



TSIG NEWS

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CMS Approves Damper Test Interval to 6 Years

After due consideration of State survey agency findings and conclusions of NFPA, CMS has issued a categorical waiver to permit a testing interval of 6 years rather than 4 years for the maintenance testing of fire and smoke dampers in hospital heating and ventilating systems, so long as the hospital's testing system conforms to the requirements under 2007 edition of NFPA 80 & 2007 edition of NFPA 105. The 6-year testing interval shall commence on the date of the last documented damper test. This is truly good news knowing now that both The Joint Commission and CMS will survey hospitals in a consistent manner—assuring the same damper testing intervals. However, please remember that you must test any newly installed dampers 1-year after installation and keep in mind that both TJC and CMS's acceptance of the 6-year interval applies only to hospitals—not business or other occupancies.



Recession Equals Innovation Written by Ode Keil

During tough financial times hospitals face many challenges. The leaders of hospitals must balance the present and the future of the hospital. This challenge should keep anyone who plays a part in setting a hospital budget up at night.

Budgeting for the present is perceived by many healthcare executives as the only way to assure critical resources for short term survival. Anyone who has been through an economic downturn in the healthcare business knows the drill. Cut expenses, freeze hiring, passive layoffs as unfilled positions are cut, wage freezes, benefits reductions, and staff cuts. All of these acts are time proven to help hospitals survive tough times. They all have high negatives. Expense cutting often means deferred maintenance and capital spending. The effect is a higher cost of playing catch up when the economic picture improves. Hiring freezes put greater workloads on the remaining staff. Burnout may lead some to seek employment elsewhere. High performing employees are particularly at risk when they feel "used". Passive layoffs create the same burden as hiring freezes with a more permanent impact. Once the economy improves managers are in the difficult position of having to justify the resources that were in place for years. This becomes a frustrating yo-yo exercise over the span of several downturns. Any reduction in operational or capital budgets simply assures higher costs during future years to play catch up. The bottom line is that no organization has ever cost cut its way to greater success.

Budgeting for the future is a change in the motive behind innovations. Savvy managers know that assuming there is nothing that can be done except the tried and true cost cutting measures listed above is cutting off one of the greatest opportunities they will ever have to stimulate innovation.

One key constraint can be that the budget will be built assuming the normal revenue and expenses will occur during the budget year – *even if the belief is that they will not* – and that expense drivers will be managed to reflect patient care volumes. This approach carried through an entire budget year will help hold the critical staff resources of a hospital and can help avoid the psychological crash that activation of the usual suspects for cost management causes.

A second constraint is that effective ways to grow have to be developed by all services. Clinical services can grow through greater use of hospital facilities and services by physicians who split admissions between two or more hospitals and by adding strong new physicians to key service lines. Support services can create "growth" by assuming responsibility for services that have been provided via contracts and by improving operational efficiency. Facility managers can use the skills of maintenance and engineering team members to take responsibility for a variety of small construction projects that may have been traditionally handled by contractors. This approach can save substantial labor and materials costs. The effect can be impressive. For example, if a hospital has a 5% operating margin and use of in house staff to do small construction saves a million dollars the net effect is the same as if twenty million dollars in new revenue was generated. The savings can be redirected to other uses in the hospital.

(continued on page 2)

Recession Equals Innovation (continued from cover)

A third constraint is that quality must be improved across the board. Holding every manager accountable for this is critical to assuring the most “bang for the buck”. Quality is not free but processes that yield quality results normally are more efficient as there is less rework and for hospitals fewer patient care errors that generate enormous legal and settlement costs for patient injuries and deaths due to staff errors and equipment failures.

A fourth constraint is that no matter how bad things get some capital will be made available. This has to be acknowledged as everyone in healthcare management knows that critical patient care and building equipment fails either due to old age or unexpectedly during economic hard times. Failing to provide funds for these critical needs simply assures higher patient risk, disenchanted physicians and staff, and a declining reputation in the community. Many hospitals depend on endowment dividends for capital. When stocks and other investments sour some capital can be generated from operations. This approach eliminates the use of the word “emergency” from the budget lexicon. Again, this is important from a psychological point of view. A reduction in capital is a less threatening approach.

