The Environment of Care in the Survey Process

The building tour

Preparation for survey involves being ready to display the real work of the organization’s staff. The building tour is particularly relevant to assessing environment of care standards.

The building tour

During the building tour, the surveyor examines compliance of the physical plant with the 1997 Life Safety Code® (LSC®), published by the National Fire Protection Association (NFPA), and assesses compliance with the management of the environment of care standards in selected care settings (“health care” occupancy and “outpatient ambulatory” occupancy) and noncare areas.

Following are answers to commonly asked questions about the building tour.

When will the building tour take place? This tour should be completed before the review of environment of care documents.

What is the purpose of the building tour? The purpose of the building tour is to

- address environment of care standards.
- orient the surveyor to the organization’s programs for managing safety, life safety, security, hazardous materials and waste, emergency management, medical equipment, and utility systems.
- assess other standards in noncare settings that do not require a structured interview or visit.
- address above-the-ceiling issues in selected care settings, including
  - penetrations of smoke, fire, or corridor walls;
  - smoke or fire walls that are noncontinuous from slab to slab and outside wall to outside wall;
  - penetrations or discontinuities of rated enclosures such...
Ethyl Chloride
A single unit is manageable

Ethyl chloride, useful as a topical anesthetic, is sometimes found in patient areas. This product is very effective, working immediately to numb feeling. It is also highly flammable. Using the NFPA “degrees of flammability” scale of 1 to 4, ethyl chloride is ranked a 4, or most flammable.

However, flammable liquids are safely used in clinical settings every day. Single containers or small amounts of alcohol, acetone (nail polish remover, hair spray), butane, and xylene are typically out in the open because they are needed clinically and must be within easy reach. Similarly, it is acceptable to keep a single unit (bottle or can) of ethyl chloride in the open. But remember—bulk amounts of any flammable product should be kept in a flammable storage locker.

Less risky alternatives to ethyl chloride do exist—for example, lidocaine in jelly, spray, solution, and swabs. Fluorimethane is a nonflammable substitute. However, ethyl chloride works immediately, whereas these alternatives take time.

Note that there are many compounds that sound similar to ethyl chloride (chemical composition C₂H₅Cl). So to clarify, here’s the chemistry:

- **Ethylene oxide** is a gas sterilant with chemical composition CH₂OCH₂. In undiluted form, the vapor is explosive.
- **Ethyl ether** is a solvent, no longer used as a general anesthesia agent in the United States. Its chemical composition is C₂H₅OC₂H₅. Ether is extremely flammable.
- **Ethylene glycol** is used in antifreeze. Its chemical composition is HOOC₂H₄OH. It is a “normal” combustible material.

**Correction: No recap**
An error appears in the “Sharps Management” article in the January/February 2001 issue of Environment of Care® News. On page 3, in the section titled “Practice safe work habits,” the word don’t is missing.

The line in question should read, “Clinical staff, don’t recap those needles. Dispose of them in the sharps container.”

We regret any confusion caused by this error.
Survey Process
(continued from page 1)

as hazardous areas, stairwells, chutes, and shafts;
— corridor walls that are not slab to slab or do not end at a monolithic ceiling;
— the presence of required smoke detectors or fire dampers; and
— the presence of required fireproofing on structural members such as columns, beams, and trusses.

 Determine whether there are issues related to the LSC® that are not identified in your Statement of Conditions™.

Who will participate in the building tour? Participants within the health care organization may include
— the facilities manager,
— the safety officer,
— the chief building engineer, and
— other designated staff.

What will occur during the building tour? In applicable occupancies, the surveyor will begin by discussing the Statement of Conditions™ (reviewed during the document review session) with the facilities manager and safety officer. The surveyor and facilities manager will then plan the tour using a building tour checklist (hospitals only). The tour will include noncare areas where environment of care and infection control issues need to be addressed. For example, high-risk areas (particularly in hospitals) may include
— the boiler room;
— the emergency generator (generator testing, utility management program);
— the loading/receiving dock;
— central storage areas or warehouse;
— the laundry area, if applicable;
— food service;
— oxygen/medical gas storage rooms;
— areas designated as hazardous, such as locker rooms, clean and soiled linen rooms, and oxygen storage rooms;
— the bottoms of chutes (to check for fire protection and management of the space to minimize trash or laundry accumulation and injury and accident prevention practices); and
— heating and air conditioning equipment rooms to evaluate storage practices and utility systems maintenance.

