TSIG NEWS

TSIG CONSULTING, INC
740 Broadway, Suite 1001, New York, NY 10003
212-420-8724
www.tsigconsulting.com

FIRST QUARTER 2016

ISSUE 43

Inside this issue:

BENEFITS OF SPRINKLERS

Lori Dinney, MS, CHSP, PE

Properly installed and maintained automatic fire sprinkler systems help save lives. Because they react so quickly, they can dramatically reduce the heat, flames, and smoke produced in a fire. Per the National Fire Protection Association (NFPA):

- Sprinklers typically reduce the chances of dying in a fire and the average property loss by one-half to two-thirds compared to where sprinklers are not present.
- NFPA has no record of a fire killing more than two people in a completely sprinklered institutional building where the system was working properly.

The primary reason sprinklers fail most often (64%) is due to the shutting off of the system before fires began, as may occur in the course of routine inspection or maintenance. Other leading causes include manual intervention that defeated the system (17%), lack of maintenance (6%), and inappropriate system design for the type of fire (5%). Only 7% of sprinkler failures were attributed to component damage.

When sprinklers operate but prove ineffective, the reason usually had to do with an insufficiency of water applied to the fire, either because water did not reach the fire (44%) or because not enough water was released (30%). Other leading reasons resulted from system component damage (8%), manual intervention that defeated the system (7%), lack of maintenance (7%), and inappropriate system for the type of fire (5%).

Per NFPA 101, The Life Safety Code, 2000 edition, as adopted by The Joint Commission (TJC), new health care facilities are required to be equipped with sprinkler protection. What are the benefits of these sprinklers, and what are the benefits of existing health care facilities that are sprinklered?

NEW VS. EXISTING HEALTH CARE

TJC defines new health care facilities, or portions thereof, as those whose building plans were approved after March, 2003, the date when TJC adopted the 2000 edition of NFPA 101. Therefore, existing health care facilities are those whose building plans were approved prior to March, 2003.

CORRIDOR WALLS

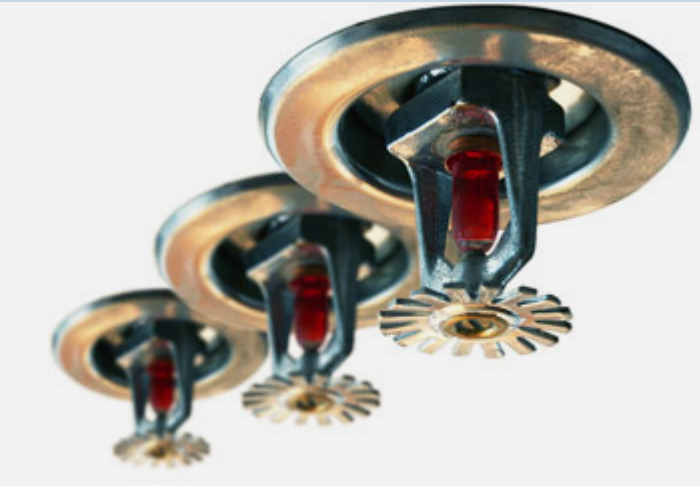
There are many benefits to being sprinklered. First and foremost, corridor walls are not required to be rated in smoke compartments that are fully sprinklered. They must be constructed to limit the transfer of smoke. This means they are not required to be constructed to the floor deck above; they can terminate at

Continued on next page

the ceiling tile as long as the ceiling tile is designed to limit the transfer of smoke. An architectural, exposed, suspended-grid acoustical ceiling tile with penetrating items such as sprinklers, ducted HVAC supply and return air diffusers, speakers, and recessed lighting fixtures is capable of limiting the transfer of smoke without any special protection.

EGRESS CAPACITY

The egress capacity for approved components of the means of egress is very different for sprinklered versus nonsprinklered smoke compartments.



AREA	Stairways (inches	Doors, Ramps, Corridors
Health care sprinklered	0.3	0.2
Health care nonsprinklered	0.6	0.5

What this correlates to is this: a 44-inch stair with a 33-inch door in a sprinklered facility can accommodate **146 occupants**, whereas it can only accommodate **66 occupants** in a nonsprinklered facility. This can result in a deficiency in the number of exits in existing facilities that are not sprinklered.

TRAVEL DISTANCE

The benefits of sprinklers also include an increase in travel distance.

In a nonsprinklered smoke compartment, the travel distance from an exit access door of a room to an exit is **100 feet** and is **150 feet** from the most remote point in a room to an exit. In a sprinklered smoke compartment, these distances can be increased 50 feet to **150 feet** and **200 feet**, respectively.

SMOKE DAMPERS

The Life Safety Code permits smoke dampers to be omitted at duct penetrations in smoke barriers in smoke compartments that are fully sprinklered and are fully ducted, meaning there is no return-air plenum within the compartment. This omission recently became permitted in the International Building Code (IBC), so if your facility falls under a local jurisdiction that follows the IBC, this omission is allowed.

DELAYED EGRESS LOCKS

There are only certain locking arrangements that are permitted in health care facilities with certain exceptions for psychiatric areas. KEEP IN MIND THERE ARE CATEGORICAL WAIVERS THAT PERMIT OTHER AREAS TO BE LOCKED UNDER CERTAIN CONDITIONS.

