

APPROVED: Revisions to Emergency Management Standards for Critical Access Hospitals, Hospitals, and Long Term Care

This article contains revisions to standards EC.4.10 and EC.4.20 related to emergency management for the **critical access hospital, hospital, long term care, and Medicare/Medicaid-based long term care** programs, effective **January 1, 2008**. The revised text is noted in the box on pages 3–10 in **strikeout and underlined text**; explanatory text follows.

The revisions on pages 3–10 reflect an “all-hazards” approach to emergency preparedness that permits appropriately flexible and effective responses. The revised standards emphasize a “scalable” approach that can help manage the variety, intensity, and duration of the disasters that can affect a single organization, multiple organizations, or an entire community. The revisions also stress the importance of planning and testing response plans for emergencies during conditions when the local community cannot support the health care organization.

Over the past five years, the Joint Commission has studied a variety of disasters that impacted health care organizations, including floods; widespread electrical utility outages; the terrorist attacks of September 11, 2001; the Florida hurricanes of 2004; and hurricanes Katrina and Rita that struck the Gulf Coast in 2005. In formulating these standards changes, the Joint Commission was debriefed by health care organizations affected by these disasters, engaged emergency management experts, served on national emergency management

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Executive Editor

Jaclyn Graham

Project Manager

Christine Wyllie

Associate Director, Publications

Cecily Pew

Executive Director, Publications

Catherine Chopp Hinckley

Vice President, Learning

Charles Macfarlane, FACHE

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IN SIGHT

This column informs you of developments and potential revisions that can affect your accreditation and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they were rejected at some point in the process.

APPROVED

- Revised Joint Commission International hospital accreditation standards and survey process, **effective January 1, 2008**
- Revisions to the emergency management standards in the “Environment of Care” (EC) chapter for the **critical access hospital, hospital, Medicare/Medicaid-based long term care, and long term care** programs, **effective January 1, 2008** (see pages 3–10 in this issue)
- Revisions to time frames for completing history and physical examinations in Standard **PC.2.120** for the **critical access hospital and hospital** programs, **effective January 1, 2008** (see page 15 in this issue)
- Revisions to clarify procurement and donation of organs and other tissues in Standard **LD.3.110** for the **critical access hospital and hospital** programs, **effective January 1, 2008** (see an upcoming issue of *The Joint Commission Perspectives*® for more information)
- Revisions to the requirement for in-person evaluation of a patient in restraint or seclusion in Standard **PC.12.90** for the **hospital** program, **effective immediately for survey and scoring** (see page 16 in this issue)
- Field review of the proposed requirement regarding oversight of health care industry representatives for the **ambulatory care, critical access hospital, hospital, and office-based surgery** programs, **effective January 1, 2008**

JOINT COMMISSION FIELD REVIEW

Field review notifications are sent out electronically as well as posted on The Joint Commission Web site. If you would like to be added to the electronic notification list, please contact the Division of Standards and Survey Methods at 630/792-5912.

- Disease Specific Care Chronic Obstructive Pulmonary Disease—evaluate the effectiveness of COPD programs
- Proposed revisions to medication management Standard **MM.4.10**
- Standards Improvement Initiative: Revised Improving Organization Performance chapter for the **ambulatory care, critical access hospital, hospital, home care, and office-based surgery** programs
- Standards Improvement Initiative: Revised Management of Information chapter for the **ambulatory care, critical access hospital, hospital, home care, and office-based surgery** programs

IN COMMITTEE OR BOARD REVIEW

- Conflict management Standard **LD.2.40** for the **critical access hospital and hospital** programs
- Leadership requirement in Standard **LD.3.10** addressing the culture of safety for the **ambulatory care, behavioral health care, critical access hospital, home care, hospital, laboratory, long term care, Medicare/Medicaid-based long term care, and office-based surgery** programs
- Implementation of the revised “Leadership” (LD) chapter for the **ambulatory care, behavioral health care, critical access hospital, home care, hospital, laboratory, long term care, and office-based surgery** programs
- 2008 National Patient Safety Goals for the **ambulatory care, behavioral health care, critical access hospital, home care, hospital, laboratory, long term care, and office-based surgery** programs


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Approved: Revisions to Emergency Management Standards (continued)

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panels, and reviewed the current literature on emergency management. From these studies, the Joint Commission concluded that it is not sufficient to require health care organizations to plan for a single event; rather, they should be able to demonstrate sufficient flexibility to respond effectively to combinations of escalating events.

Specific revisions to the emergency management standards include the following:

- Standard EC.4.10 has been **replaced** by standards **EC.4.11 through EC.4.18**. While some of the EPs in these standards are new, many are existing expectations that have been relocated or moderately edited. Edits were made in response to organizations requesting clearer guidance in their emergency management planning efforts.
 - The addition of requirements for managing the follow-
1. Communication (*see Standard EC.4.13*)
 2. Resources and assets (*see Standard EC.4.14*)
 3. Safety and security (*see Standard EC.4.15*)
 4. Staff responsibilities (*see Standard EC.4.16*)
 5. Utilities management (*see Standard EC.4.17*)
 6. Patient clinical and support activities (*see Standard EC.4.18*)
- The addition of requirements for evaluating the performance of these six critical areas during planned exercises.
 - The addition of a requirement for escalating at least one exercise per year to evaluate how effectively the organization performs when it cannot be supported by the local community. 

Joint Commission



Requirement

Official Publication of Standards Revision

Revisions to Emergency Management Standards EC.4.10 and EC.4.20

APPLICABLE TO **CRITICAL ACCESS HOSPITAL (CAH), HOSPITAL (HAP), LONG TERM CARE (LTC), AND MEDICARE/MEDICAID-BASED LONG TERM CARE (LT2)**
ALL STANDARDS AND RATIONALES APPLY TO CAH, HAP, LTC, AND LT2.

ALL EPs APPLY TO CAH, HAP, LTC, AND LT2 EXCEPT WHEN OTHERWISE NOTED.

Effective January 1, 2008


Environment of Care (EC)

Introduction to Emergency Management

Catastrophic emergencies are a threat to any health care organization, regardless of size, scope, or location. A single emergency can temporarily affect demand for services; however, multiple emergencies that occur concurrently or sequentially can adversely impact patient safety and the organization's ability to provide care, treatment, and services for an extended length of time. This is especially true in situations where the community cannot adequately support the organization. Power failures, water and fuel shortages, flooding, and communication breakdowns are just a few of the hazards that can disrupt patient care, and pose risks to staff and the organization.