To evaluate compliance with the LSC®, the surveyor will also be looking at above-the-ceiling areas (in applicable occupancies) and will be visiting certain care settings.

In a large health care organization, several care settings not visited during other survey activities may be visited to focus on life safety issues.

What kinds of questions might be asked during the building tour? Surveyors’ specific questions are often suggested by materials they read during the document review or other activities. Many of the questions are open ended, to encourage discussion among the tour participants.1

Surveyors may ask open-ended questions.

Reviewing the standards to be addressed during the activity is good preparation. Turn the standards into questions like the following and see if you can answer them:
— Are newly constructed and existing environments of care designed and maintained to comply with the LSC®? If a building in which care recipients are housed or receive treatment does not comply with the LSC®, has the Joint Commission approved an equivalency or an acceptable Plan for Improvement? (EC.1.5.1)

Relative to hazards posed by existing LSC® deficiencies or construction activities:
— Do exits provide free and unobstructed access? (EC.2.5)
— Are fire alarm, detection, and suppression systems impaired? (EC.2.5)
— Does the organization have a nonsmoking policy that is communicated and enforced throughout all buildings? (EC.1.1.2)

Surveyors to Focus on Individual-Centered Evaluation in 2001

Joint Commission surveyors will focus more on individual-centered evaluation and systems analysis during surveys in 2001. At their annual conference held during the first week of January, surveyors learned techniques for evaluating multiple organization functions by reviewing the care provided to one individual at a time, instead of surveying a single function across multiple individuals. Although it is not a major change in survey process, this approach will allow surveyors to see how the organization’s departments and systems work together for the benefit of an individual. This change will affect the environment of care only to the extent that environment of care systems become involved in direct care.

1 Staff education and orientation questions may be addressed to staff encountered during the building tour, except in care settings that will be visited during other scheduled survey activities, when it will be the responsibility of the member of the survey team conducting the visit to ask such questions.

The surveyor will pay particular attention to areas above ceilings and away from care settings. Identification of structural deficiencies in hidden or remote spaces is a critical part of evaluating the accuracy and completeness of the Statement of Conditions™.

March/April 2001 Environment of Care® News 3
Q&A

Our standards experts tackle storing flammable liquids, using perimeter wall storage, and more.

Every day, our environment of care technical experts receive calls from readers like you. This Q & A column features answers to the questions our experts hear most often. If you’d like further information from our staff, please contact the Joint Commission’s Standards Interpretation Group in the Division of Accreditation Operations, at 630/792-5900, or e-mail them at ecnews@jcaho.org.

No electronic signatures

Q We are using the Power Statement of Conditions™ (SOC™). Is an electronic signature acceptable in lieu of a handwritten signature for the SOC™ Part 4: Plan for Improvement (PFI) sheets?

A No, not at this time. At the time of survey, an organization should print hard copies of all Part 4: PFI sheets and present them to the surveyor(s) for signature. Signed photocopies should be given to the surveyor(s), who will in turn forward them to Joint Commission central office archives. The organization should retain original signed copies to be presented during subsequent surveys.

Infectious waste hauling regulations

Q Is there a federal requirement for infectious waste to be hauled by a regulated carrier to a regulated destination (that is, landfill, incinerator)?

A Hazardous waste is normally defined and regulated by each state and by federal agencies such as the EPA, OSHA, DOT, and NRC. Infectious waste or medical waste is not defined as “hazardous” by the federal government at this time. Each state may regulate infectious waste as it sees fit.

Observation rules in the 2001 fire drill standard

Q In the new EC.2.9.2 standard (formerly EC.2.10), I see no language about observing smoke compartments distant from the actual drill location. Does this mean that I no longer need to complete and keep observation reports from even the adjacent, or above and below, smoke compartments?

A The 2001 fire drill standard EC.2.9.2 no longer mandates the previous observation rules found in the former EC.2.10. The Joint Commission now allows organizations to develop their own fire plans regarding staff participation and observations.

Fire drill/emergency management drill

Q Can fire drills be utilized as emergency management drills if there is a full implementation, including the fire department?