Delayed egress locks are permitted provided the entire facility, not just the smoke compartment, is fully sprinklered, or the facility is equipped with full fire detection. This would require every room to be equipped with sprinklers or fire detection. In addition, this type of lock is permitted provided not more than one such device is located in any egress path. A CATEGORICAL WAIVER PERMITS MORE THAN ONE SUCH DEVICE IN A PATH OF EGRESS.

INTERIOR FINISH

There is a difference between new and existing facilities where interior finish is concerned. For new facilities, interior wall and ceiling finish materials are required to be Class A or Class B with a couple exceptions but no exceptions for sprinklers. There are no requirements for floor finish. For existing facilities, existing materials for interior walls and ceilings are required to be Class A or B with an exception for Class C in rooms that are fully sprinklered. Newly installed materials for interior walls and ceilings are required to be Class A but are permitted to be Class B in smoke compartments that are fully sprinklered. Newly installed floor finish is required to be Class I in corridors and exits except in fully sprinklered smoke compartments where no interior floor finish requirements apply.

REMOTENESS OF EXITS

In new buildings/areas, where two or more exits are required from a space or floor, at least two of them are required to be located where they are considered remote from each other. This means they must be placed at a distance from one another not less than **one-half** the length of the maximum overall diagonal dimension of the floor or area served. In fully sprinklered buildings, this dimension can be lowered to **one-third**.

HAZARDOUS ROOMS

In new facilities/areas that are required to be sprinklered, storage rooms that contain combustibles and are greater than 100 sq. ft. and other rooms defined as hazardous are also required to have walls rated for 1 hour. Storage rooms that contain combustibles and are between 50 and 100 sq. ft. are not required to have rated walls but must have doors with closers and positive latching hardware. Storage rooms less than 50 sq. ft. are only required to have positive latching hardware when fronting a corridor. In existing facilities, storage rooms containing combustibles and greater than 50 sq. ft. and other rooms defined as hazardous are required to either be sprinklered OR be constructed with walls rated for 1 hour.

CONSTRUCTION TYPE

In new facilities, which are required to be sprinklered, the construction type required is based on the number of stories of the building. In existing facilities, it is based on the number of stories AND whether or not the building is fully sprinklered.

- Type II (000), Type III (211), Type IV (2HH), and Type V(111) construction are all permitted for 2-story existing facilities that are fully sprinklered but are only permitted for new 1-story facilities.
- Type III (200) and Type V (000) construction are permitted for existing 1-story sprinklered facilities but not for any new facilities.

PASS-THROUGH OPENINGS

Pass-through openings such as mail slots and pharmacy pass-through windows are permitted in health care facilities in smoke compartments that do not contain any patient sleeping. The maximum size requirement for the opening is **20 sq. in.**; however, this can be increased to **80 sq. in.** for rooms that are fully protected by sprinklers.

HIGH-RISE BUILDINGS

In the near future, TJC will be adopting a more recent edition of NFPA 101, the 2012 edition, once the Centers for Medicare and Medicaid Services (CMS) approves the use of it. When this edition is adopted, all high-rise buildings will be required to be fully sprinklered within 12 years of the adoption date. A high-rise building is defined as a building where the height from the lowest level of fire department vehicle access to the floor level of the highest occupiable floor is greater than 75 feet.

Based on the benefits discussed, it is obvious why it is much more advantageous to be equipped with sprinkler protection.

Preventing & Responding To Operating Room Fires
By Wayne Kestler, CHFM, CJCP, CEM

Operating room fires are actually quite common in healthcare. Some estimates indicate that as many as 700 operating room fires occur each year in the United States. Since not all states are obligated to report operating room fires, the real numbers are likely to be much higher. The basic elements of a fire are always present during surgery. A misstep in procedure or a momentary lapse of caution can quickly result in a catastrophe. A slow reaction or the use of improper fire-fighting techniques or tools can lead to damage, destruction, or even death. Given the tremendous potential for human and economic disaster resulting from surgical patient fires, it is surprising that perioperative fire safety receives so little attention.

It's important to note that fire response in the operating room is very different from the response that occurs in other areas of a healthcare organization. "RACE"—Rescue, Alarm, Contain, Extinguish—is the acronym that describes the fire response in which most health care staff have practiced, and this approach makes sense in other fire situations. For example, a fire that starts in a supply closet would involve staff members first rescuing patients, then sounding the fire alarm, containing the fire, and extinguishing it, if possible. But in the case of an operating room fire (unless it's completely so out of control that evacuation is necessary), the surgical staff should do the following:

- Control the fire by disconnecting the patient's oxygen, and then ventilating the patient with air.
- Further contain the fire by removing any burning materials from the patient.
- Rescue the patient by caring for him or her.

This difference between the normal RACE response and operating room fire response demonstrates why it's so important to have a fire plan specifically designed for the surgical arena.

PART 1: Creating a Specific Fire Plan for the Operating Room

In creating a fire plan, one size does NOT fit all. The plan to deal with surgical fires must be specific to the operating room and should differ with respect to details, but still be coordinated with the fire plan utilized throughout the rest of the organization.