No organization can predict the nature of a future emergency, nor can it predict the date of its arrival. However, organizations can plan for managing six critical areas of

ing six critical areas regardless of the cause(s) of an emergency situation:

1. Communication (*see Standard EC.4.13*)
 2. Resources and assets (*see Standard EC.4.14*)
 3. Safety and security (*see Standard EC.4.15*)
 4. Staff responsibilities (*see Standard EC.4.16*)
 5. Utilities management (*see Standard EC.4.17*)
 6. Patient clinical and support activities (*see Standard EC.4.18*)
- The addition of requirements for evaluating the performance of these six critical areas during planned exercises.
 - The addition of a requirement for escalating at least one exercise per year to evaluate how effectively the organization performs when it cannot be supported by the local community. 

emergency response in order to assess their needs and prepare staff to respond to events most likely to occur regardless of the cause(s) of an emergency situation. The six critical areas of emergency management are as follows:

1. **Communication (see Standard EC.4.13).** In the event that community infrastructure is damaged and/or an organization's power or facilities experience debilitation, communication pathways, whether dependent on fiber optic cables, electricity, satellite, or other conduits, are likely to fail. Organizations must develop a plan to maintain communication pathways both within the organization and to critical community resources.
2. **Resources and assets (see Standard EC.4.14).** A solid understanding of the scope and availability of an organization's resources and assets is as important, and perhaps more important, during an emergency than during times of normal operation. Materials and supplies, vendor and community services, as well as state and federal programs, are some of the essential resources that organizations must know how to access in times of crisis to ensure patient safety and sustain care, treatment, and services.
3. **Safety and security (see Standard EC.4.15).** The safety and security of patients are the prime responsibility of the organization during an emergency. As emergency situations develop and parameters of operability

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Revisions to EM Standards EC.4.10 and EC.4.20 (continued)

shift, organizations must provide a safe and secure environment for their patients and staff.

4. Staff responsibilities (see Standard EC.4.16). During an emergency, the probability that staff responsibilities will change is high. As new risks develop along with changing conditions, staff will need to adapt their roles to meet new demands on their ability to care for patients. If staff cannot anticipate how they may be called to perform during an emergency, the likelihood that the organization will not sustain itself during an emergency increases.

5. Utilities management (see Standard EC.4.17). An organization depends on the uninterrupted function of its utilities during an emergency. The supply of key utilities, such as power or potable water, ventilation, and fuel, must not be disrupted or adverse events may occur as a result.

6. Patient clinical and support activities (see Standard EC.4.18). The clinical needs of patients during an emergency are of prime importance. The organization must have clear, reasonable plans to address the needs of patients during extreme conditions when the organization's infrastructure and resources are taxed.

When organizations have a sound understanding of their response to these six critical areas of emergency management, they have developed an "all hazards" approach that supports a level of preparedness sufficient to address a range of emergencies, regardless of the cause.

Organizations should also identify potential hazards, threats, and adverse events, and assess their impact on the care, treatment, and services they must sustain during an emergency. This assessment is known as a Hazard Vulnerability Analysis (HVA) and is designed to assist organizations in gaining a realistic understanding of their vulnerabilities, and to help focus their resources and planning efforts. Finally, organizations should use the information from their assessments to develop Emergency Operations Plans, which should be tested regularly, and use the lessons learned to improve.

Organizations should note that additional standards in other chapters are integral to organization-wide emergency preparedness, including processes for the following:

- Maintaining continuity of information in Standard IM.2.30

- Responding to an influx, or the risk of influx, of infectious patients in Standard IC.6.10
- Identifying and mitigating impediments to patient flow in Standard LD.3.15 (**HAP only**)
- Granting disaster privileges in Standards (**HAP:** MS.4.110) and (**LTC:** HR.4.35)
- Assigning disaster responsibilities in Standard HR.1.25

Standard EC.4.11

The organization plans for managing the consequences of emergencies.

(**CAH:** Corresponds to COP 485.623 (c)(3) and (c)(4))

Rationale for EC.4.11

An emergency in a health care organization or in its community can suddenly and significantly affect demand for its services or its ability to provide those services. Therefore, it is important that organizations define a comprehensive approach to identifying risks and mobilizing an effective response within the organization as well as in collaboration and co-ordination with essential response partners in the community.¹ CAH, HAP

Elements of Performance for EC.4.11

B 1. The organization's leaders (**HAP:** including those of the medical staff) (**LTC, LT2:** including the administrator, the medical director, the nursing leader, and other clinical leaders) actively participate in emergency management planning.

B 2. The organization conducts a Hazard Vulnerability Analysis (HVA) to identify events that could affect demand for its services or its ability to provide those services, the likelihood of those events occurring, and the consequences of those events.

Note: *The HVA is evaluated at least annually as part of EP 11.*

A 3. The organization (**CAH, HAP:** together with its community partners) prioritizes those hazards, threats and events identified in its HVA.

A 4. When developing its emergency operations plan (see Standard EC.4.12), the organization communicates its needs

¹ **CAH, HAP:** *National Incident Management Requirements (NIMS) are requirements for hospitals to enhance the efficiency and effectiveness of its response and recovery roles in coordination with their community. Developing a relationship with local public health, public safety and other emergency management agencies enables hospitals to gain further insight about the availability of training, exercises, as well as capabilities (equipment and procedures) provided by local agencies.*

Revisions to EM Standards EC.4.10 and EC.4.20 (continued)

and vulnerabilities to community emergency response agencies and identifies the capabilities of its community in meeting their needs.

For each emergency identified in its HVA, the organization defines (EPs 5–8):

- A 5.** Mitigation activities designed to reduce the risk of and potential damage due to an emergency
- A 6.** Preparedness activities that will organize and mobilize essential resources
- A 7.** Response strategies and actions to be activated during the emergency
- A 8.** Recovery strategies and actions designed to help restore the systems that are critical to resuming normal care, treatment and services

A 9. The organization keeps a documented inventory of the assets and resources it has on-site, that would be needed during an emergency (at a minimum, personal protective equipment, water, fuel, staffing, medical, (CAH, HAP: surgical,) and pharmaceuticals resources and assets).

Note: *The inventory is evaluated at least annually as part of EP 11.*

B 10. The organization establishes methods for monitoring quantities of assets and resources during an emergency.

B 11. The objectives, scope, performance, and effectiveness of the organization's emergency management planning efforts are evaluated at least annually.

Standard EC.4.12

The organization develops and maintains an Emergency Operations Plan.

(CAH: Corresponds to COP 485.623 (c)(3) and (c)(4))

Rationale for EC.4.12

A successful response relies upon planning around the management of six critical areas: communications; resources and assets; safety and security; staffing; utilities; and clinical activities. It is important for organizations to develop a comprehensive Emergency Operations Plan (EOP) as documentation to help guide the organization in its emergency response and recovery efforts. While the EOP can be formatted in a variety of ways, it must address these six critical areas to serve as a blueprint for managing care and safety during an emergency.

Some emergencies can escalate unexpectedly and strain the organization and the entire community. An organization cannot mitigate risks, plan thoroughly, and sustain an effective response and recovery without preparing its staff and collaborating with the community, suppliers and external response partners as well. Such an approach will aid the organization in developing a scalable response capability

and in defining the timing and criteria for decisions that involve sheltering in place, patient transfer, facility closings, or evacuation.

Elements of Performance for EC.4.12

B 1. The organization develops and maintains a written Emergency Operations Plan (EOP) that describes an “all-hazards” command structure for coordinating six critical areas (see EC.4.13 through EC.4.18) within the organization during an emergency.

B 2. The EOP establishes an incident command structure (**CAH, HAP:** that is integrated into and consistent with its community's command structure²).

A 3. The EOP identifies to whom staff report in the organization's incident command structure.

The EOP describes processes for initiating and terminating the response and recovery phases, including the following (EPs 4 and 5):

A 4. Who has the authority to activate the phases

A 5. How the phases are to be activated

B 6. The EOP identifies the organization's capabilities and establishes response efforts when the organization cannot be supported by the local community for at least 96 hours in the six critical areas.

Note: *An acceptable response effort would be to temporarily close or evacuate the facility, consistent with their designated role in their community response plan.*

A 7. The EOP identifies alternative sites for care, treatment or service that meet the needs of its patients during emergencies.