None of this is intended to convey a sense that a hospital should simply go plunging off a financial cliff. Rather it is encouragement to use the budgeting process to seek innovation when resources are likely to be constrained. One of my favorite success stories is about Southwest airlines. When the airline was in deep financial trouble a consultant recommended fare hikes and elimination of things like free drinks. The founder of the airline looked at the consultant’s report and did virtually the opposite of every recommendation. The long term result has been an airline that has a tightly knit staff and has been consistently growing and profitable while those around them have faltered and either failed or been forced to take drastic action, including going through bankruptcy, to hang on. For Herb Kelleher there was no hanging on. There was only innovation.

Accountability for Interim Life Safety Measures

By: Barbie Pankoski, CHFM, CHSP

In recent years there has been a significant emphasis on the part of regulatory agencies such as The Joint Commission to assure the assessment and implementation of Interim Life Safety Measures (ILSM) when Life Safety Code deficiencies can not be immediately corrected. However, often times organizations miss one critical component of this process by failing to provide effective training of the personnel affected and / or reinforcing what the necessary actions are required of them to carry out those defined measures. Often the Facilities Management, Safety Officers and Environment of Care Managers are responsible for the assessment process and have sufficient training on this process but fail to effectively communicate and or deliver the education to the staff affected and/or contractors that are actually performing the work.

It is essential that staff and contractors not only understand the importance of protecting occupants in a healthcare setting during periods when the Life Safety Code is not met but also have a clear understanding as to the nature of the problems as well as the expectation of their modified responsibilities. Maintenance Staff as well as contractors should be familiar with the hospital’s Interim Life Safety Measures. Not only should affected staff be familiar with the reasons why the ILSM’s are in place, but also should be able to describe how they would implement the process. Imagine you telling a surveyor that staff received training on ILSM only to discover that upon questioning of staff, the surveyor finds that no one can describe their role, or worst yet— state they were totally aware of the fact they were under ILSM! Not a good scenario nor one that I am sure you would care to see happen during your next survey.

In order to manage this activity, you will need to establish sound and reliable training for those that are actually performing the work and/or are in responsible for carrying out the measures that are in place. The accountability in protecting patients falls to those who have been trained to implement the measures, it is up to us, to pass that training on to the respective parties that actually implement the procedures.

In our next issue we will provide you with some fool-proof means of developing just such effective training processes that you can consider adopting to assure you meet your future ILSM needs.

How TSIG Can Help?

Written by Ralph G. Heiman

During trying economic times when budgets are slashed, it is not uncommon for senior leadership to instruct Facility Directors and Safety Managers to minimize the use of outside consultants. We at TSIG know this fact first hand and sympathize with the needs of our clients whose financial hardships limit the use of our services. However, if The Joint Commission were to show up on your doorstep and the survey result with a poor outcome, those responsible for managing the Physical Environment may face serious consequence as a result.

As Ode mentioned in our cover article "...reduction in operational or capital budgets simply assures higher cost during future years to play catch up". We at TSIG understand this all too well and have seen how adverse outcomes have affected organizations and those who serve in managing Environment of Care, Emergency Management and Life Safety programs. We also realize too that when those responsible, when denied the resources to acquire and independent audit / review, expert preparation of the SOC or damper survey, face answering some very serious questions: How else can we determine the status of our programs to evaluate our processes and complete the Periodic Performance Review? How can we be sure the building is structurally sound and will meet NFPA 101 requirements? How can we best be assured that our Emergency Operation Plan is going to meet the standards?

One of the biggest fallacies is that the expectation of the Facility Directors and Safety Managers have the time to do all the important and necessary work associated with the accreditation process. Nothing can be further from the truth, these managers have their hands full trying to meet the needs of the hospital and managing a difficult environment suitable for its purpose. Those who expect these Managers to deal with all the accreditation issues generally fail to understand the complex nature of their roles. The time necessary is simply not there to do everything that is expected of these key positions. We have seen this scenario unfold numerous times, until the realization hits home- when that 18 month window for survey is fast approaching and that something needs to be done in a hurry. Therefore we believe the answer lies with the effective and continuous utilization of a qualified consultant service provider. The use of TSIG Consultants does have some unseen advantages that many administrators may be unaware of. We can provide specialized expertise, can be retained on a short term basis to fill a particular need and serve as an ongoing resource up to, and including, during time of survey. We come with a unique support system comprised of regulatory experts and can deliver the necessary services unique to your organizational needs or augmented as required.