A Even though a fire is a genuine emergency, the Joint Commission typically looks at fire drills/plans and emergency preparedness or emergency management drills/plans separately (see EC.2.9.1 and EC. 2.9.2).
Although there may be many similarities between these types of drills, the Joint Commission does not want to see a “doubling up” of these drills (such as a fire drill covering both type of drill requirements at once). If this is done, the opportunity to address situations other than fire emergencies is lost.

If an organization is being visited by the local fire department with some regularity, perhaps the fire department would be willing to participate in a drill scenario other than fire—for instance, a bomb threat or a hazmat response.

**Electrical safety of nonclinical equipment**

**Q** It’s my understanding that items such as microwaves, staff refrigerators, and other nonclinical items need to be checked only upon original installation. In the past our biomedical engineering department used to check them annually, but I believe that requirement has been relaxed to just incoming inspection. Is my understanding correct?

**A** While it’s probably a good idea to perform the annual checks you’ve described, Joint Commission standards do not require them. This type of equipment is addressed by EC.1.1.a. It’s up to the organization to determine how to check and maintain the pieces of equipment you have listed.

**Flammable liquids storage cabinets**

**Q** Please clarify when flammable liquids storage cabinets should be used. Our pharmacy did an inspection and found four cans of fixative in a locked cabinet. The cans are flammable and the pharmacy said they need to be in a flammable liquids storage cabinet. The cans are locked up, and only staff have the key, and there are no ignition sources anywhere. The local fire department does not have a problem with this at all.

**A** Bulk quantities of flammable liquids should be stored in an approved flammable liquid storage cabinet, per NFPA 30.

From your example, you could have limited quantities of flammable liquids stored in standard cabinets, as allowed by your local fire authority.

**Perimeter wall storage in a sprinklered space**

**Q** What type of storage is allowable in a sprinklered area? We have heard that there should be no storage against the wall—up to the ceiling. In other words, all storage within the room should remain 18" below the sprinkler heads within the room. However, the 1999 edition of NFPA 13, Appendix A, Section A-5-6.6, does support the note in the SOC™ Part 4, 6B.4, which states that “Perimeter room wall shelving may extend up the ceiling when not located directly below any sprinkler head.” Before we communicate this to staff, I wanted to verify that storage against the wall, up to the ceiling, is permissible as long as it is not obstructing a sprinkler. I have already checked with the local fire marshal and he concurs with NFPA 13.

**A** The Joint Commission allows storage of materials on perimeter wall shelving up to the ceiling in a sprinkled room (as addressed in the 1999 NFPA 13, Appendix A, Section A-5-6.6) when this shelving, including storage thereon, is not located directly below any sprinklers. Any other room shelving and storage thereon cannot be located above a plane 18" below the ceiling sprinkler defectors.

**Potted plants in isolation areas**

**Q** Is it allowable to have potted plants in protective isolation rooms?

**A** Soil is the natural growing place for a large number of bacteria and fungi. The best-designed and maintained mechanical ventilation system could be rendered ineffective if potted plants are introduced into protective isolation spaces—those serving high-risk immuno-suppressed patients. Organizations should have potted plant policies for areas serving that population. In less sensitive areas, potted plants are encouraged, at the discretion of infection control review. Obviously, nontoxic plants are preferred.
Mercury is a severe, chronic problem, and this organization is very large and complex,” says Gary M. Tencer, assistant director of occupational and environmental safety for Duke University Hospital in Durham, North Carolina. That makes reducing and eliminating mercury a multi-tentacled operation. The entire organization includes Duke’s hospital, clinics, medical school, research facilities, and university—including all the staff, students, faculty, and visitors. “The hospital and clinics, of course, are focused differently from the rest of the organization,” says Tencer. “They have distinctive needs.”

The recent partnership between the American Hospital Association (AHA) and the Environmental Protection Agency (EPA) is prompting health care organizations to reduce the volume and toxicity of waste they produce. The goals are to phase out mercury use by 2005 and to cut total waste production in half by 2010.

“The mercury problem crosses a lot of groups—patient care, engineering, clinical, housekeeping, purchasing, lab, utilities,” says Wayne Thomann. He’s director of the occupational and environmental safety office and safety officer for Duke University Health System as well as head of University Hospital’s safety committee. “When all these groups come together in committee, Thomann says, “they have to develop a management plan. And it’s not one plan for utilities, one for hazardous materials, one for clinical, one for nursing. It’s one plan for Duke—the organization as a whole—that addresses all units and subunits.”