Standard EC.4.13

The organization establishes emergency communications strategies.

(CAH: Corresponds to COP 485.623 (c)(3) and (c)(4))

Rationale for EC.4.13

The organization maintains reliable surveillance and communications capability to detect emergencies and communicate response efforts to organization response personnel, patients and their families, and external agencies. The organization plans for backup communications processes and technologies (for example, cell phones, land lines, bulletin boards, fax machines, satellite phones, ham radio, text messages) if primary communications systems fail. It is important that responders and incident managers use common terminology;

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² **National Incident Management Requirements (NIMS)** is a nationally standardized incident management system, which provides guidelines for common functions and terminology to support clear communication and effective collaboration in an emergency situation.

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there simply is little or no room for misunderstanding in an emergency situation.

Elements of Performance for EC.4.13

- B 1.** The organization plans for notifying staff when emergency response measures are initiated.
- B 2.** The organization plans for ongoing communication of information and instructions to its staff once emergency response measures are initiated.
- B 3.** The organization defines processes for notifying external authorities when emergency response measures are initiated.
- B 4.** The organization plans for communicating with external authorities once emergency response measures are initiated.
- B 5.** The organization plans for communicating with patients and their families during emergencies, including notification when patients are relocated to alternative care sites.
- B 6.** The organization defines the circumstances and plans for communicating with the community and/or the media during emergencies.
- B 7.** The organization plans for communicating with purveyors of essential supplies, services, and equipment once emergency measures are initiated.

The organization plans for communicating in a timely manner with other health care organizations that together provide services to a contiguous geographic area (for example, among health care organizations serving a town or borough) regarding the following (EPs 8–11):

- B 8.** Essential elements of their command structures and control centers for emergency response
- B 9.** Names and roles of individuals in their command structures and command center telephone numbers
- B 10.** Resources and assets that potentially could be shared in an emergency response
- B 11.** Names of patients and deceased individuals brought to their organizations in accordance with applicable law and regulation, when requested
- B 12.** The organization defines the circumstances and plans for communicating information about patients to third parties (such as other health care organizations, the state health department, police, Federal Bureau of Investigation).
- B 13.** The organization plans for communicating with identified alternative care sites.
- B 14.** The organization establishes backup communication systems and technologies for the activities identified above.

Standard EC.4.14

The organization establishes strategies for managing resources and assets during emergencies.

(CAH: Corresponds to COP 485.623 (c)(3) and (c)(4))

Rationale for EC.4.14

During emergencies, health care organizations that continue to provide care, treatment and services to their patients must sustain essential resources, materials, and facilities. The emergency operation plan should identify how resources and assets will be solicited and acquired from a range of possible sources, such as vendors, neighboring health care providers, other community organizations, state affiliates, or a regional parent company. To address emergencies of long duration or broad geographic scope, the organization's plan must proactively identify, locate, acquire, distribute and account for critical resources and supplies. The plan should also recognize the risk that some assets may not be available from planned sources and that contingency plans will be necessary for critical supplies. This situation may occur when multiple organizations are vying for a limited supply from the same vendor.

The infrastructure for supplying and supporting the health care organization is complex, and the Hazard Vulnerability Analysis will help identify risks to this infrastructure that can be mitigated. Planning must address managing and maintaining the facility, but also must consider evacuation of the entire facility when the environment is no longer deemed safe.

Elements of Performance for EC.4.14

The organization plans for the following (EPs 1–11):

- B 1.** Obtaining supplies that will be required at the onset of emergency response (medical, pharmaceutical and non-medical)
- B 2.** Replenishing medical supplies and equipment that will be required throughout response and recovery, including personal protective equipment where required
- B 3.** Replenishing pharmaceutical supplies that will be required throughout response and recovery, including access to and distribution of caches (stockpiled by the organization or its affiliates, local, state or federal sources) to which the organization has access
- B 4.** Replenishing non-medical supplies that will be required throughout response and recovery (for example, food, linen, water, fuel for generators and transportation vehicles)

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- B 5.** Managing staff support activities (for example, housing, transportation, incident stress debriefing);
- B 6.** Managing staff family support needs (for example, child care, elder care, communication)
- B 7.** Potential sharing of resources and assets (for example, personnel, beds, transportation, linens, fuel, personal protective equipment, medical equipment and supplies) with other health care organizations within the community that could potentially be shared in an emergency response
- B 8.** Potential sharing of resources and assets with health care organizations outside of the community in the event of a regional or prolonged disaster
- B 9.** Evacuating (both horizontally and, when required by circumstances, vertically) when the environment cannot support care, treatment, and services
- B 10.** Transporting patients, their medications and equipment, and staff to an alternative care site or sites when the environment cannot support care, treatment, and services
- B 11.** Transporting pertinent information, including essential clinical and medication-related information, for patients to an alternative care site or sites when the environment cannot support care, treatment, and services

Standard EC.4.15

The organization establishes strategies for managing safety and security during emergencies.

(CAH: Corresponds to COP 485.623 (c)(3) and (c)(4))

Rationale for EC.4.15

Controlling the movement of individuals into, throughout, and out of the organization during an emergency is essential to the safety of patients and staff, and to the security of critical supplies, equipment, and utilities. The organization determines the type of access and movement to be allowed by staff, patients, visitors, emergency volunteers, vendors, maintenance and repair workers, utility suppliers, and other individuals when emergency measures are initiated. Factors influencing access and movement vary depending upon the type of emergency and local conditions (that is, the decision by the organization to shelter staff families, the allowance for or prohibition against firearms, mutual aid agreements with nearby facilities or vendors).

During an emergency, the campus or immediate environment around the organization may be under the authority of the local police or sheriff serving the larger community. Access to and from the organization on local roads and interstates could be subject to local, state or even federal control. As an incident evolves, this responsibility and authority may shift from one

agency to another. For this reason, it is important that the Emergency Operations Plan includes reference to any existing community command structure to provide for on-going communication and coordination with this structure. In the absence of such a command structure, the organization maintains direct contact with the agencies charged with community security.

Elements of Performance for EC.4.15

- B 1.** The organization establishes internal security and safety operations that will be required once emergency measures are initiated.
- B 2.** The organization identifies the roles of community security agencies (police, sheriff, national guard) and defines how the organization will coordinate security activities with these agencies.
- B 3.** The organization identifies process that will be required for managing hazardous materials and waste once emergency measures are initiated.
- B 4. (CAH, HAP only)** The plan identifies means for radioactive, biological, and chemical isolation and decontamination.
- B 5. (LTC, LT2 only)** The organization identifies residents who might be susceptible to wandering once emergency measures are initiated.

The organization establishes processes for the following (EPs 6–8):

- B 6.** Controlling entrance into and out of the health care facility during emergencies
- B 7.** Controlling the movement of individuals within the health care facility during emergencies
- B 8.** Controlling traffic accessing the health care facility during emergencies

Standard EC.4.16

The organization defines and manages staff roles and responsibilities.

(CAH: Corresponds to COP 485.623 (c)(3) and (c)(4))

Rationale for EC.4.16

To provide safe and effective patient care during an emergency, staff roles are well defined; staff are oriented and trained in their assigned responsibilities; and staff maintains their competencies over time. Staff roles in emergencies are determined largely by the priority emergencies defined in the Hazard Vulnerability Analysis, and the reporting relationships in the command and control operations of the organization. As such, staff must stand ready to adjust to changes in patient volume or acuity, work procedures or conditions, and response partners within and outside the organization. **(Note: Standards MS.4.110 and HR.1.25 define the processes for accepting licensed independent practitioners and others as**

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volunteers during emergencies.) Staff roles and responsibilities may be documented in the EOP using a variety of formats: job action sheets, checklists, flow charts, etc.