To be effective, a hospital's operating room fire plan should assign specific duties to each member of the perioperative team, including the primary surgeon, the anesthesiologist, the scrub nurse, and the circulating nurse. The specific fire plan should establish what everyone on the team should do to prevent fire, to extinguish a fire and to ensure the safety of the patient. This specific fire plan should also assume that the patient is in the middle of a surgical procedure when the fire breaks out and therefore is at extreme risk. Lastly, the plan should also determine exactly how the perioperative team will manage the fire quickly and address the interrupted procedure.

The most obvious and easiest method of fighting fires is to prevent them from starting. This can be accomplished by training staff to understand the fire triangle. Staff can learn how to prevent its three elements (i.e., heat, fuel and oxygen) from combining in the operating room by controlling heat sources, especially by following laser and ESU safety practices; also by managing fuels, particularly by allowing sufficient time for patient preparation; and by minimizing oxygen concentration through judicious use of oxygen and tenting drapes. Although many devices and methods exist to minimize the risk of completing the fire triangle during surgery, they have to be consistently employed to be effective. It also can be helpful to keep a bowl of water or saline in the operating room. In some cases, this may be enough to extinguish a small fire. If staff members douse part of the surgical drapes, all drapes covering the patient should be removed, and then the patient should be re-draped. This ensures that no other sparks have occurred where they cannot be seen. Healthcare organizations may also want to have instructions on how to care for a burn patient in the operating room.

This could include instructions regarding fluid control, pain control, and wound control. Staff members can refer to these instructions as they prepare the patient for transport to a burn unit or another area of the hospital. Another component of a specific operating room fire plan should be to post an evacuation check sheet. This tool can help account for all personnel in the operating room and determine any medical equipment and supplies necessary for an evacuation.

PART 2: Educate Staff to Ensure Effectiveness of the Specific Fire Plan

To reduce the risk of surgical fires, organizational staff should be educated on surgical fire prevention strategies. Every member of the surgical team should receive this education, including surgeons, anesthesiologists, nurses, and so forth. Areas to emphasize in training efforts include the following:

- How to minimize fire ignition risks, such as proper equipment use and care;
- How to minimize oxidizer risks, including reducing oxygen concentration;
- How to minimize fuel risks, such as properly preparing the patient for surgery;
- Specific risks for the types of surgery conducted in the organization.

It may be helpful to educate nurses and physicians together so that they are encouraged to discuss the best strategies for surgical fire prevention. By involving the staff in the development of surgical fire protocols, a healthcare organization can ensure staff buy-in and participation. Education for perioperative staff members should review flammability levels of the materials and substances that staff members use in their work. These substances include not just alcohol-based prepping agents, but drapes, towels, gowns, hoods, and masks, as well as the dressings, ointments, equipment, and supplies used during surgery.

The staff should also be educated on how to effectively respond to a fire. Each staff member must know his or her role during a fire and be able to flawlessly execute that role. Fire response education should include the following:

How to quickly extinguish a fire, treat the patient, safely remove the patient, if necessary, safely evacuate the operating room when necessary, as well as to have a preplanned alternate room/area to evacuate to; activate the fire safety alarm systems, prevent the spread of smoke, locate and use fire extinguishers.

PART 3: Fire Drills in the Surgical Arena

Healthcare organizations should conduct surgical fire drills to make sure that staff members understand their roles during a fire. Participating in a simulated fire drill usually provides more in-depth instruction than learning about fire response in a classroom setting or meeting. Regular fire drills are a critical aspect of operating room fire response. It is recommended that surgical staff take part in special drills that focus on the following:

Properly using operating room fire-fighting equipment;
Dealing with patient rescue and escape;
Identifying and locating medical gas, ventilation, and surgical systems and controls;
When, where, and how to shut off these systems;
Using the organization's alarm system and its procedure for contacting the local fire department.

After completing a drill, it will be helpful to conduct a debriefing session to evaluate the fire response, highlight aspects that went well, and identify areas that require improvement. Drill critiques can help an organization determine the need for additional training, the need to revise response procedures, and/or the need to adjust certain aspects of fire response, such as the most appropriate door from which to evacuate or the most effective way to extinguish an operating room fire. Such critiques and evaluations must be documented.

Part 4: Responding to Different Types of OR Fires

According to the American Society of Anesthesiologists operating room fires are defined as "fires that occur on or near patients who are under anesthesia care, including surgical

Continued on next page

fires, airway fires and fires within the airway circuit". Airway fires are a specific type of surgical fire that occurs in a patient's airway. Airway fires may or may not include fire in the breathing circuit. Below are some of the suggested responses to a surgical wound fire and a patient airway fire:

Suggested Response to a Surgical Wound Fire

Shut down medical gases;
Pour saline into the surgical site;
Remove the surgical drapes to the floor, along with any material that may have been burning;
Search for and extinguish any additional flames;
If there's smoke in the room, determine whether it's necessary to evacuate;
Save all materials for a subsequent investigation.