Tencer is the one charged with directing that effort for hazardous materials. “The EPA has defined mercury as a persistent bioaccumulative toxin; it’s bad in landfills, and it’s found everywhere.”

**Fluorescent bulbs**

Duke has already had one success with mercury reduction—its fluorescent light bulb program. In the past, when a bulb burned out, it went into the trash. By itself, the little bit of mercury in one light bulb is not a problem. However, in a large organization, tens of thousands of bulbs are discarded over time. Duke recognized the problem years ago. The organization’s first idea was to compact the bulbs into a drum and dispose of them as hazardous waste, but before it could implement this plan, recycling the bulbs became an option. In the recycling process, intact bulbs are run through a shredder, the mercury is recaptured, and all parts are reused. In a year and a half, Duke has recycled more than 40,000 bulbs from the medical center facilities.

Moreover, the organization replaces the burnt-out bulbs with new low-mercury ones. Within a few years, all the old bulbs will be purged from the system. Besides being more environmentally friendly, the new bulbs retain their illumination longer than the old
ones. And, though the new bulbs and the recycling effort involve increased costs, the organization views the expenditure as worthwhile—an investment in the environment.

“Increasingly, everyone seems willing to be a partner in this effort, because of the environmental stewardship side,” Tencer says. “Each person has a piece he or she can put toward the goal.”

**Mercury thermometers**

Mercury thermometers, in use by the thousands, are a second example of a device that can be phased out and replaced with alternatives. But where to start? First, there’s the Patient Relations department, which sends care baskets home with patients, usually including thermometers. By doing this, Duke was contributing to the mercury problem in the community. “This problem was fairly easy to solve,” says Tencer. “Just exclude the mercury thermometer from the care basket.” Getting this message out to all departments was the solution here.

Further in the hospital, thermometers break every day, and the environmental safety staff members are called to respond to the spills. They take this opportunity to educate others about mercury-reduction goals. In addition, they make their case in newsletters, posters, and brochures. “It costs $200 for every thermometer cleanup. It’s a lot cheaper to replace them…. Even though each nonmercury device costs $4.00 versus $0.50 for each mercury one, bulk purchasing can bring down costs. – Gary M. Tencer

**Sphygmomanometers**
The sphygmomanometer, or blood pressure monitoring device, provides a far more complex example of the multiple reaches of mercury abatement. Because these instruments contain so much mercury (about two pounds each), they’re obvious targets for cleanup. And after eight or nine years, Duke’s hospitals have managed to purge most of them—but it has been difficult. First, care providers resisted the call to substitute aneroid, or needle-type, blood pressure devices, because the mercury device has always been the standard for accuracy. Second, also with regard to accuracy, the aneroid devices need more maintenance than the mercury ones—for example, they need regular calibration. Still, the mercury devices also need occasional cleaning, which involves removing the mercury and introduces the potential for spills.

**Communicating with clinics**
To complicate the mercury problems, Duke is in the process of acquiring and building many clinics, and the designers specify the equipment for each. Thus far, the communication links between the safety committee and the clinic designers have not been well established, so mercury devices are still purchased. Moreover, some manufacturers of mercury-based devices questioned the EPA’s view and Duke’s effort to eliminate the devices. Now, however, some facilities have agreed to replace the old mercury devices with the aneroid devices. Yet another wrinkle comes from Duke’s research community, whose research protocols, specified by granting agencies, often require mercury devices as the standard for accurate, consistent research results. Thus, safety staff members have had to educate grant providers and researchers, and researchers have had to petition granting agencies to allow the use of nonmercury devices.

It is extremely difficult to track down all the devices containing mercury in such a large organization—thus the need for partnerships throughout the organization and good education on the risks of mercury exposure. “We’re in the early stages of accomplishing all we want,” Tencer and Thomann say. “But we’re moving toward a goal.”

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The EPA has defined mercury as a persistent bioaccumulative toxin. – Gary M. Tencer

It costs $200 for every thermometer cleanup. It’s a lot cheaper to replace them…. Even though each nonmercury device costs $4.00 versus $0.50 for each mercury one, bulk purchasing can bring down costs. – Gary M. Tencer
Stored Emergency Power Supply Systems

Where can they be used?

