



**2015**

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# The Healthcare Environment

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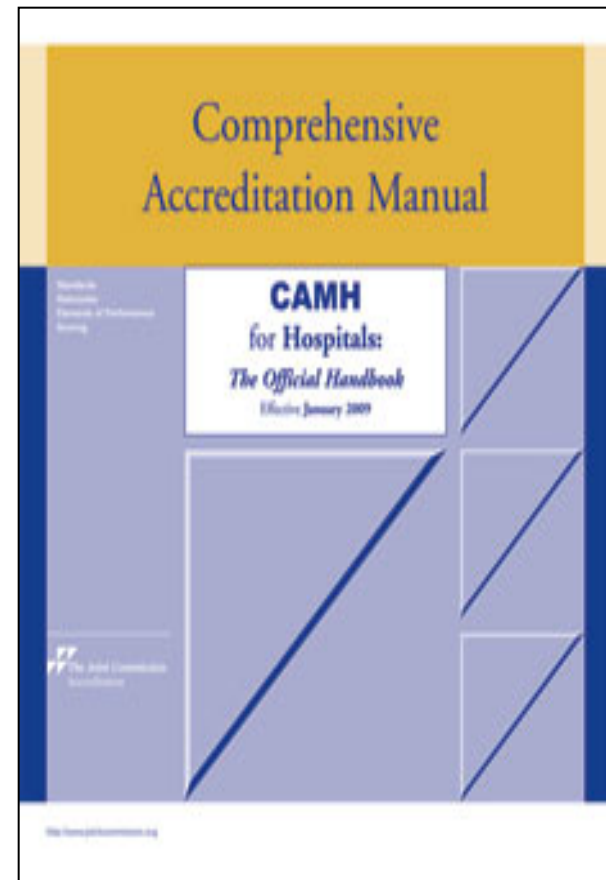
Department of Engineering


The Joint Commission




# 2014 CHALLENGING STANDARDS

## THE TOP 10 EC & LS ISSUES





Standard	Rank	2014 Non Compliance	2013 Non Compliance
EC.02.06.01	1	56%	39%
EC.02.05.01	2	53%	47%
IC.02.02.01	3	52%	46%
LS.02.01.20	4	50%	52%
RC.01.01.01	5	49%	52%
EC.02.03.05	6	48%	45%
LS.02.01.10	7	46%	48%
LS.02.01.30	8	43%	45%
LS.02.01.35	9	43%	36%
EC.02.02.01	10	36%	34%



Standard	Rank	2014 Non Compliance	2013 Non Compliance
MM.03.01.01	11	35%	35%
PC.01.03.01	12	33%	27%
PC.02.01.03	13	29%	18%
EC.02.05.09	14	27%	21%
PC.03.01.03	15	26%	20%
MM.04.01.01	16	25%	22%
LD.01.03.01	17	23%	19%
LD.04.01.05	18	22%	14%
EC.02.05.07	19	21%	23%
IC.02.01.01	20	20%	13%

# Top Eight Cited Standards: 2011 – 2014

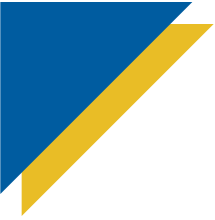
Standard	2014	2013	2012	2011
EC.02.06.01: Built Environment	#1	#8	#7	#11
EC.02.05.01: Utility Systems Risks	#2	#4	#10	#13
LS.02.01.20: Means of Egress	#4	#1	#2	#2
EC.02.03.05: Fire Safety Systems	#6	#7	#5	#5
LS.02.01.10: General Bldg Req's	#7	#3	#3	#3
LS.02.01.30: Protection	#8	#6	#6	#4
LS.02.01.35: Extinguishment	#9	#9	#9	#10
EC.02.02.01: HazMat & Waste	#10	#11	#11	#15

# What is your approach to ESC?

- ▶ Do you have a team approach or is one person responsible?
- ▶ Do you do what you need to do to “make it go away” or are the issues analyzed to determine why the non compliance is present?
- ▶ Do you use this standard ESC response: “We have re-educated the “Fill In The Blank”?”
- ▶ Have you looked at patient safety events and near misses/close calls in relation to non compliance identified during your survey?
- ▶ Have you considered what the short term and long term impact will be if you are unsuccessful in correcting the RFIs?