Suggested Response to a Patient Airway Fire

Disconnect the breathing circuit from the tracheal tube;
Remove the tracheal tube and have another surgical team member extinguish it;
Remove any other portions of the burned tube, such as any cuff protective devices that may remain in the area;
Reestablish the airway and resume ventilating with air until certain nothing is left burning in the airway;
Examine airway for extent of damage;
Save all materials for a subsequent investigation.

Part 5: The Dangers of Fire Blankets

Some organizations install wool fire blankets coated with fire retardants on the wall of the operating room, with the expectation that staff members will use them when they need to smother a fire. Although fire blankets can be helpful in other areas of a health care organization, they present some significant risks in surgical arena. For example, a fire blanket draped on a patient during an operating room fire can burn while oxygen is being delivered to the patient. Fire blankets can also inadvertently force a sharp instrument into a patient or trap a fire next to a patient, causing more severe burns.

Part 6: Fire Extinguishers

Fire extinguishers are not usually needed to extinguish operating room fires. In fact, fire extinguishers are used in only a few of the hundreds of operating room fires each year. Although fire extinguishers are not the first solution to an operating room fire, they may be necessary to put out fires that engulf a patient or extend beyond a patient into the room.
To ensure proper fire response, organizations should make sure that the fire extinguishers located within the operating room are appropriate. CO_2 extinguishers are effective at suppressing fires on surgical drapes, once the drapes have been pulled off the patient. They release a fog of cold carbon dioxide gas and snow. This smothers and cools a fire without leaving a residue. The cold fog may help minimize any injuries from the fire and is unlikely to injure the patient.

A word to the wise, when extinguishing burning materials, it's important to avoid stomping on them because the materials could stick to shoe covers and ignite surgical scrubs. Instead staff should drop burning materials to the floor and extinguish them with water, or a fire extinguisher. Neither water-based nor dry chemical extinguishers are normally recommended for use in the operating room because they can contaminate the surgical site, and cleanup afterward may be difficult.

Organizations should make sure that designated fire extinguishers are mounted inside the surgical suite and are inspected monthly and maintained annually. Surgical staff should be trained to know where fire extinguishers are located and how to use them.

Given the potential for human and economic disaster resulting from operating room fires, all healthcare organizations should ensure that surgical staff be prepared to prevent fires, to fight fires, and care for a patient, should a fire occur.

Failure Mode and Effects Analysis vs. Root Cause Analysis for Sentinel Events

by Dean Samet, CJCS, CHSP

When trends and/or significant harm to patients occur, The Joint Commission issues a Sentinel Event Alert. TJC has defined a sentinel event as “An unexpected occurrence involving death or serious physical or psychological injury, or risk thereof (which includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome).” Posted February 9, 2016, Joint Commission E-Alerts listed updated Sentinel Event (SE) Data and statistics.

TJC expects accredited organizations to identify, investigate, and respond to all Sentinel Events. Some SEAs that have a direct or indirect connection to the Environment of Care (EC) chapter include: Inpatient Suicides; Infant Abductions; Fatal Falls; Medical Gas Mix-Ups; Bed Rail-Related Entrapment Deaths; Preventing Surgical Fires; Preventing Adverse Events Caused by Emergency Electrical Power System Failures; Preventing Accidents and Injuries in the MRI Suite; Behaviors that Undermine a Culture of Safety; Preventing Violence in the Healthcare Setting; and Medical Device Alarm Safety in Hospitals.

Appropriate Sentinel Event responses include conducting a timely, thorough, and credible root cause analysis (RCA) of what did go wrong and why; implementing certain improvements to reduce risks; and monitoring the effectiveness of those improvements. TJC defines an RCA as a process for identifying basic or causal factor(s) underlying variation in performance, including the occurrence or possible occurrence of a sentinel event.

The main purpose of a root cause analysis is to identify the root cause(s) of an event that, if fixed, could prevent that event from happening again. However, there is a proactive systematic approach, called a failure mode and effects analysis (FMEA), for identifying ways that a process can or might fail and how it can be made safer before an SE occurs. FMEA is a very comprehensive method for determining the things that could go wrong and what would allow them to go wrong.

RCA and FMEA each has a role in the other. RCA is used in the FMEA process to identify actionable factors that could or might lead to identified failure modes. FMEA, generally used as a proactive approach, can also be used after a RCA is completed to test the safety and efficacy of a proposed redesign based on the results of that RCA.

Processes that can benefit from performing a FMEA are those that are high-risk for errors that might have significant patient care impact or potential damage to very expensive pieces of medical or diagnostic equipment. The steps involved in FMEA include:

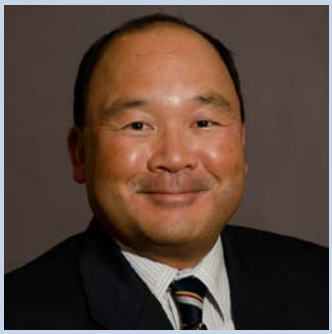
- Assemble a team with a range of knowledge bases and skills who are familiar with the project
- Diagram the process
- Brainstorm potential failure modes and determine their effects
- Prioritize failure modes
- Find root causes of the failure modes
- Redesign the process
- Analyze and test the new process
- Implement and monitor the redesigned process

Continued on page 14

NEWS FROM OUR CEO

Ralph Heiman

We would like you all to welcome our newest member of the TSIG Consulting team, Byron Kitagawa, HEM, who joined our firm in February of 2016. Byron comes to us with an outstanding background of experience and vast knowledge of regulatory compliance with over 20 years of hands-on experience in managing and maintaining Environment of Care (EC), Life Safety (LS) and Emergency Management (EM) programs. Byron currently resides in San Diego County, California.