There are less than a half dozen companies around the country who are truly qualified to help an organization through the entire accreditation process. We at TSIG feel we are the best and have a proven record of successful survey outcomes to evidence this fact. Sure there are others that claim to use so-called experts, or are supplemented by former surveyors, but have limited expertise in the full accreditation process and less yet that maintain the level of expertise we have for those knowledgeable with the physical Environment. They may be able to assist you with document review and perhaps mock surveys, but what about a comprehensive SOC, or the creation of state of the art designing of floor plans, updated Auto Cad drawings and smoke & fire barrier drawings?

So how can TSIG help you during these difficult times to meet the accreditation requirements and stay ahead of any issues that will impact your performance and perhaps your future? Here are just a few ways:

- Consider having us perform a comprehensive 3-day EC/EM/LS Audit or full mock survey. We can assure you the confidence in knowing that all your documentation is organized and ready to meet the compliance challenge.
- You can't get away from a properly completed and thorough SOC. Even if you are doing the survey yourself, a pair of independent eyes is crucial. You don't have the funds available- we will work with you on spreading the cost over a year after the completion of our work.
- Send us your latest CAD drawings of your renovations and we will incorporate them into your base set. Doing it incrementally is inexpensive and avoids a wholesale site survey under panic situations.
- Let us review your smoke & fire barriers to be sure they are accurate and correct, taking advantage of suites and showing only what is required by code. With limiting barriers, you reap the benefit of the "less is more" approach, we can save your institution significant expenditure for penetration repairs and ongoing maintenance while still meeting code requirements and developing outstanding Life Safety Plans for your buildings.

We are here to help you for the "long run". We share your financial pain, and will assist you in any way we can. Simply call on us and we will jointly find a cost effective solution to meet your organizational needs. There is definitely a return on investment when you choose the right consulting group to aid your compliance needs and we hope you choose TSIG.

A New Approach to Full Accreditation

Written by Karim Bhimani and Glen Krasker

TSIG Consulting is pleased to announce a new approach to successfully achieving accreditation via your next TJC and CMS survey. We now offer the Integrated Accreditation Solution (IAS), representing a full spectrum of accreditation and regulatory compliance consulting services to the healthcare industry. This can be achieved via our collaborative partnership with Critical Management Solutions- an industry leading consulting firm with an unsurpassed record of success in achieving outstanding accreditation survey outcomes. Founded by Glenn Krasker, former Director of the Joint Commission's Hospital Accreditation Program, Critical Management Solutions offers a wealth of experience and unique insight to this partnership with TSIG. While with The Joint Commission, Glenn was responsible for the accreditation of over 5,100 of the nation's hospitals; including all survey activity and the management of 200 physician, nurse, and hospital administrator surveyors. As head of the Standards Interpretation Group and author of many current-day standards, Glenn is a recognized Joint Commission expert. He was also instrumental in the redesign of the modern accreditation and survey process and implementation of the Joint Commission's sentinel event policy and protocol. He has successfully navigated many organizations through the process of regaining accreditation, achieving continuous survey readiness, and the challenge of investigating medical errors. As such, he brings a wealth of talent to this new partnership with TSIG.

*Through the Integrated Accreditation Solution, we now provide the **full range of accreditation and regulatory compliance services including:***

- Comprehensive and integrated Joint Commission mock surveys that encompass all aspects of your organization, from clinical to environmental;
- A continuous TJC/CMS standards compliance program;
- Use of former TJC and CARF surveyors- who each have conducted hundreds of actual surveys, bringing you as realistic a mock survey experience as possible;
- Consultants with expertise in the following areas:
 - Physicians (including psychiatrists)
 - Nurses
 - Pharmacists
 - Behavioral health experts
 - Infection control practitioners
 - Performance improvement specialists
 - Environment of Care and Life Safety Code® authorities;
- The capacity to meet the needs of all healthcare organizations, from complex integrated delivery systems with a wide variety of programs and services (such as a hospital's) with a home health agency, behavioral health program, long-term care facility, and Joint Commission-surveyed laboratory) to freestanding hospitals; and
- The ability to successfully navigate organizations through the post-survey process of submitting clarifications (challenging and overturning Requirements for Improvement, or RFIs) and reversing adverse (Preliminary Denial of Accreditation and Conditional) accreditation decisions.