Are hospitals responsible for stored emergency power supply systems (SEPSSs)? No. Hospitals are not affected by the SEPSSs requirement in EC.2.10.4.1 (formerly EC.2.14). (See Table A, below.) Not unless they have associated ambulatory care or other clinics.

Hospitals must have generators

A hospital must have an on-site prime mover (that is, a generator). NFPA 99® requires it—it’s called a “type 1 system.” NFPA 99® does not permit hospitals to have SEPSSs. A hospital must have a prime mover that can be refueled. A SEPSS would not be acceptable because it will run out of power at some point, and that would certainly compromise many patients.

SEPSSs are intended to automatically supply illumination or power to critical areas and equipment that is essential for safety to human life. Included are:

- systems that supply emergency power for such functions as illumination for safe exiting,
- ventilation where it is essential to maintain life,
- fire detection and alarm systems,
- public safety communications systems, and
- processes where the electrical current interruption would produce serious life safety or health hazards to patients, visitors, or staff members.

Table A: Joint Commission standard EC.2.10.4.1

<table>
<thead>
<tr>
<th>EC.2.10.4.1. Emergency power systems are maintained, tested, and inspected.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intent of EC.2.10.4.1</strong></td>
</tr>
<tr>
<td>Hospitals demonstrate reliability of the emergency power systems by ...</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Items c and d address generators—type 1 systems.</th>
<th>Items a and b address SEPSSs—and other type 3 systems.</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. testing each generator 12 times a year with testing intervals not less than 20 days and not more than 40 days. These tests shall be conducted for at least 30 continuous minutes under a dynamic load that is at least 30% of the nameplate rating of the generator; and</td>
<td>a. testing all battery-powered lights required for egress. Testing includes:</td>
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<tr>
<td>d. testing all automatic transfer switches 12 times a year with testing intervals not less than 20 days and not more than 40 days.</td>
<td>• a functional test at 30-day intervals for a minimum of 30 seconds, and</td>
</tr>
<tr>
<td><strong>Note:</strong> Hospitals may choose to test to less than 30% of the emergency generator’s nameplate. However, these hospitals shall (in addition to performing a test for 30 continuous minutes under operating temperature at the intervals described above) revise the existing documented management plan to conform to current NFPA 99® and NFPA 110® testing and maintenance activities. These activities shall include inspection procedures for assessing the prime mover’s exhaust gas temperature against the minimum temperature recommended by the manufacturer. If diesel-powered generators do not meet the minimum exhaust gas temperatures as determined during these tests, they shall be exercised for 30 continuous minutes at the intervals described above with available EPSS load, and exercised annually with supplemental loads of:</td>
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<tr>
<td>• 25% of nameplate rating for 30 minutes, followed by</td>
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<tr>
<td>• 50% of nameplate rating for 30 minutes, followed by</td>
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<tr>
<td>• 75% of nameplate rating for 60 minutes, for a total of two continuous hours.</td>
<td>• an annual test for a duration of 1½ hours;</td>
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<td>b. testing stored emergency power supply systems (SEPSSs), whose malfunction may cause a severe jeopardy to life and safety of the occupants. Testing includes:</td>
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<tr>
<td>• a quarterly functional test for 5 minutes or as specified for its class, whichever is less, and</td>
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<tr>
<td>• an annual test at full load for 60% of the full duration of its class.</td>
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</tbody>
</table>

SEPSSs are intended to automatically supply illumination or power to critical areas and equipment essential for safety to human life. Included are systems that supply emergency power for such functions as illumination for safe exiting, ventilation where it is essential to maintain life, fire detection and alarm systems, public safety communications systems, and processes where the current interruption would produce serious life safety or health hazards to patients, visitors, or staff members.

Note: Other non-SEPSS battery backup emergency power systems that an organization has determined to be critical for operations during a power failure (eg, laboratory equipment, medical records) should be properly tested and maintained in accordance with manufacturers’ recommendations.