Having spent the previous 11 years as a Life Safety Code Surveyor for the Joint Commission, Byron's significant experience includes having surveyed over 500 hospitals, including critical access hospitals, long-term care facilities and ambulatory surgery centers. Byron not only possesses a comprehensive understanding of the survey process, he has also reviewed countless sets of Life Safety Plans, progress and updates of Building Integrity & Compliance with NFPA 101- including preparation of Statement of Conditions and Life Safety audits, as well as detailed evaluations of Management Plans & Annual Evaluations, including other EC related documentation such as ILSM procedures and implementations, Risk Assessments, etc.

Prior to working for the Joint Commission, he served as the Senior Safety Management Specialist for Sharp Healthcare in San Diego- a 2007 recipient of the prestigious Malcolm Baldrige Award and where he acquired over 10 years working experience, enhancing the Environment of Care, Fire Safety, Hazardous Materials and Waste, and Medical Equipment programs.

TSIG Calendar for Tradeshow Attendance

In the upcoming months our staff will be present at the following shows :

- May 4-6 : Ken Gregory will be representing TSIG at the South Carolina Society for Healthcare Engineers (SCSHE)
- May 12: George Rivas will be presenting "Ventilation Intimidation- Managing HVAC Processes for High-risk Areas" at the 6th Annual Northern Ohio Society for Healthcare Engineering (NOSHE) Conference at the Marriott Key Center in Cleveland Ohio
- May 24-25, Wayne Kestler is speaking at the annual Shriners Hospital's Facility Managers Meeting in St. Louis, MO
- June 7-10: Ken Gregory will be representing TSIG at the Georgia Association for Healthcare Facility Managers (GAHFM) conference
- July 10-13: Annual ASHE Conference & Expo in Denver, CO.
- August 3 : TSIG Physical Environment Symposium at the Cleveland Clinic Administrative Campus. The speakers will be Larry Barlow, George Rivas, Noam Aberbach, Lori Dinney, Pamela Jerome and Ken McGraw

Joint Commission Scoring and Survey Process- An Explanation

By Ken McGraw

It seems as if the more I survey organizations across the country, the more confusion and mis-understanding of the scoring categories, findings, and potential for a re-survey I note. There are, typically, questions as to "how the Joint Commission will survey this and how it will be scored." There are also many questions relating to the "Re-survey" process and what all that means when there are findings that could, potentially, result in a re-survey.

Let's discuss scoring categories to get a better understanding of these categories:

The Joint Commission Elements of Performance are broken down into two categories:

1.The "A" category is scored on a "Pass/Fail" basis. There must be 100% compliance to be considered successful. This category relates to:

a. Structural requirements (policies and procedures to support the EP)

b. A high Risk performance issue or outcome that requires full compliance (National Patient Safety Goals, etc.)

c. A Medicare requirement that requires full compliance
Note: One or more occurrence of a non- compliant "A" Element of Performance will result in an RFI. (Requirement for Improvement)

Examples:

EC.01.01.01. Not having documented Management Plans for the disciplines within the Environment of Care.

EC.02.01.01. Not have a policy/procedure relating to patient elopement

LS.02.01.20. During the Building Tour the surveyor notes that there is a door that can be mistaken for an exit. The surveyor noted that there was not a "No Exit" sign on the door. This is an "A" scoring category so this finding would result in an RFI (Requirement for Improvement.) Additionally, follow up action would be required through an Evidence of Scoring Compliance (ESC).

LS.02.01.35. During the Building Tour the surveyor noted that there was not a type "K" fire extinguisher located within 30 feet of grease producing equipment in the main kitchen. This being an "A" scoring category, it would result in a Requirement for Improvement (RFI) with required follow up through an Evidence of Scoring Compliance (ESC).

2. The "C" category is based upon frequency . This means that the EP is scored based upon the number of times the organization is found non-compliant. This allows for a single observation to be identified without necessarily requiring an Evidence of Scoring Compliance, or a Measure of Success (MOS) as a follow up action.
Note: These findings will, typically, appear on the final Accreditation Report as Opportunities For Improvements (OFIs). Noted and referenced with Life Safety findings, three (3) or more of these occurrences will result in an RFI. (Requirement for Improvement)

Continued on next page

Examples:

LS.02.01.10. During the Building Tour the surveyor notes one fire door that did not have the required positive latching hardware so therefore did not close/latch properly when tested. This is a “C” scoring category that would require multiple findings to be scored as “non-compliant.” This would therefore result in an OFI. (Opportunity for Improvement and would not require any additional follow up.