G. Krasker

The Integrated Accreditation Solution approach offers numerous **benefits to your organization**. The most successful environment of care, emergency management, and Life Safety management programs in hospitals function as an integrated component of overall hospital operations. As the environment of care is a management process that can not operate in a vacuum from clinical and other administrative activities, it makes sense that an integrated, well-coordinated approach to standards compliance and survey preparation will reap better results. (More on these full accreditation services in our next issue)

For more information on the Integrated Accreditation Solution, please contact Karim Bhimani at 212-420-8724 (ext 141)

Welcome TSIG's Newest Members

In an effort to better serve the hospital community TSIG has embarked on a major expansion of our expert staff, services and resources. To achieve this we have recently hired some new very experienced and talented persons to work with us; Mr. Henry Saunders and Mrs. Barbara Pankoski.



Mr. Henry Saunders has over 25 Years experience with construction and maintenance management of Healthcare Facilities. As a former Director of Electrical Operations for a 600 bed facility and later promoted to the Manager of Plant Operations, Henry has extensive experience in the electrical engineering and life safety needs for healthcare facilities. His professional expertise in Utilities Management, Electrical Distribution and Emergency Power Generation has proven him an outstanding consultant, committed to meeting the needs of clients through effective process improvement and successful survey outcomes as a result. Henry has significant knowledge and experience with all aspects of the Physical Environment including: Environment of Care, Emergency Management and Life Safety. Henry has successfully prepared hundreds of Statement of Conditions and numerous reviews of construction plans, infection control assessments, Interim Life Safety Measures, various risk assessments and updating of Life Safety floor plans. Henry is a former U.S. Naval Air Traffic Controller (Ops Specialist and EW) and attended Saddleback College. Henry has several years of active participation and extensive training with NFPA 101 Life Safety Code. His professional affiliations are with both NFPA & ASHE.



Barbara Pankoski, CHFM, CHSP, CERT recently joined TSIG as a full-time Field Consultant. Barbara has over 18 years experience as a regulatory expert in healthcare, having served as a Compliance and Commissioning Manager in a multi-hospital system and as a nationally recognized Regulatory Compliance Consultant. Her past experience includes over 20 Environment of Care Joint Commission Surveys, Engineering project management relating to compliance, construction and commissioning, development of policies and procedures, educational training and management of the Environment of Care and Life Safety codes. Barbara has a thorough knowledge of the Environment of Care and Life Safety regulatory Codes and Standards. Barbara's areas of experience include Environment of, Care, Life Safety, CARF, Behavioral Health Risk Assessments, Infection Control Risk Assessments, Interim Life Safety Measures, Statement of Conditions, Emergency Management, and Hospital Facilities Engineering Management.

“Maintaining Exits and Exit Passageways”

By Ken Gregory

As a life safety consulting touring hospitals throughout the country, I often see deficiencies regarding “exits and “exit passageways” not being maintained properly. I believe this to be the case primarily because the codes regarding this issue are not always effectively communicated to staff responsible for maintaining these critical pieces of insuring compliance with NFPA 101 Life Safety Code (LSC), and more importantly to the safety of the facilities occupants.

NFPA 101, 2000 edition defines the following:

Exit - That portion of a means of egress that is separated from all other spaces of a building or structure by construction or equipment as required to provide a protected way of travel to the exit discharge NFPA.101:3.3.61*

**Annex Explanation – Exits include exterior exit doors, exit passageways, horizontal exits, exit stairs and exit ramps. In the case of a stairway, the exit includes the stair enclosure, the door to the stair enclosure, stairs and landings inside the enclosure, the door from the stair enclosure to the outside or to the level of exit discharge, and any exit passageway and it’s associated doors if such are provided so as to discharge the stair directly to the outside. In the case of a door leading directly from the street floor to the street or open air, the exit comprises only that door.*

Doors of small individual rooms, such as in hotels, while constituting exit access from the room, are not referred to as exits except where they lead directly to the outside of the building from the street floor. NFPA 101:A.3.3.61 (This could mean patient rooms in many cases in a hospital)