*Note:* Class defines the minimum time for which the SEPSS is designed to operate at its rated load without being recharged.
### Table B: NFPA 99® Electrical System Type Requirements by Setting

<table>
<thead>
<tr>
<th>NFPA 99®, 1996 edition</th>
<th>Chapter 12 Hospital</th>
<th>Chapter 12 Hospital Laboratory</th>
<th>Chapter 13 Ambulatory</th>
<th>Chapter 13 Ambulatory Laboratory</th>
<th>Chapter 14 Clinic</th>
<th>Chapter 15 Medical Dental Office (if inhalation anesthesia, go to Ambulatory)</th>
<th>Chapter 16 Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type 1 electrical system</strong></td>
<td>Required 12-3.3.2</td>
<td>Required only if critical care areas are present 13-3.3.2</td>
<td>Required if life support equipment required 14-3.3.2</td>
<td>Required if life support equipment required 15-3.3.2</td>
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<td></td>
<td>Required 16-3.3.2</td>
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<tr>
<td><strong>Type 2 electrical system</strong></td>
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<tr>
<td><strong>Type 3 electrical system</strong></td>
<td>Permitted if no critical care areas are present 13-3.3.2</td>
<td>Permitted if no life support required 14-3.3.2</td>
<td>Permitted if no life support required 15-3.3.2</td>
<td>Permitted if no life support, anesthesia, has battery backup 16-3.3.2</td>
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<tr>
<td><strong>Level 1 gas</strong></td>
<td>If installed 12-3.4.1</td>
<td>If installed (med air may be simplex) 13-3.4</td>
<td>If installed (if not rendered incapable, med air may be simplex) 14-3.4.1</td>
<td>Required if over 3,000 cu ft 15-3.4.1</td>
<td>If installed (med air may be simplex) 16-3.4.1</td>
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<tr>
<td><strong>Level 3 gas</strong></td>
<td>Permitted if not served by central gas system</td>
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<tr>
<td><strong>Level 4 gas</strong></td>
<td>If installed 12-3.4.4</td>
<td>If installed 13-3.4.4</td>
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<tr>
<td><strong>Level 1 vacuum</strong></td>
<td>If installed 12-3.4.3</td>
<td>If installed 13-3.4.1</td>
<td>If installed (if not rendered incapable, vacuum may be simplex) 14-3.4.2</td>
<td>If installed and surgical 15-3.4.6</td>
<td>If installed 16-3.4.2</td>
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<tr>
<td><strong>Level 3 vacuum</strong></td>
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<td></td>
<td>If not surgical, 15-3.4.7</td>
<td></td>
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<tr>
<td><strong>Level 4 vacuum</strong></td>
<td>If installed 12-3.4.5</td>
<td>If installed 13-3.4.5</td>
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</table>

### Some ambulatory settings can have SEPSSs

Very limited areas are permitted to use SEPSSs. Table B, above—which contains the requirements of NFPA 99® relating to power systems, gas, and vacuum—shows exactly what settings are permitted to have SEPSSs. An example of a permitted application would be an outpatient clinic with no anesthesia or life support, where only enough power to terminate minor procedures and evacuate the facility is needed.

NFPA 99® defines type 3 systems to include SEPSSs. Type 3 systems are allowed to be a) generators; b) SEPSSs (battery systems); or c) batteries that are integral to equipment.

### Which Joint Commission standards apply?

In Joint Commission standard EC.2.10.4.1, items c and d address type 1 systems, which are generators. However, items a and b address type 3 systems, which includes SEPSSs. (See Table A.)

### A simple emergency light is not a SEPSS

Suppose a hospital installs an emergency lighting system in addition to its prime mover. Is this considered a SEPSS? No. Therefore, a hospital is not responsible for testing these non-SEPSS systems using items a and b of EC.2.10.4.1. The requirements for SEPSSs apply only to organizations that are permitted to use SEPSSs.

Of course, any non-SEPSS battery backup emergency power systems that an organization has determined to be critical for operations during a power failure (for example, those for laboratory equipment or medical records) should be properly tested and maintained in accordance with manufacturers’ recommendations.
HITF Highlights
Healthcare Interpretations Task Force comments
At its recent meeting, the Healthcare Interpretations Task Force made the following interpretation:

**Document to be interpreted:** 1997 NFPA 101®, LSC® Section 1–3.13.2

**Background information:** Section 1–3.13.2 of the 1997 LSC® states that existing life safety features, such as, but not limited to, automatic sprinkler, fire alarm, and standpipe systems, and horizontal exits, if not required by the code, shall either be maintained or removed. Section 4–6–12.2 of the 2000 LSC® now refers to existing life features “obvious to the public,” if not required by the code, to be either maintained or removed.