LS.02.01.30. During the Building Tour the surveyor noted three (3) penetrations not properly sealed in two smoke barrier walls. Although a “C” scoring category, there were multiple findings , therefore scored as non-compliant resulting in an RFI (Requirement for Improvement. This would require follow-up documentation through an Evidence of Scoring Compliance. (ESC)

LS.02.01.35. During the Building Tour the surveyor noted one (5) areas where communication cables were being supported by AASS piping or supports. Being a “C” scoring category, this would result in a Requirement for Improvement (RFI) within required follow up through an Evidence of Scoring Compliance due to multiple findings.

It must be noted that within the two scoring categories, the EPs are scored on a 3 point scale. In addition to scoring compliance specifically stated in the EP, the surveyor can also score based upon track record achievements.

Note: Reference below information from 2016 Environment of Care Essentials:

Results from Number of Occurrences

Score	Designation	Category “A”	Category “C”	Track Record	Outcome on Report
2	Satisfactory Compliance	None	None	12 months	“C” Category: OF
1	Partial Compliance	N/A	Two	6-11 months	“C” Category, Partial Compliance. OFI
0	Insufficient Compliance	One or more	3 or more	Fewer than six months	“A” or “C” will result in an RFI

When looking at how the above mentioned scoring categories impact the survey process and the eventual level of accreditation we must look at how The Joint Commission reviews and defines the criticality or impact to the safety performance of the organization.

The organization’s processes and ability to identify risk within the organization is critical in this initiative. Realizing that the level of risk can and does vary depending on the potential impact to the organization. The more immediate the risk, the more immediate the assessment and mitigation initiatives must be implemented. With this being said The Joint Commission utilizes a “Criticality” model to identify the requirements into four (4) levels:

Immediate Threat To Health and Safety: This is the highest level of Risk and requires the most immediate response. This is noted when there has been a finding during survey that may have or have serious adverse effects on the health and safety of patients.

Example: Failure of the Master Fire Alarm Panel with no Interim Life Safety Measures implemented.

Situational Decision Rule: The second highest level of Risk that will automatically trigger and adverse accreditation decision.

Example: Failure to comply with accepted time frames established for a PFIs in the Statement of Condition.

Direct Impact: The third level relates findings during survey that have a direct impact on patients and can, potentially, create an immediate risk to patient safety, quality of care, treatment, or services.

Example: EC.02.05.01. Failure to have a process to maintain appropriate pressure relationships, air exchange rates, and filtration efficiencies.

Indirect Impact: The lowest level of Risk, these findings pose less immediate risk to the patient care or safety.

Example: EC.02.05.07. Failure to perform and document monthly 30 second test of Emergency Lights required for exit.

When noting the above addressed scoring potentials we are looking at the impact that the scoring potentials have on the outcome of the organization's survey and how the accreditation process is impacted when the organization is going through their tri-annual survey, resulting in the following Decision Rules:

1. Accredited
   - AO1: This Decision Rule is given when the organization is in full compliance with all standards at the time of survey or has successfully addressed all RFIs in its first submission of the ESC. (Evidence of Scoring Compliance)
   - A02: After the completion of a successful on-site follow-up survey, is compliant with all identified RFI's.
2. Accreditation with Follow Up Survey:
   - AFS01: The organization systemic patterns, trends, and repeat findings primarily with direct impact and/or risk related standards
   - AFS02: The organization demonstrates systemic patterns, trends, and repeat findings with indirect findings
   - AFS03: The organization fails to successfully address all RFIs in an ESC or MOS. (after two opportunities)
   - AFS04: At least two on site ESC demonstrate the need for continued monitoring to assess whether the organization sustains improvement
   - AFS05: The organization, which has failed to resolve one or more of its original RFIs, may be scheduled for a second Accreditation with Follow Up Survey
     - Note: The Accreditation with Follow-up Survey could occur within 30 days or up to six months after the decision is rendered.
3. Contingent Accreditation:
   - CONT01: If, as a result of direct observation or another determining method, the Immediate Threat to Health or Safety abatement survey demonstrated that the organization implemented sufficient corrective action to warrant removal of the Immediate Threat, the Accreditation Committee may change the decision to Contingent
   - CONT02: If the organization had received a decision of Accreditation with Follow up Survey and failed to resolve all requirements. (after two opportunities)
   - CONT03: Evidence of fraud or abuse by the organization

Continued on next page

4. Preliminary Denial of Accreditation
   PDA01: An Immediate Threat to Health and Safety exists for patients, staff, or the public
   PDA02: The organizations patients have been placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings.
   PDA03/PDA04: Risk to the patient based upon not having required and appropriate licenses by health care providers, and provided non-accredited services
   PDA05: Mis-reprensenting or falsifying documentation
   PDA06: Organization failed to clear non-compliant standards as a result of a follow up survey
5. Denial of Accreditation
   DA01: The organization does not permit the performance of any survey by The Joint Commission
   DA02: The organization has failed to resolve an Accreditation with Follow-Up Survey or Contingent Accreditation statues prior to withdrawing from the accreditation process
   DA03: The organization has failed to submit payment for survey fees or annual fees
   DA04: The organization has repeatedly failed to submit an ESC or MOS.

What's different in 2016?

Accreditation with Follow-up Survey (AFS):

Previously The Accreditation Committee of the Board of Commissioners of The Joint Commission made all AFS determinations.

This had a tendency to delay the process of making the decision and corrective follow-up actions.