Exit Passageway – NFPA 101:7.2.6*

**Annex Explanation – An exit passageway serves as a horizontal means of exit travel that is protected from fire in a manner similar to an enclosed interior exit stair. Where it is desired to offset exit stairs in a multistory building, and exit passageway can be used to preserve the continuity of the protected exit by connecting the bottom of one stair to the top of the stair that continues to the street floor. Probably the most important use of an exit passageway is to satisfy the requirement that at least 50 percent of the exit stairs discharge directly outside from multistory buildings (see 7.7.2). Thus, if it is impractical to locate the stair on an exterior wall, and exit passageway can be connected to the bottom of the stair to convey the occupants safely to an outside exit door. In buildings of extremely large area, such as shopping malls and some factories, the exit passageway can be used to advantage where the travel distance to reach an exit should be otherwise excessive. NFPA 101:A.7.2.6*

Although this article is focusing on these two critical parts, there are many important components to the process of egress. The LSC is designed around the idea of getting an occupant from anywhere inside the building all the way to the public way (street typically) as safely as possible. If you think of walking out of a room into a smoke resistant tunnel, this would be a level of defense called an “exit access corridor” leading to an “EXIT”. In healthcare and ambulatory occupancies the next level of protection is the smoke barriers you pass through. This is designed to allow a great level of protection by allowing additional time protected from smoke until the fire/smoke can be controlled, or until you can egress patients to exits. At this point you enter an “EXIT” as an even higher level of defense.

Exits are designed to provide the significant amount of time that is going to be required to egress to the outside of the building. In most cases in the hospital setting, this is going to be “exit stairs”

Many factors go in to determining what level of protection will be required, but in hospitals this is typically a one (1) or two (2) hour fire resistive rating depending on height, meaning you will be provided at least one or two hours of protection from the fire if all exit components operate properly.

All of the components of a stairwell (exit) are designed to provide this higher level of protection. The walls and doors are all rated to provide this protection. Damage to these components diminish the capability of the exit to provide this protection, therefore strict rules reside regarding maintenance of exits. For example, simple things like propping a fire door open chances damaging the door and its ability to operate properly. Damage could occur to the door itself, the hinges, the closure, and the latching. Storing items in a stairwell creates obstructions and an increased combustible load in many cases. These are all extremely critical components of protection of the exit and ability to egress.

Another critical rule is the restriction of items not required for the proper operation of the exit. What this means is that items such as conduits, pipes, duct work, etc. in the exit enclosure that do not serve the exit cannot be located there.

NFPA 101:7.1.3.2.1e states that penetrations into and opening through an exit enclosure assembly shall be prohibited except the following; Electrical conduits serving the stairway, required exit doors, ductwork and equipment necessary for independent stair pressurization, water or steam piping necessary for heating or cooling of the exit enclosure, sprinkler piping, and standpipes. The only exceptions are existing penetrations protected in accordance with 8.2.3.2.4, and penetrations for fire alarm circuits protected with metal piping. What this means basically is that items such as conduits, pipes, duct work, etc. traversing the exit, that do not serve the exit, cannot be located there. For example, using the stairwell for a pipe chase is unacceptable. The exit enclosure shall also not be used for any purpose that has the potential to interfere with its use as an exit.

As stated in the code references at the beginning of this article, "Exit Passageways" are an extension of the exit stair enclosure, therefore would be expected to follow similar rules. NFPA 7.2.6.1* states that "exit passageways" used as exit components shall conform to the general requirements of section 7.1 and the requirements of 7.2.6. These are the same requirements governing "Exits" in the previous paragraph. The two exceptions regard types of windows allowed if the building is fully sprinklered

Surveyors visiting your facility almost certainly put a lot of focus on exit access corridors for obstructions because it is a considerable issue and sometimes focus is lost on other egress components by the facilities in turn. These are two critical components to pay attention to. There are MANY more requirements to exits and egress components. This is not all inclusive of the other requirements and/or regulations governing exits. It is just meant to bring to your attention to often overlooked critical components of the path of egress. Be sure and check with your local Authority Having Jurisdiction (AHJ) for specific requirements.