Elements of Performance for EC.4.16

B 1. Staff roles and responsibilities are defined in the Emergency Operations Plan for all six critical areas (communications, resources and assets, safety and security, utilities and clinical activities).

B 2. Staff are trained for their assigned roles during emergencies.

B 3. The organization communicates to Licensed independent practitioners their roles in emergency response and to whom they report during an emergency.

B 4. The organization establishes a process for identifying care providers and other personnel (such as identification cards, wrist bands, vests, hats, badges, computer print-outs) assigned to particular areas during emergencies.

Standard EC.4.17

The organization establishes strategies for managing utilities during emergencies.

(CAH: Corresponds to COP 485.623 (c)(3) and (c)(4))

Rationale for EC.4.17

Different types of emergencies can have the same detrimental impact on an organization's utility systems. For example, brush fires, ice storms, and industrial accidents can all result in a loss of utilities required for care, treatment, services, related transport and building operations. Organizations, therefore, must have alternative means of providing for essential utilities, whether through: negotiated relationships with the primary suppliers; Memoranda of Understanding (MOUs) with other organizations in the community alternative equipment at the organization; or provision through a parent entity, etc. Organizations should determine how long they expect to remain open to care for patients, and plan for their utilities accordingly. Because some emergencies may be regional in scope or of long duration, organizations should not rely solely on single source providers in the community. Where possible, organizations should identify other suppliers outside of the local community in case the communities' infrastructure is severely compromised and unable to support the organization.

Elements of Performance for EC.4.17

Organizations identify an alternative means of providing for the following utilities in the event that their supply is compromised or disrupted (EPs 1–5):

B 1. Electricity

B 2. Water needed for consumption and essential care activities

B 3. Water needed for equipment and sanitary purposes

B 4. Fuel required for building operations or essential transport activities

B 5. Other essential utility needs (for example, ventilation, medical gas/vacuum systems)

Standard EC.4.18

The organization establishes strategies for managing [patient] clinical and support activities during emergencies.
(CAH: Corresponds to COP 485.623 (c)(3) and (c)(4))

Rationale for EC.4.18

The fundamental goal of emergency management planning is to protect life and prevent disability. The manner in which care, treatment and services are provided may vary by type of emergency. However, certain clinical activities are so fundamental to safe and effective care that the organization should determine how it will re-schedule or manage [patient] clinical needs even under the most dynamic situations or in the most austere care environments.

The emergency triage process will typically result in [patient]s being quickly treated and discharged, admitted for a longer stay, or transferred to a more appropriate source of care. It is especially important to identify and triage [patient]s whose clinical needs are outside of the usual scope of service of the organization. A catastrophic emergency may result in the decision to keep all [patient]s on the premises in the interest of safety or, conversely, in the decision to evacuate all [patient]s because the facility is no longer safe. Planning for clinical services must address these situations accordingly.

Elements of Performance for EC.4.18

The organization plans to manage the following during emergencies:

B 1. the clinical activities required as part of [patient] scheduling, triage, assessment, treatment, admission, transfer, discharge, and evacuation;

B 2. clinical services for vulnerable populations served by the organization, including [patient]s who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions;

B 3. personal hygiene and sanitation needs of its [patient]s;

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B 4. the mental health service needs of its [patient]s; and

B 5. mortuary services.

B 6. The organization plans for documenting and tracking [patient]s' clinical information.

Standard EC.4.20

The organization regularly tests its emergency operation plan.

Introduction

Periodic testing of an emergency operation plan enables organizations to assess the plan's appropriateness, adequacy, and the effectiveness of logistics, human resources, training, policies, procedures, and protocols. Exercises should stress the limits of the organization's emergency management system. The goal of this testing is to assess the organization's preparedness capabilities and performance when systems are stressed during an actual emergency.

Exercises should be developed using plausible scenarios that are realistic and relevant to the organization. Events should be based on each organization's Hazard Vulnerability Analysis (HVA). Exercises should also validate the effectiveness of the plan and identify opportunities to improve.

This standard will assist health care organizations to test their emergency operation plan, identify deficiencies, and take corrective actions to continuously improve the effectiveness of their emergency operation plan. Only a thorough and objective evaluation of performance during an emergency management event or planned exercise will demonstrate how effective the organization's planning efforts have been.

It is important to communicate the strengths and weaknesses of the performance revealed by the exercise to all levels of the organization, including administration, clinical staff, governing body, and those responsible for managing the patient safety program.

Elements of Performance for EC.4.20

Number and Types of Exercises

A 1. (CAH, HAP, LTC only) The [organization] tests its Emergency Operations Plan twice a year, either in response to an actual emergency or in a planned exercise.

Note 1: Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code®) that does not offer emergency services nor is community-designated as a disaster-receiving station need to conduct only one emergency preparedness exercise annually.)

Note 2: Tabletop sessions, though useful, are **not** acceptable substitutes for exercises.

A 2. (CAH, LTC only) [Organizations] that offer emergency services or are community-designated disaster receiving stations conduct at least one exercise a year that includes an influx of actual or simulated [patients].

A 3. (CAH, HAP, LTC only) At least one exercise a year is escalated to evaluate how effectively the organization performs when it cannot be supported by the local community.

Note: Tabletop sessions are acceptable in meeting the community portion of this exercise.

A 43. (CAH, HAP, LTC only) [Organizations] that have a defined role in the community-wide emergency management program participate in at least one community-wide exercise a year.

Note 1: "Community-wide" may range from a contiguous geographic area served by the same health care providers to a large borough, town, city, or region.

Note 2: Exercises for EC.4.20, EPs 2 and 3 may be conducted separately or simultaneously.

Note 3: Tabletop sessions are acceptable in meeting the community portion of this exercise.

54. Not Applicable

Scope of Exercises

B 65. (CAH, HAP, LTC only) Planned exercise scenarios are realistic and related to the priority emergencies identified in the [organization]'s Hazard Vulnerability Analysis.

76. Not Applicable

A 87. (CAH, HAP, LTC only) During planned exercises, an individual whose sole responsibility is to monitor performance (and who is knowledgeable in the goals and expectations of the exercise) documents opportunities for improvement.³

During planned exercises, the [organization] monitors, at a minimum, the following six critical areas (EPs 9–14):

A 98. (CAH, HAP, LTC only) Communication, including the effectiveness of communication both within the [organization] as well as with response entities outside of the [organization], such as local governmental leadership, police, fire, public health, and other health care organizations within the community

A 109. (CAH, HAP, LTC only) Resource mobilization and allocation, including responders, equipment, supplies, personal protective equipment, and transportation

A 11. (CAH, HAP, LTC only) Safety and security

A 12. (CAH, HAP, LTC) Staff roles and responsibilities

A 13. (CAH, HAP, LTC) Utility systems

Continued on page 10

³ This individual may be a staff member of the organization who is not participating in the exercise.

Revisions to EM Standards EC.4.10 and EC.4.20 (continued)

A 1440. (CAH, HAP, LTC) Patient clinical and support care activities

B 1544. (CAH, HAP, LTC) Exercises are critiqued to identify deficiencies and opportunities for improvement based upon monitoring activities and observations during the exercise.