New:

- The Joint Commission Chief Medical Officer will make the AFS decisions. (Exceptions may still go to the Accreditation Committee)
- Decisions are made within 10 days of survey
- A follow up survey, typically, occur with 4 months

Preliminary Denial of Accreditation (PDA)

Previously PDA decisions were based on the identified risks for a serious or adverse outcome and this decision did not, at all times, consider any subsequent improvements made

New:

- All corrective action and evidence of standards compliance is required to be completed within 45 days
- A follow-up survey is conducted after the evidence of standards compliance is reviewed to verify the corrective actions.
- Reviewing the Accreditation History will show a "time limited" PDA decision and the accreditation status will be upgraded to AFS.
- There will be a second follow-up survey to verify sustainability of the improvement

Conclusion

The scoring process that is used by The Joint Commission can be very confusing. When looking at the scoring process we must look at not so much what the score is, but what is the potential impact to the survey process, and how does this scoring impact the perception of the quality of care that the organization is providing.

The more we, as Healthcare Leaders, understand the requirements of the standards and how and what we must do to be compliant, the less we have to be concerned about the "Scoring" process and the impact. The ultimate goal that we all have is to be able to manage our respective areas as effectively, efficiently, and as safely as possible. The Joint Commission requires quality processes that ensure that we are effective, we are efficient, and we maintain a safe environment.

The better we understand the requirements of the standards, the easier it becomes and the less we have to be concerned about the scoring process.

See It – Cite It

The New Joint Commission Survey Imperative

By Ode Keil

The Joint Commission (TJC) & the Centers for Medicare & Medicaid Services (CMS) have been intertwined since the beginning of the Medicare program. When the legislation authorizing the Medicare program was signed into law it included a clause stating that any hospital accredited by the then Joint Commission on Accreditation of Hospitals would be deemed to meet the Medicare Conditions of Participation (COP's) making organizations eligible for Medicare funding without being inspected by a regulatory agency. The deemed status arrangement always had strings attached. The agreement came with a requirement for an annual report to Congress comparing Joint Commission survey findings to those of CMS teams conducting "validation" surveys. It also included administration of the deemed status arrangement by the CMS staff responsible for the Medicare program.

Over the course of several decades the administrative aspects of the program were relatively benign. TJC deemed status seemed permanent. During the decades of the 80's & 90's politicians & industry groups began to aggressively challenge what they perceived as a sweetheart deal between TJC, CMS & accredited organizations. Early changes include elimination of announced surveys & more integration of Medicare COP language into TJC standards. There was also a call for CMS to open the deemed status arrangement to more organizations. Eventually CMS made significant changes in the deemed status arrangement that led to opportunities for organizations to enter into the same arrangement TJC & the American Osteopathic Association had at the inception of the Medicare program. The change of rules had one new string attached- Deemed status was no longer permanent. Each "Deemed" organization is required to periodically undergo a rigorous examination by a team from CMS to determine if it continues to meet the "deeming" requirements. This is clearly a master & servant relationship. As part of the deeming arrangement CMS is now much more actively administering the relationships with the organizations granted deemed status. The CMS leadership is imposing increasingly prescriptive compliance requirements on the organizations.

To date the noteworthy changes associated with the EC standards include the separation of Life Safety into a stand-alone chapter, a requirement that all SOC plans of correction integrated into accreditation reports, the requirements for facilities & medical equipment introduced during late 2013 and, most recently, elimination of judgement calls by Joint Commission & other deemed status surveyors. The phrase used to describe this change is "See one – Cite One". The direction by CMS is exactly what the phrase implies. Any deficiency identified by a surveyor is to be documented as a Requirement for Improvement. Over the course of the next year or so it will result in all TJC standards & elements of performance being classified as "A" or immediate impact. The "C" category that allowed surveys latitude to score full, partial or non-compliance will disappear. For CMS this cleans up the long standing problem of requiring CMS staff & state agency inspectors to cite all deficiencies while allowing the Joint Commission & other independent accreditors the latitude to overlook some deficiencies. Examples over the time I have been involved with Joint Commission matters were small life safety deficiencies found in one or two locations & minor paperwork discrepancies.

The elimination of judgement by surveyors is likely to drive already high percentages of organizations found to be out of compliance with a number of EC & Life Standards even higher. Many organizations have benefitted from the "C" category standards in the form of "Indirect" & consultative findings. These types of findings gave Joint Commission surveyors some latitude to moderate the impact of findings on survey outcomes. They also gave the surveyors an opportunity to fulfill a Joint Commission desire to be educational & inspirational. The consultation that accompanied many of the lesser findings often paved the way for organizations to achieve better, more consistent results through re-engineering of existing processes.