*If we can be of assistance with your compliance efforts, feel free to contact us at:
info@tsigcosnulting.com*

Updated Generator Testing Procedures -- A Change for the Better

Although not adopted by TJC or CMS yet, it looks like this document (NFPA 110 2010 edition) stands a good chance at being adopted. The change involves reducing the current run time of Load bank testing from 2 hours to 90 continuous minutes. Of course organizations are only required to annually load bank an EPS if they do not meet the required monthly 30% of nameplate load rating.

The following is a comparison between the present documents (NFPA 110 -2005 Edition) to the new document (NFPA 110 -2010 Edition).

NFPA 110 – 2005 Edition

Load bank requirements

25% for 30 minutes of continuous run time

Followed by

50 % for 30 minutes of continuous run time

Followed by

75% for 60 minutes of continuous run time

Total elapsed time

2 hours of continuous run time

NFPA 110 – 2010 Edition

Load bank requirements

50% for 30 minutes of continuous run time

Followed by

75% for 1 hour of continuous run time

Total elapsed time

90 minutes of continuous run time

The applicable TJC standard for the yearly test is EC.02.05.07, EP 5; it should never be confused with the 4 hour test required every 3 years as noted in the NFPA 110 and TJC standard EC.02.05.07, EP 7. The NFPA has clarified their testing requirements concerning multiple tests, they (NFPA) now say that the four hour load test required every 3 years can be combined with the monthly test and the annual load bank test – 1 test (which is excepted by TJC). An example would be you have scheduled your tri-annual load test for next month – you would include the data for your monthly and if required your annual load bank test to satisfy the standard, making sure to meet all the requirements of testing procedures of course.

The organizations requirements for monthly testing of EPSS has not changed for 2010, you are still required to test the units monthly for a minimum of 30 minutes at 30% nameplate load or at the minimum exhaust stack temperature recommended by the manufacturer, also remember the minimum 20 day and maximum 40 day testing interval.

Always a hot topic is the Weekly inspections, the NFPA says it has not and does not require the operation of an EPPS during weekly inspections. The NFPA backs up this statement with a note in the annex (A.8.4.1) it states: “Weekly inspection does not require running of the EPS. Running unloaded generators as part of this weekly inspection can result in long term problems such as wet stacking.” They also state that they view it as a waste of fuel and it is not really testing the generator that much since it is not under load.

An important item to remember is the AHJ (Authority Having Jurisdiction) they tend to have different testing requirements for EPSS, so I strongly recommend that before you make any changes to your testing procedures make sure to ask the local AHJ their view and will they be recognizing the NFPA’s new 110 - 2010 Edition.

Lastly within the NFPA 110 2010 edition there is also a change to chapter seven Installation Acceptance testing. In this chapter you will find step by step procedures to be followed when performing acceptance tests of new EPPS. This chapter should be reviewed carefully as the need for better data recording and documentation are required as noted in 7.13.4.1.1 thru 7.13.4.1.3, for example in 7.13.4.1.3 there is a list of 12 testing procedures spelled out that need to be met to satisfy the acceptance test. Of course with all code revisions it is always safe to wait till the document has been adopted by TJC, CMS or your local AHJ before your organization makes any procedural changes, Good luck.

TJC Realigns National Patient Safety Goals for 2010

The Joint Commission recently revised the 2010 National Patient Safety Goals (NPSGs) and several were in response to concerns from organizations about the significant time & resources necessary to comply with the goals. Although no new Patient Safety Goals have been issued for 2010 according to the Joint Commission, several changes to the current goals have been made for future means of compliance.

The revisions include simplification and clarification of certain goals, as well as the removing altogether of some requirements, while moving others directly into the standards. The changes are an effort to reflect The Joint Commission's "continuing efforts to focus the NPSGs on those topics that are of highest priority to patient safety and quality care".

By reducing the number of goals, organizations can now better focus their efforts on the most important issues. Moving a requirement to the standards means that it is no longer necessary to "spotlight" the issue. The changes are similar to the Joint Commission's Standards Improvement Initiative, which the standards have undergone and the goal of these improvements are to clarify language and ensure relevancy to the settings in which they apply.