B 1642. (CAH, HAP, LTC) Completed exercises are critiqued through a multi-disciplinary process that includes administration, clinical (CAH, HAP: (including physicians)), and support staff.

B 1743. (CAH, HAP, LTC) The [organization] modifies its emergency operations plan in response to critiques of exercises.

B 1844. (CAH, HAP, LTC) Planned exercises evaluate the effectiveness of improvements that were made in response to critiques of the previous exercise.

Note: *When improvements require substantive resources that cannot be accomplished by the next planned exercise, interim improvements must be put in place until final resolution.*

B 1945. (CAH, HAP) The strengths and weaknesses identified during exercises are communicated to the multidisciplinary improvement team responsible for monitoring environment of care issues. (See Standard EC.9.20)

The Joint Commission Awarded Grant to Study Smoke-Free Hospital Campuses

The Joint Commission will begin a first-of-its kind study of smoke-free hospital campuses in June 2007. The project, which will seek input from nearly all of America's hospitals, is being funded by a grant from the Robert Wood Johnson Foundation's Substance Abuse Policy Research Program.


Although many studies have examined the development, adoption, and effects of indoor smoke-free policies in health care settings, this Joint Commission study represents the first systematic evaluation of the challenges to implementing, or the impact of transitioning to, a smoke-free hospital campus. The study recognizes a new trend emerging on hospital campuses where smoking is prohibited outdoors, at entranceways, on grounds, and in parking areas.

"The Joint Commission introduced standards in 1992 to make hospital buildings smoke-free, resulting in the nation's first industry-wide ban on smoking in the workplace. Now it's time to examine the increasing shift from no-smoking policies indoors toward a complete ban on smoking anywhere on the grounds of health care organizations," says Jerod M. Loeb, Ph.D., executive vice president, Division of Research, the Joint Commission. "The Robert Wood Johnson Foundation grant will provide a more complete picture of the gaps that exist between these two approaches."

The electronic survey will be distributed to more than 4,200 Joint Commission-accredited hospitals in the United States. The survey will explore hospital smoking policies, gathering data on the experiences of hospitals that have successfully implemented smoke-free campus policies, as well as the experiences and perceptions of hospitals that have not yet adopted such policies.

Survey responses will be analyzed relating to hospital demographic characteristics and hospital performance on the Joint Commission's smoking cessation counseling core measures.

This study is the Joint Commission's third externally funded research project to address the subject of smoking since 2002. The previous two studies, funded by the Smoking Cessation Leadership Center at the University of California, San Francisco, focused on improving the rate at which hospitals provide smoking cessation counseling to their patients.

For more information about the smoke-free hospital campus study, please contact project director Scott Williams, Psy.D., Division of Research, the Joint Commission, at swilliams@jointcommission.org. 


UPDATE: Standards Improvement Initiative—The Joint Commission Seeks Feedback on Proposed Infection Control Revisions

Over the past six months, The Joint Commission central office staff and surveyors have worked with dedicated user groups to improve the clarity and relevance of the “Surveillance, Prevention, and Control of Infection” (IC) chapter as part of its Standards Improvement Initiative.

The Joint Commission is currently seeking feedback from the field on these proposed revisions to the current IC chapter for the **ambulatory care, critical access hospital, home care, hospital, and office-based surgery** programs. **Note:** *This chapter will be revised for the behavioral health care, long term care, and laboratory programs in 2008.*

Comments and feedback will be gathered via an online survey **through June 13, 2007**, from both accredited and non-accredited health care organizations, Joint Commission advisory groups, payers, purchasers, consumers, governmental

agencies, experts, and Joint Commission surveyors. Visit the following Web site to participate in this survey and contribute your feedback: http://www.jointcommission.org/Standards/SII/sii_ic.htm.

The Standards Improvement Initiative is part of a continuous effort to eliminate non-essential standards and ensure that the remaining standards are understandable and relevant to the care setting to which they apply. This initiative involves extensive communication and interaction with health care organizations to gain their perspectives and advice on how to improve the content and organization of the standards. For more information, visit <http://www.jointcommission.org/Standards/SII/>. Questions can be sent to standardsimprovement@jointcommission.org. 



Revisions to Performance Measurement Requirements for Disease-Specific Care Effective July 1, 2007

As reported in the February 2007 issue of *The Joint Commission Perspectives*[®], revisions to the performance measurement requirements for the **disease-specific care certification** program become **effective July 1, 2007**.

As a reminder, the revised requirements are as follows:

- **Organizations seeking disease-specific care certification are required to have gathered performance measure data for a minimum of four months before the initial on-site certification review.**

- **Certified organizations must collect monthly data points.**
- **Certified organizations collecting data on Stage II measures must report data to the Joint Commission quarterly.***

Please refer to page 14 of the February 2007 issue of *Perspectives* for further information.

*** Note:** *The implementation date for quarterly data submissions is forthcoming. Look to future issues of The Joint Commission Perspectives[®] for additional information.*

UPDATE: The Joint Commission Launches Strategic Surveillance System and Redesigned Extranet

The Joint Commission is officially launching two improvement projects in **early July 2007**: 1) the redesigned *The Joint Commission Connect*[™] extranet site with enhanced security controls, and 2) the release of the Strategic Surveillance System for the **hospital program**. Details on each launch follow.

The Joint Commission Connect[™] Extranet Redesign

The Joint Commission is currently redesigning its *The Joint Commission Connect* (formerly “Jayco[®]”) extranet site, the Joint Commission’s main electronic communication link with its customers. The redesigned site, available in **early July 2007**, will include the following new features, for **all programs**:

- **Enhanced security controls** to allow organizations to apply security settings for individuals. An organization will be able to allow certain individuals access to either all of the accreditation tools on the site, or limit access by tool. For example, an individual can be allowed access to only the electronic application for accreditation (e-App) or the electronic Statement of Conditions[™]. In a customer satisfaction survey conducted by the Joint Commission in 2006, 92% of accredited organizations said it would be helpful to limit user access within the extranet.
- A **“What’s Due” section** that provides an at-a-glance display of accreditation tasks due for submission, such as Evidence of Standards Compliance, Measures of Success, the Periodic Performance Review, and the e-App. (See the screen shot on page 13.)
- A **“New Reports” section** that provides an at-a-glance display of recently posted organization reports, such as Accreditation Reports. (See the screen shot on page 13.)
- For users with access to multiple organizations, a **drop-down menu** will allow the user to switch from one organization site to another.
- A **“Disease Certification” tab** for organizations that are both accredited and disease-specific care certified, allowing the user to easily switch from accreditation to certified extranet home pages.
- A **“Quicklink”** to update extranet contacts and apply security settings. (See the screen shot on page 13.)

See the screen shot on page 13 for a sample of the redesigned extranet page.

The Joint Commission Launches its Strategic Surveillance System

To coincide with the redesigned *The Joint Commission Connect* extranet site, the Joint Commission is officially launching its Strategic Surveillance System (S3) in **early July 2007** for the **hospital program**.

Access to S3 is available on The Joint Commission Connect site under the “Quality Improvement Tools” section. (See the screen shot on page 13.) As noted in the March 2007 issue of *The Joint Commission Perspectives*[®], initial access is limited, but those with initial access can add additional users.