Continued on next page

Continued from Dean Samet's article on page 7

A root cause analysis, which primarily focuses on systems and processes, is the most common form of comprehensive systematic analysis used for identifying the factors that underlie a sentinel event. The Joint Commission expects organizations to identify, investigate, and respond to all sentinel events. The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. The majority of SEs reviewed by TJC have multiple root causes. Topping off the list, but in no particular order (and depending on the specific event) are the following root cause categories and subcategories:

- Human Factors: Staffing levels, staffing skill mix, staff orientation, in-service education, competency assessment, staff supervision, resident supervision, medical staff credentialing/privileging, medical staff peer review, other (e.g., rushing, fatigue, distraction, complacency, bias)

- Leadership: Organizational planning, organizational culture, community relations, service availability, priority setting, resource allocation, complaint resolution, leadership collaboration, standardization (e.g., clinical practice guidelines), directing department/services, integration of services, inadequate policies and procedures, non-compliance with policies and procedures, performance improvement, medical staff organization, nursing leadership

- Communication: Oral, written, electronic, among staff, with/among physicians, with administration, with patient or family

- Assessment: Adequacy, timing, or scope of; assessment; pediatric, psychiatric, alcohol/drug, and/or abuse/neglect assessments; patient observation; clinical laboratory testing; care decisions

- Physical Environment: General safety, fire safety, security systems, hazardous materials, emergency management, smoking management, equipment management, utilities management

Please refer to the following TJC standards for additional information on Sentinel Events and patient safety:

Standard EC.02.01.01 –The hospital manages safety and security risks.
EP 1- The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. (See also EC.04.01.01, EP 14) Note**:** Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

Standard LD.04.04.05 –The hospital has an organization wide, integrated patient safety program within its performance improvement activities.
EP 7 - The leaders define patient safety event and communicate this definition throughout the organization. Note**:** At a minimum, the organizations definition includes those events subject to review in the "Sentinel Events" (SE) chapter of this manual. The definition may include any process variation that does not affect the outcome or result in an adverse event, but for which a recurrence carries significant chance of a serious adverse outcome or result in an adverse event, often referred to as a close call or near miss.

EP 8 - The hospital conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the "Sentinel Events" (SE) chapter of this manual.

EP 10 - At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. *(See also* LD.04.04.03, EP 3) Note**:** For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter.

The G.O. Team's NFPA 101 Q & A

by **G**abriel Villegas, LEED AP and **O**lya Villegas, LEED AP

Question: Does NFPA specify the installation height for stairwell signage?

Answer: Stair identification signs within the enclosure on each landing in stairs serving five or more stories should be mounted at 5' above the floor landing. 5' measurement should be taken to the bottom of the sign. *NFPA 101 2000 Edition Section 7.2.2.5.4*

Question: What should be taken into consideration while converting a patient room into a storage room?

Answer: The size of the area and its contents should be evaluated. If the room is over 100 sf and is used to store a significant volume of combustibles, then it would fall under a definition of hazardous as per NFPA 101. It should also be noted that since a change of use for the space occurred, requirements of NFPA 101 Chapter 18 New Healthcare Occupancy would need to be met.

NFPA 101 2000 Edition Section 3.3.13.2 NFPA 101 2000 Edition Chapter 18

Question: Should hazardous areas located in existing business occupancy of the hospital protected by both sprinklers and a 1 HR barrier?

Answer: As per NFPA 101 2000 Edition, hazardous areas protected by sprinklers located in an existing business occupancy meet Life Safety Code requirements and do not need to be protected by a 1HR barrier. *NFPA 101 2000 Edition Section 39.3.2.1/8.4.1.1*

Question: What are the rating requirements for mechanical areas?

Answer: Provided a mechanical space meets the definition of a hazardous area, it would only need to comply with NFPA 101 2000 Edition Section 19.3.6.2.2. It would be required to have a 30 minute, smoke resistant wall separating it from the corridor. If the room is sprinklered, the walls need only to be designed to limit the passage of smoke.

NFPA 101 2000 Edition Section 19.3.6.2.2

Question: Can mechanical rooms be used as storage?

Answer: There is no specific code that prohibits this, yet, two limitations come to mind. Mechanical space cannot be used for storage purposes if it functions as a plenum. Besides, if there is electrical equipment in the room, no items can be stored within 36" proximity to it. However, should local authority prohibit use of mechanical spaces for storage, it take precedence.

Question: Can a mail slot be located in a corridor that serves as means of egress?

Answer: If it is a rated wall such as a fire barrier or a smoke barrier, a mail slot cannot be located in it, unless it is equipped with a fusible-link activated or smoke activated shutter protecting it. However, if it is a corridor wall, it is permitted in smoke compartments other than those containing patient

sleeping provided the following conditions are met:

It does not exceed 20 sq. in. (80 sq. in. where the room is sprinklered)

The opening is installed at or below half the distance from the floor to the room ceiling

NFPA 101 2000 Edition Section 18/19.3.6.5

TSIG CONSULTING, Inc. Accreditation Services / CAD CAFM / Web Tools

740 Broadway, New York, NY 10003

[t] 212.420.8724 [f] 212.420.4792

www.tsigconsulting.com

TSIG News

ISSUE 43

FIRST QUARTER 2016

WHAT OUR CLIENTS SAY ABOUT TSIG:

Tom (Murray),
I would like to thank you so much for all your help assisting River Crest and Doctors Hospital in preparation of survey. We truly appreciate everything you've done for us and we look forward to continuing to work with you.

Sincerely,
Christy Messer CEO Associate Corporate COO
NeuroPsychiatric Hospital & Research Institute
Bremen, IN 46506