Summary of the changes:

- Requirements that were moved to the standards but are still requirements include elements related to topics such as verbal orders, medication safety and fall reduction programs.
- While no new goals have been developed for 2010, effective January 1, 2010, organizations must have fully implemented the requirements related to health care-associated infections which were established with the 2009 NPSGs.
- The Joint Commission did not include the medication reconciliation goal (Goal #8) in these changes because it is still being evaluated and refined; it expects to send a revised version of the NPSG to field review in early 2010 and for approval by the Standards and Survey Procedures Committee in spring 2010.

| NPSG | Change and Program Applicability |
|----------|--|
| 01.01.01 | EP 1 was deleted for all programs |
| 01.02.01 | The goal was deleted for the home care, laboratory and long term care programs |
| 02.01.01 | The goal moved to the standards for all programs |
| 02.02.01 | The goal moved to the standards for all programs |
| 02.03.01 | The goal was deleted for the ambulatory care, behavioral health care, home care, long term care, and office-based surgery programs |
| 02.05.01 | The goal moved to the standards for all programs |
| 03.03.01 | The goal moved to the standards for the ambulatory care, behavioral health care, critical access hospital, home care, hospital, long term care, and office-based surgery programs |
| 03.04.01 | EP 7 was deleted |
| 03.05.01 | The goal was deleted for the home care program |
| 07.02.01 | The goal was deleted for all programs |
| 07.04.01 | The goal was deleted for the ambulatory care, home care, and office-based surgery programs |
| 09.02.01 | The goal moved to the standards for hospital and critical access hospital programs |
| 10.01.01 | The goal moved to the standards for the long term care program |
| 11.01.01 | The goal was deleted for the ambulatory care and office-based surgery programs |
| 13.01.01 | For the ambulatory care, behavioral health care, critical access hospital, home care, hospital, long term care and office-based surgery programs, EPs 1 and 2 moved to the standards and EPs 3 and 4 were deleted. For the laboratory program, EPs 1 and 4 were deleted. |
| 16.01.01 | The goal moved to the standards for applicable programs |

Summary 2009 2010 Standards Compare

By Barbara Pankowski

In comparing the 2009 Joint Commission Environment of Care, Emergency Management and Life Safety standards to the pre-publication of the 2010 standards, there were some changes in each chapter. Some of the changes were minor such as; EC 01.01.01 EP 3, the standard changed by changing the wording from "everyone" to, "patients and" everyone "else". Also, EM 02.02.15 EP 8, "emergency situation" was changed to "disaster" and EM 02.02.01, EP 7, changed word "purveyors" to "suppliers". However there were some more significant changes that could cause major headaches if not addressed by the facility.

Environment of Care

EC 02.03.03, EP 3, added the word "only" in the requirement. The facility has to perform fire drills: "only in areas of the building that the hospital occupies". This is a more significant change because it clarifies questions many facilities have asked regarding buildings that are not occupied.

There were several scoring changes under EC 02.03.05, Maintains fire safety equipment and fire safety building features; EP 1, (Supervisor Signaling Devices) and EP 2, (Valve Tamper Switches and Water Flow Devices) were changed from a scoring category of "C" to an "A". No partial credit here, you either have it all or you don't have any of it. EP 11, (Fire pumps under flow) is now a Direct Impact Score and EP 13 (automatic fire-extinguishing systems in a kitchen) is no longer a direct impact score. EP 16, (on portable fire extinguishers) added the words, "The completion date of the maintenance is documented." Last but certainly not least under EC 02.03.05, EP 19 (automatic smoke-detection shutdown devices for air-handling equipment) Changed from "A" scoring with direct impact to "C" scoring with direct impact scoring.

Under EC 02.03.05, Reliable emergency electrical power source, EP 4 (The hospital provides emergency power for the following: Elevators (at least one for non-ambulatory patients), Scoring was changed from "C" scoring to "A" scoring. This should not be a problem for most facilities, as most already have at least one elevator on emergency power.

EC.04.01.01 Collects information to monitor conditions in the environment, EP 15 (Every 12 months, the hospital evaluates each environment of care management plan) Changed to Direct Impact score in 2010. This should be a particular EP for all facilities to pay close attention to, often it is one that facilities tend to forget to do or perform haphazardly, this could have a big impact on an organizations score.

EC.02.04.03 Inspects, tests, and maintains medical equipment, EP 14, this standard was not part of the 2009 original publication by TJC but is part of the 2010 pre-publication: For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The dates of these activities are documented. A. Facilities should ensure this standard is addressed in there management plan.

