a preference to move these requirements back to the EC chapter, as these requirements are critical for managing a safe environment. The revised chapter reflects this recommendation from the field.

Revised standard numbering

All numbers for standards and elements of performance will be changed as a result of the reorganization of the requirements under review through the Standards Improvement Initiative. Because all numbers for all requirements will be changed from the current numbers, this is an opportune time to modify the numbering system. The new numbering system is presented for the first time in the proposed revised EC chapter. This numbering

system will benefit organizations in a couple key ways:

1. The new numbering system will accurately sort when the standards are in electronic documents that an organization might create for internal use;
2. When new requirements are added in the future, the new numbering system will be able to accommodate the new requirements, preserving a logical order and minimizing the need for frequent renumbering.



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CRITICAL ENVIRONMENT OF CARE INFORMATION ENCLOSED

"As a large Behavioral Healthcare Facility serving the greater tri-state area we have on occasion found the need to seek out expert consulting advice for several important Joint Commission and Fire and Life Safety Code compliance projects. After considering several firms and based on the recommendations of other satisfied customers we chose TSIG Consulting to help us meet our project goals and expectations.

I can say without exception that TSIG Consulting has consistently met and often exceeded our expectations. They have a great staff of seasoned, knowledgeable experts in the field of Healthcare and Fire and Life Safety that we have come to depend on when we need answers and solutions to our problems."

Kent A. Bouchard HEM, CHSP
Dir. Environmental Health and Safety
Four Wind Hospital