Benefits of S3

Hospitals accredited by the Joint Commission will have access to S3 in July 2007. This new tool provides a series of risk assessment and comparative performance measure reports to help hospitals improve their care processes and prioritize the actions to take for improvement. S3 uses data the Joint Commission currently has, including past survey findings, ORYX[®] core measure data, data from the Office of Quality Monitoring (complaints and non self-reported sentinel events), data from an organization’s e-App, and MedPAR data. Reports will be posted and updated quarterly on each organization’s secure Joint Commission extranet site.

S3 offers the following benefits to hospitals:


- Hospitals will have access to national and state benchmarks as well as select groups, to compare themselves to others.
- Hospitals with a common owner will be able to compare S3 data among each hospital to identify trends or common areas for improvement.
- S3 helps drive and monitor systems improvement throughout an organization by providing ongoing quantitative feedback.
- S3 allows organizations to drill-down to certain performance areas so they can compare themselves to others on a well-defined basis.

Beta Test Information

Between February and April 2007, nearly 100 hospital staff members participated in a beta test of the S3 tool, representing roughly 50 different hospitals or hospital systems. Feedback was gathered on the tool’s functionality, usability, performance, and value. This feedback is currently being

assessed by Joint Commission staff; overall, feedback has been positive. Hospitals are pleased with the tool's potential for assisting with performance improvement efforts throughout their organization. Some changes have already been implemented as a result of this feedback, and additional changes are anticipated for future releases of the tool.

Additional Information

For more information on S3, see articles in the September 2006 (introduction to the tool), March 2007 (user roles descriptions), and May 2007 (reminder to update ownership information) issues of *Perspectives*. 

S3 Access and Redesigned Extranet

The screenshot shows the S3 Access and Redesigned Extranet website. At the top, there is a navigation bar with links for Home, Contact Us, Change Password, JointCommission.org, QualityCheck.org, Org Search, and Log Out. Below this is the main header for 'The Joint Commission Connect™' with a search box for Organization Name, Address, and Joint Commission ID #, and the Joint Commission logo. A secondary navigation bar includes links for Accreditation Home and Disease-Specific Care Certification Home. The main content area is divided into several sections:


- WHAT'S DUE:** A table showing due dates for ESC (5/21/2007) and NEW REPORTS (Other Correspondence, Accreditation Reports, Award Letters) with dates ranging from 4/6/2007 to 5/21/2007. A 'New!' callout is placed over the table.
- Notification of Scheduled Events:** A section with an 'Official Email: click here to review' link.
- Your Account Representative:** A sidebar section containing fields for Name, Phone Number, and Email address, along with support hours (Monday - Friday, 8 a.m. - 5 p.m. CT).
- Quicklinks:** A section with a link to 'Update Your Contact/Access'.
- Other Sites:** A list of links including Performance Measurement System, State Regulatory Agencies, Board of Commissioners, Professional and Technical Advisory Committees, State Hospital Associations, and SAMHSA.
- Accreditation Tools:** A central section with sub-sections:
 - Continous Compliance Tools:** Periodic Performance Review (PPR), e-Statement of Conditions Part 2 & Part 4, Complaint Response, Self-Report Sentinel Event, Sentinel Event Activities.
 - Application for Accreditation:** Application, Quality Check Service Profile.
 - Reports:** Accreditation Report, Priority Focus Process, Quality Report, ORYX Performance Measure Report, Correspondence, Sentinel Event Correspondence.
 - Pre-Survey:** Survey Agenda, Survey Activity Guides.
 - Accreditation Contracts and Fees:** Contracts, Fee, Billing and Invoice Information.
 - Post-Survey:** Evidence of Standards Compliance, Measure of Success, Publicity Kit, Survey Evaluations.
 - Quality Improvement Tools:** Strategic Surveillance System. A 'New!' callout is placed over this section.
- What's New:** A section listing recent updates:
 - The Joint Commission Extends Date for Completing the Electronic Plans for Improvement (3/23/07) - Requires Adobe Reader
 - Updated National Quality Improvement Goal Data for Hospitals (3/9/07)
 - Notification of Scheduled Events Changing to Local Time - March 1, 2007 (2/27/07)

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APPROVED: Revisions to Standard LD.3.110, Element of Performance 12, for Critical Access Hospitals and Hospitals

This article contains revisions to Standard LD.3.110, Element of Performance (EP) 12, for the **critical access hospital** and **hospital** programs, **effective January 1, 2008**. The revised text is noted in the box below in ~~strikeout~~ and underlined text; explanatory text follows.

Standard LD.3.110, EP 12 has been revised to clarify its requirements on the procurement and donation of organs and other tissues. EP 12 requires hospitals to have a policy that addresses opportunities for asystolic recovery (often known as “donation after cardiac death”). While EP 12 does not require hospitals to provide for asystolic recovery, it does require that the policy be mutually agreed upon by the hospital, its medical staff, and its Organ Procurement

Organization (OPO). The Joint Commission has become aware of instances in which a hospital and its medical staff agree that they will not provide for asystolic recoveries. An OPO may not agree with these decisions. The revisions to EP 12 provided below are not effective until January 1, 2008. In the interim, a hospital that cannot reach an agreement with its OPO will **not** be cited as noncompliant by the Joint Commission; however, surveyors will continue to survey for the following three elements: 1) the presence of a policy on asystolic recovery, 2) evidence that the hospital and its medical staff are in agreement about the policy, and 3) that the hospital involved its OPO in its discussion about asystolic recovery. 

Joint Commission



Requirement

Official Publication of EP Revision

Revisions to Standard LD.3.110, EP 12

APPLICABLE TO **CRITICAL ACCESS HOSPITAL AND HOSPITAL**

Effective January 1, 2008

Standard LD.3.110

Leaders implement policies and procedures developed with the medical staff's participation for procuring and donating organs and other tissues.

(Critical access hospital: Corresponds to COP 485.643(a-f))

A 12. The [organization] works with the Organ Procurement Organization (OPO) and tissue and eye banks to do the following:

- Review death records to improve identification of potential donors
- Ensure that the necessary testing and placement of potential donated organs, tissues, and eyes takes place, in order to maximize the viability of donor

organs for transplant and maintain potential donors while preliminary suitability is determined

- Educate staff about donation issues
- Develop a donation policy that addresses opportunities for asystolic recovery, ~~based on an organ potential for donation,~~ that is mutually agreed upon by the hospital and its medical staff and the designated OPO. **Note:** Refer to the following bulleted requirement if the hospital and its medical staff are unable to secure agreement with the designated OPO.
- When the hospital and its medical staff agree not to provide for asystolic recovery and cannot achieve agreement with the designated OPO, the hospital documents its efforts to reach an agreement with its OPO, and the donation policy addresses the hospital's justification for not providing for asystolic recovery.

APPROVED: Revisions to Standard PC.2.120 for Critical Access Hospitals and Hospitals

This article contains revisions to Standard PC.2.120 for the **critical access hospital** and **hospital** programs, **effective January 1, 2008**. The revised text is noted in the box below in ~~strikeout~~ and underlined text; explanatory text follows.

Standard PC.2.120, addressing the timeframe in which a history and physical examination must be conducted, has been revised to align with the Centers for Medicare & Medicaid Services' Final Rule on these timeframes, published

in late November 2006. The revised standard below requires that a medical history and physical examination be completed no more than 30 days before nor later than 24 hours after inpatient admission. For a medical history and physical examination that was completed within 30 days before inpatient admission, an update documenting any changes in the patient's condition must be completed within 24 hours after inpatient admission or before surgery. **P**



Official Publication of Standard Revision

Revisions to Standard PC.2.120

APPLICABLE TO CRITICAL ACCESS HOSPITAL AND HOSPITAL

Effective January 1, 2008

Standard PC.2.120

The [organization] defines ~~in writing the~~ time frame(s) for conducting the patient assessment(s).