**Question:** Must nonrequired smoke dampers, fire dampers, or combination fire/smoke dampers, that are not obvious to the public, be maintained or removed?

**Answer:** No.

**Note:** The HITF made an interpretation on a requirement of the 2000 LSC®. Although the Joint Commission requires compliance with the 1997 LSC®, in this one specific instance, compliance with this exception of the 2000 LSC® edition would be acceptable.

SUD Update
What the Joint Commission will do
At a recent meeting, Joint Commission representatives informed the Food and Drug Administration (FDA) that the Joint Commission will not enter into a contract to assess hospital compliance with the new FDA requirements respecting the reprocessing of single-use devices (SUDs).

Rather, the Joint Commission will survey hospitals for selective compliance with these requirements against the existing standard, which requires that accredited organizations be compliant with relevant laws and regulations. Information about an organization’s SUD reprocessing activities will be gathered as part of the survey application. Any circumstance identified in this context as constituting an “immediate threat to patient safety” would be acted on and reported in accordance with established Joint Commission policy.

FDA staff concurred that the approach already provided for in Joint Commission policies and procedures is reasonably supportive of the FDAs overall objectives.
Videotaping or Filming for Training Purposes

Patient rights and informed consent vs. education

Health care organizations (HCOs) may want to film or videotape patient care activities, particularly for the purposes of training. If so, they are faced with a situation that has two laudable, yet competing, objectives: (1) training staff and educating the public to better understand health care and (2) protecting the privacy of individual patients.

If conscious, the patient is able to give consent to be filmed or videotaped in the interests of the first goal. However, in the emergency department situation, there are times when it is desirable to film, but it is not possible to get consent. Under these circumstances, the two goals are at odds. This situation should be resolved by using the organization’s mechanisms for resolving ethical conflicts or uncertainty (such as an ethics committee).

Because one of the goals is directed at the community at large, it is especially important to include the community’s perspective in resolving this conflict.

Questions and answers

When the decision is made to film or videotape, a number of questions may arise.

1. Can staff members of an HCO or a designated agent film or videotape patient care activities in the emergency department?

   Yes. It is appropriate to film or videotape patient care activities in the emergency room, provided that patients—or their family members or surrogate decision makers—give informed consent.

2. Do hospital staff members have to get patients’ consent to film or videotape their care while it is being provided?

   Yes. In a situation where the patient is comatose or otherwise unable to give informed consent and no surrogate decision maker is available, the hospital (or its designated agent) may film or videotape patient care activities, within a policy stating that informed consent is required before that patient’s film or videotape can be used for any purpose.

3. Does the HCO have to control or otherwise sequester the film or videotape until informed consent is obtained before using it for educational purposes?

   No. The HCO (hospital or ambulatory emergent or urgent care center) has an obligation to inform the community it serves that filming or videotaping may be occurring when emergency services are provided. Examples include posting signage such as “Filming or Videotaping Is Under Way;” posting “advance notice” signage in the public areas of the hospital and the emergency department (for example, in the lobby or waiting rooms); and including information about a filming or videotaping possibility in HCO advertisements.

4. What happens if consent is not given, then the patient is either removed from the film or videotape or the film or videotape is destroyed.

   If consent is not given, follow these steps:
   - The HCO (hospital or ambulatory emergent or urgent care center) has an obligation to inform the community it serves that filming or videotaping may be occurring when emergency services are provided. Examples include posting signage such as “Filming or Videotaping Is Under Way;” posting “advance notice” signage in the public areas of the hospital and the emergency department (for example, in the lobby or waiting rooms); and including information about a filming or videotaping possibility in HCO advertisements.

5. In what ways can an HCO inform its patients that filming or videotaping may occur during their visit to the emergency department?

   During a survey process, the surveyor will determine the organization’s procedures for maintaining patient confidentiality and obtaining informed consent. Such activities include, but are not limited to,

   - review of patient confidentiality policies;
   - review of informed consent policies;
   - interviews of staff members on the processes used to maintain patient confidentiality; and
   - interviews of staff members on the processes for obtaining informed consent.

In addition, the surveyor will determine the process used by leadership to approve the filming activities.

Program standards addressing patient confidentiality

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<td>RI.2.2.2, RI.2.4. See Manual.</td>
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