EC.04.01.03 Analyzes identified environment of care issues, EP 2, wording has changed from "improve the environment of care" to: "resolve environmental safety issues". This may seem insignificant, however it is not, what the surveyors are going to want to see is the facility resolves their environmental safety issues that they have identified, not just improved them. EP 3, the wording in the standard has changed, the standard no longer clarifies to whom the facility has to report improvement activities to, the standard removed the words "to leaders" and "priority improvement activities".

EC.04.01.05 Improves its environment of care, EP 1 (The hospital takes action on the identified opportunities) Changed wording, "to improve the environment of care" replaced with "to resolve environmental safety issues". EP 2 (The hospital evaluates changes to determine if they resulted in improvements in the environment of care) Changed wording "resulted in improvements in the environment of care" and replaced with "resolved environmental safety issues". Bottom line, is the surveyors are going to want to see resolve and closure to environmental safety issues.

Emergency Management

EM.02.02.07 the [organization] prepares for how it will manage staff during an emergency, EP 6, (The Emergency Operations Plan describes how the hospital will manage the family support needs of staff) This is really the only significant change for Emergency Management, “pet care” was added.

Life Safety

LS.01.01.01 The [organization] designs and manages the physical environment to comply with the Life Safety Code EP 4, This Element of performance was not included in the original 2009 draft version but rather came out as an addition in June 2009. Many hospitals have still not included it in their management plans. **“For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains documentation of any inspections and approvals made by state or local fire control agencies. C”**

LS.02.01.20 The [organization] maintains the integrity of the means of egress Both EP 8 (Exits discharge to the outside at grade level or through an approved exit passageway that is continuous and terminates at a public way or at

an exterior exit discharge) and EP 30 (Signs reading "No Exit" are posted on any door, passage, or stairway that is neither an exit, nor an access to an exit, but may be mistaken for an exit.) were changed from a scoring category of “C” to an “A” and EP 8 is now a Direct Impact score.

LS.02.01.30 The [organization] provides and maintains building features to protect individuals from the hazards of fire and smoke. In 2009, EP 24 was moved to EP 25 and the new standard was added as **“In buildings, exit stairs connecting three or fewer floors are fire rated for 1 hour; exit stairs connecting four or more floors are fire rated for 2 hours”**.

LS.02.01.35 The [organization] provides and maintains systems for **extinguishing fires, EP 9** (Class K-type portable fire extinguishers are located within 30 feet of grease-producing cooking devices) This standard has a scoring change from a “C” category to an “A” category.

LS.03.01.30 The [organization] provides and maintains building features to protect individuals from the hazards of fire and smoke. EP 7 Changed wording from 2009: “ Existing wall and ceiling interior finishes” to **“Wall and ceiling interior finishes of exits and enclosed corridors”** Removed in 2010: **“In new construction, wall and ceiling interior finishes are rated Class A.”**

LS.02.01.50 The [organization] provides and maintains building services to protect individuals from the hazards of fire and smoke, EP 4 (New Elevators), this standard changed from a scoring category of a “C” to an “A” with a Direct Impact score.

LS.03.01.20 The [organization] maintains the integrity of the means of egress. EP 4 (Exits discharge to the outside at grade level or through an approved exit passageway) this standard changed from a scoring category of a “C” to an “A” with a Direct Impact score. EP 18, (Signs reading "No Exit" are posted on doors to stairs in areas that are not conforming exits and that may be mistaken for exits), this standard also changed from a “C” scoring category to an “A”, but with no direct impact attached.

These changes represent only a sample of what actions an organization might take to address the revised 2010 standards. However, should you seek additional information on how you can assure successful processes are implemented, feel free to contact us at info@tsiconsulting.com for additional information.



Dear Sir:

We just finished our survey and wanted to express to TSIG our sincere thanks for all the hard work you put into preparing our hospital's EC documents and our Statement of Conditions. Our Life Safety Surveyor was very black and white, and extremely detailed in his document review and building survey. There were so few things that he uncovered that he stated during the closing conference that the home office probably won't even think that he was here (he usually has a long list). He said it was the best survey he's ever had regardless of the size of hospital. Thanks for all your help! We greatly appreciate your hard effort and look forward to continue using your services in the future.

Curtis Lancaster

Faith Regional Health Services