(Critical access hospital: Corresponds to COP 485.635 (a)(3)(vii) and (b)(1))

Elements of Performance for PC.2.120

A 1. The [organization] defines in writing ~~the~~ time frame(s) for conducting the initial assessment(s).

A 2. The ~~[organization] specifies the following time frames for these assessments:~~ A medical history and physical examination are completed no more than 30 days prior to or within ~~within no more than~~ 24 hours after ~~of~~ inpatient admission (see Standard IM.6.30, EP 10).

A 3. The ~~[organization] specifies the following time frames for these assessments:~~ A registered nurse completes a nursing assessment within 24 hours of inpatient admission.

A 4. ~~The [organization] specifies the following time frames for these assessments:~~ A nutritional screening, when warranted by the patient's needs or condition, is completed within ~~no more than~~ 24 hours of inpatient admission.

A 5. ~~The [organization] specifies the following time frames for these assessments:~~ A functional status screening, when warranted by the patient's needs or condition, is completed within ~~no more than~~ 24 hours of inpatient admission.

A 6. For a medical history and physical examination that was completed within 30 days prior to inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after inpatient admission or prior to surgery.


~~6. Some of these elements may have been completed ahead of time, but must meet the following criteria: The history and physical must have been completed within 30 days before the [patient] was admitted or readmitted.~~

~~7. Some of these elements may have been completed ahead of time, but must meet the following criteria: Updates to the patient's condition since the assessment(s) are recorded at the time of admission.~~

APPROVED: Revisions to Standard PC.12.90, Element of Performance 4, for Hospitals

This article contains revisions to Standard PC.12.90, Element of Performance (EP) 4, for the **hospital** program, **effective** for survey and scoring **immediately**. The revised text is noted in the box below in ~~strikeout~~ and underlined text; explanatory text follows.

Standard PC.12.90, EP 4 was developed for hospitals that use accreditation for Medicare deemed status purposes. This requirement, addressing in-person evaluation of a patient when restraint or seclusion is initiated, has been revised by the Joint Commission to align with the Centers for Medicare & Medicaid Services' (CMS) Final Rule for

Patient Rights, issued in December 2006. The CMS Final Rule, which became effective January 8, 2007, allows a registered nurse or physician assistant to evaluate a patient within one hour of the initiation of restraint or seclusion, provided that such practitioner has been trained in accordance with CMS requirements and that this practitioner consults with the attending physician or a licensed independent practitioner as soon as possible thereafter. With respect to the CMS requirement, the Joint Commission will survey and score the revised Standard PC.12.90, EP 4 effective immediately. 

Joint Commission



Requirement

Official Publication of EP Revision

Revisions to Standard PC.12.90, EP 4

APPLICABLE TO HOSPITAL

Effective January 1, 2008

Standard PC.12.90

A licensed independent practitioner sees and evaluates the patient in person.

Elements of Performance for PC.12.90

A 1. The licensed independent practitioner primarily responsible for the patient's ongoing care, treatment, and services, or his or her licensed independent practitioner designee, or other licensed independent practitioner, evaluates the patient in person within 4 hours of the initiation of restraint or seclusion for patients ages 18 or older and within 2 hours of initiation for children and youth ages 17 and under.

A 2. At the time of the in-person evaluation, the licensed independent practitioner does the following:

- Works with the patient and staff to identify ways to help the [patient] regain control

- Revises the patient's plan for care, treatment, and services as needed
- If necessary, provides a new written order

A 3. The licensed independent practitioner evaluates the patient in person within 24 hours of the initiation of restraint or seclusion, if the patient is no longer in restraint or seclusion when an original verbal order expires.

A 4. ~~For~~ In hospitals that use accreditation for Medicare deemed status purposes, a physician or other licensed independent practitioner must evaluate the patient within one hour of the initiation of restraint or seclusion. A registered nurse or physician assistant may evaluate the patient within one hour of the initiation of restraint or seclusion, provided that they are trained and that they consult with the attending physician or other licensed independent practitioner as soon as possible after their evaluation, as required by the Centers for Medicare & Medicaid Services' Interim Final Rule for Patient Rights, ~~effective August 1, 1999~~ effective January 8, 2007.

WHO Collaborating Centre on Patient Safety Releases Nine Life-Saving Patient Safety Solutions


In May 2007, the World Health Organization's (WHO) Collaborating Centre on Patient Safety unveiled nine solutions to prevent health care errors that harm millions of people daily throughout the world. The nine *Patient Safety Solutions* are available for use by WHO Member States, and address the following challenges and strategies:

1. Look-alike, Sound-Alike Medication Names
2. Patient Identification
3. Communication During Patient Hand-Over (or "Hand-Off")
4. Performance of Correct Procedure at Correct Body Site
5. Control of Concentrated Electrolyte Solutions
6. Assuring Medication Accuracy at Transitions in Care
7. Avoiding Catheter and Tubing Mis-Connections
8. Single Use of Injection Devices
9. Improved Hand Hygiene to Prevent Health Care-Associated Infection (HAI)

The purpose of the solutions is to guide the re-design of care processes to prevent inevitable human errors from reaching patients. In 2005, WHO designated The Joint

Commission and Joint Commission International as its Collaborating Centre on Patient Safety (Solutions). The Joint Commission International Center for Patient Safety operationalized this effort by identifying widespread problems and challenges to safe care, identifying promising solutions, and vetting them through an extensive field review process that garnered feedback from health care providers, practitioners, and other experts from more than 100 countries.


The *Patient Safety Solutions* were developed with the assistance of an international steering committee of patient safety experts and patient representatives, as well as regional advisory councils in Europe, the Middle East, and the Asia-Pacific region. A major international field review of the proposed solutions was also conducted to gather feedback from leading patient safety entities, accrediting bodies, ministries of health, international health professional organizations and practitioners, patients, and other experts.

For more information or to view the complete *Patient Safety Solutions*, please access <http://www.jointcommissioninternational.org/solutions>. 

New Special Quality Award for Hospital Quality Reports

Effective May 2007, a new special quality award will be included in Joint Commission hospital Quality Reports. The award recognizes hospital participation in the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP). Currently, 141 hospitals in 37 states and Canada are enrolled in NSQIP. The program originated in the Department of Veterans Affairs (VA) where hospitals within the VA Network experienced a 27% decline in post-operative mortality and a 45% decrease in post-operative morbidity over several years. The special quality awards on Quality Report acknowledge the extra effort that hospitals

and other health care organizations often make to improve the quality and safety of care they provide. The following special achievements are among those currently recognized under the "Special Quality Awards" section of the Joint Commission Quality Report:

- Magnet Recognition Program—American Nurses Credentialing Center
- The Medal of Honor for Organ Donation—Health Resources and Services Administration
- Get With the Guidelines—American Heart Association
- Hospital Quality Alliance participation 

Frequently Asked Questions on the Environment of Care

Generator Tests and Inaccessible Fire and Smoke Dampers

The following Frequently Asked Questions have been received by The Joint Commission's environment of care technical experts regarding generator tests and fire and smoke damper accessibility. If you have additional questions, please contact the Joint Commission's Standards Interpretation Group at 630/792-5900.

Combining Generator Tests

Q *Standard EC.7.40 requires organizations to test their emergency power supply systems at various intervals, including monthly 30-minute tests and triennial 4-hour tests. This standard also allows for either an annual 2-hour load bank test (30 minutes at 25% of nameplate, 30 minutes at 50% of nameplate, and 60 minutes at 75% of nameplate) or measuring exhaust temperature as per manufacturer's recommendations for those systems that do not meet the 30% of nameplate requirement.*

*Is it permissible to combine these tests into **one** test run? In other words, when conducting the 4-hour triennial test, is the 30 minute test requirement met? Also, if the organization has to perform an annual 2-hour load bank test, can this be combined with the 4-hour triennial test?*

A First, a few clarifications. Standard EC.7.40, Element of Performance (EP) 1 requires accredited organizations to exercise each emergency generator 12 times per year, not less than 20 days or more than 40 days apart for 30 continuous minutes. The annual 2-hour load bank test applies **only to** diesel-powered generators that do not meet the 30% of nameplate or manufacturer-recommended minimum exhaust gas temperatures (see note to EP 1). Non-diesel powered generators **are** required to conduct the test 12 times per year, not less than 20 days or more than 40 days apart, but are **not** required to meet the 30% of nameplate criteria.

Standard EC.7.40, EP5 requires generators to be tested once every 36 months for at least 4 continuous hours. This 4-hour testing requirement applies **only to** generator units that provide backup power to certain critical functions (see Standard EC.7.20, EPs 5–18). These standards reflect the testing requirements described in National Fire Protection Association (NFPA) 110, *Standard for Emergency and Standby Power Systems* (see 8.4.2, 8.4.2.3, and 8.4.9).

A longer test can satisfy the requirement for shorter tests required within the same time frame. According to Standard EC.7.40, EP 5 (see footnote), a successful 4-hour generator test can fulfill one of the monthly 30-minute tests required under

Standard EC.7.40, EP 1. The Joint Commission has discussed this issue with the Technical Committee on Emergency Power Supplies of NFPA 110 whose consensus of opinion agreed that combining the 30-minute, the 2-hour load bank test, and the 4-hour triennial exercise into one event is acceptable (provided the test at no time is less than 30% of nameplate, including during the initial start of the load bank test). This consensus of opinion is not a formal interpretation of the NFPA, the combining of tests into one event as described above will be permitted provided no other action is rendered from the NFPA.

Any use of an emergency generator that meets test criteria can fulfill a testing requirement. For example, if a generator is operated for 30 minutes during an actual power outage and the run meets the requirements of Standard EC.7.40, EP 1, that run counts as one monthly test. If a generator is operated for 4 hours as part of a peak shaving agreement with your local utility, that run can satisfy the triennial test requirement under Standard EC.7.40, EP 5.

Inaccessible Fire and Smoke Dampers

Q *Joint Commission standards require health care organizations to periodically inspect and test fire dampers and smoke dampers. In our facility, however, many dampers are inaccessible due to the way the plumbing and electrical systems were installed. How can our organization comply with the inspection requirements? Are we required to retrofit the various systems to allow access?*

A The ability to test and inspect fire barriers and, in specific situations, smoke barriers is a critical component of life safety protection in health care facilities. To ensure the reliability of these barriers, the NFPA has established testing and maintenance requirements for fire and smoke dampers. The Joint Commission references these requirements in Standard EC.5.40, EP 14.

In many health care facilities, large sections of the heating, ventilation, and air conditioning (HVAC) system are essentially inaccessible because of the way other building systems were installed. As a result, fire and smoke dampers are unable to be inspected and tested. Historically, the Joint Commission has allowed organizations to identify these damper locations on their paper Statement of Conditions™ (SOC), creating a Plan for Improvement (PFI) with an open “projected completion date.” The intent of noting inaccessible dampers on the SOC is


Continued on page 17

Frequently Asked Questions on the Environment of Care (continued)

Continued from page 16

to create a permanent record of the deficiency. The Joint Commission expects the organization to resolve these deficiencies whenever renovation, construction, or modernization provides an opportunity.

As organizations migrate their PFIs to the Electronic Statement of Conditions™ (e-SOC), they are encountering a problem with this approach. In the e-SOC, “projected completion date” is a required field, so leaving it open is no longer an option. To resolve this issue, the Joint Commission allows entering a 6-year completion date for inaccessible dampers in

any kind of occupancy. This timeframe reflects new testing frequency requirements for hospitals that were recently issued by the NFPA and will soon be adopted by the Joint Commission (see sidebar below). If an organization does not have an opportunity to resolve a damper PFI before the completion date, it can submit an extension request as needed. However, facilities personnel are encouraged to stay aware of their inaccessible dampers and be vigilant about looking for opportunities to address this potentially serious deficiency. Organizations should ensure that dampers are in the open position even if they cannot be accessed for testing. 

New Testing Frequency for Dampers

Effective in 2007, the NFPA has moved its testing requirements for fire and smoke dampers from NFPA 90A, *Standard for the Installation of Air-Conditioning and Ventilating Systems*, to NFPA 80-2007 and NFPA 105-2007. For health care occupancies, this move changes the damper inspection frequency requirement from 4 years to 6 years. (Business, ambulatory, and residential treatment occupancies must still maintain a 4-year testing cycle.) The Joint Commission will adopt this change **effective July 1, 2007**, and the new standard will be published in the September 2007 *Update* to the *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*. In addition, the updated “Environment of Care” standards will highlight the NFPA requirement to test and inspect smoke dampers one year after installation.

NFPA 80, *Standard for Fire Doors and Other Opening Protectives (2007 Edition)* Chapter 19: Installation, Testing, and Maintenance of Fire Dampers

19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.

NFPA 105, *Standard for the Installation of Smoke Door Assemblies and Other Opening Protectives (2007 Edition)* Chapter 6: Installation, Testing, and Maintenance of Smoke Dampers

6.5.2 Each damper shall be tested and inspected one year after installation. The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.

InSight (continued)

Continued from page 2


- Revisions to Standard **MS.1.20** regarding medical staff bylaws for the **critical access hospital** and **hospital** programs

CURRENTLY IN DEVELOPMENT

—STANDARDS—

- Review of telemedicine standards
- Review of current requirements addressing the equivalent credentialing and privileging process for physician assistants and advanced practice registered nurses
- Review of the Disease-Specific Care program standards to determine the need for revisions and address needed editorial changes to standards and addenda and the order of the chapters
- Health Care Staffing Services manual revision to clarify standards and elements of performance
- Development of an advanced Disease-Specific Care certi-

fication program for Chronic Obstructive Pulmonary Disease

- Transplant Center certification program standards to recognize the unique care needs of solid organ (for example, kidney, liver, heart) transplant patients
- Development of a Health Care Services Certification Program for services such as palliative care
- Comprehensive Standards Improvement Initiative encompassing the **ambulatory care, critical access hospital, home care, hospital, and office-based surgery** programs
- Proposed revisions to medication management standards **MM.4.10** and **MM.8.10** for the **critical access hospital** and **hospital** programs
- Potential 2009 National Patient Safety Goals for the **ambulatory care, behavioral health care, critical access hospital, home care, hospital, laboratory, long term care, and office-based surgery** programs 

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