# Some things to consider...

- ▶ Do you have the right people at the table to address the issues identified?
- ▶ Are you focusing on systems and processes and how to improve them?
- ▶ Have you had an issue with this requirement on previous surveys?
- ▶ What kind of follow up monitoring have you planned to determine whether or not the ESC has been effective over the long term?
- ▶ If you find that your ESC hasn't worked how do you go about fixing that?



# General Topics



# Barrier Management Symposium

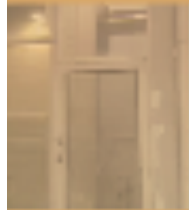
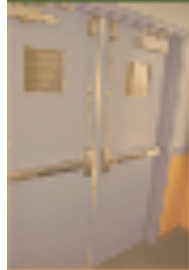
*...at no cost to the attendee...*

## Barrier Management Symposium

*Together we can make the Environment of Care  
a SAFE Environment of Care*

### Mission Statement

To provide concise, accurate education at no cost to the attendee,  
resulting in excellent barrier system management  
in healthcare buildings



# Barrier Management Symposium

## Program Developers:

- ❑ Joint Commission
- ❑ Firestop Contractors International Association
- ❑ Underwriters Laboratories

## Participating Organizations:

- ❑ American Society for Healthcare Engineering
- ❑ AWCI & Gypsum Institute
- ❑ Fire Damper Industry
- ❑ Fire Rated Glazing Industry
- ❑ National Concrete Masonry Association

# BMP Implementation Strategy

These three activities are related to the *Building Maintenance Program* (BMP):

1. Begin with compliant building features
2. Maintain these building features
  - Maintaining the feature
    - Evaluate for effectiveness
3. Inspect by schedule to determine program effectiveness
  - Evaluate door history
  - Adjust evaluation frequency
  - Adjust #2 above (maintaining) to achieve program effectiveness

# Time RE-Defined

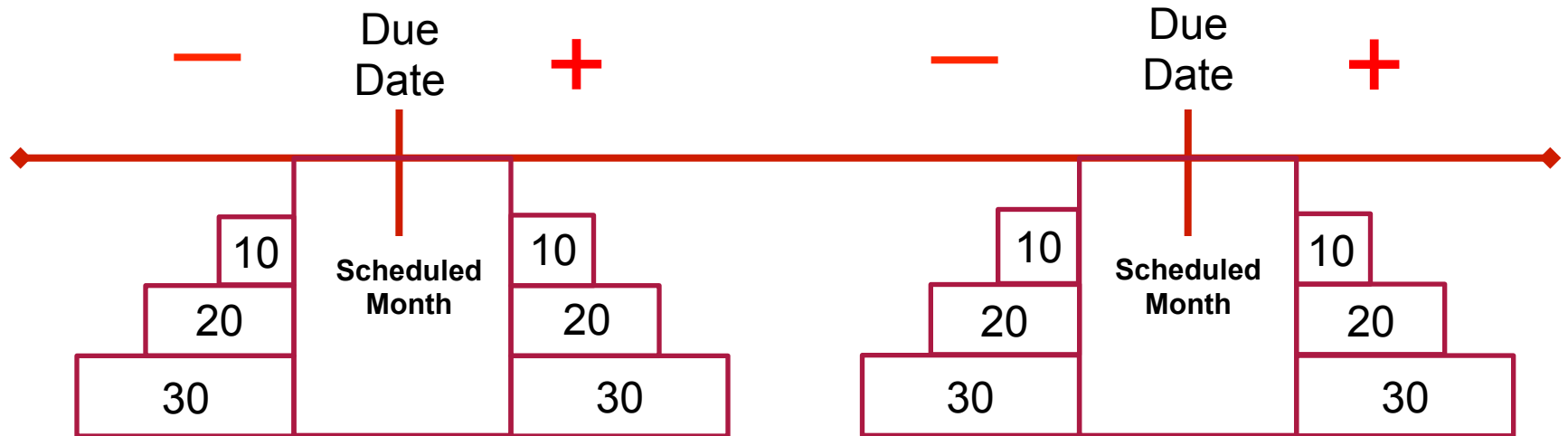
The Joint Commission EC chapter defines time as:

- ❑ Daily, weekly, monthly are calendar references
- ❑ Quarterly **is now** once every three months +/- 10 days as of **January 1, 2014**
- ❑ Semi-annual is 6 months from the last scheduled event month +/- 20 days
- ❑ Annual is 12 months from the last scheduled event month +/- 30 days
- ❑ 3 years is 36 months from the last scheduled event month +/- 45 days

NOTE 1: The above does not apply to required frequencies

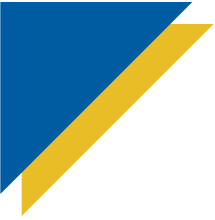
NOTE 2: An alternative of developing either a unique, written policy or adopting NFPA definitions when available is acceptable

**Quarterly: +/- 10 days**  
**Semiannual: +/- 20 days**  
**Annual: +/- 30 days**



Quarterly	Jan	February	March	Apr									
Semiannual	June	July	Aug	Sept	Oct	Nov	Dec						
Annual	Jan	F	M	A	M	J	J	A	S	O	N	D	Jan

Frequencies required by Code may not be modified  
 (e.g. EC.02.05.07 EP 4 & 7)



# Relocatable Power Taps (RPT)

(aka Power Strips)

# Relocatable Power Taps (RPTs)

- ▶ Healthcare Interpretation Task Force (12/2007) stated NFPA 70, NFPA 99 and NFPA 101 all have regulations that control the electrical components and equipment in a patient room.  
*It appears that it is the intent of these documents to restrict RPT use so that it is not used in conjunction with medical equipment*
- ▶ CMS 3/2014:
  - “RPT’s are not to be used with medical equipment in patient care areas.
    - This includes critical areas such as operating rooms, recovery areas, intensive care areas, and non-critical patient care areas such as patient rooms, diagnostic areas, exam areas, etc.”

# Relocatable Power Taps

- ▶ RPTs may be used in anesthetizing locations *if* they are part of the equipment assembly. See NFPA 99-1999 7-5.1.2.5(2)
- ▶ Ceiling drops are acceptable. See NFPA 99-1999 7-5.1.2.5(3)
- ▶ RPTs **may** be used for non-patient care equipment such as computers/monitors/printers, and in areas such as waiting rooms, offices, nurse stations, support areas, corridors, etc.
- ▶ Precautions needed if RPT's are used include:
  - ❑ ensuring they are never “daisy-chained”
  - ❑ preventing cords from becoming tripping hazards
  - ❑ installing internal ground fault and over-current protection devices
  - ❑ using power strips that are adequate for the number and types of devices used



# S&C: 14-46-LSC 9/26/2014

- ▶ CMS is permitting a categorical waiver to allow for the use of power strips in existing and new health care facility patient care areas, if you are in compliance with all applicable 2012 LSC power strip requirements and with all other 2000 LSC electrical system and equipment provisions.
- ▶ The organization must follow all requirements of the categorical waiver process
  - ❑ This includes identifying where they are located at the unit level

# Categorical Waiver Process

If the organization decides to use this categorical waiver they must

1. Ensure full compliance with the appropriate code reference
2. Document the decision to adopt the categorical waiver
  - The Relocatable Power Tap is not a LSC issue but an Environment of Care issue
    - For Environment of Care items document by Minutes in discussion at the Environment of Care Committee (or equivalent)
3. Declare the decision at the beginning of any survey

See also November 2013 *Perspectives*

# Definitions From NFPA 99-2012

- ▶ Patient bed location is defined in section 3.3.136 as the location of a patient sleeping bed, or the bed or procedure table of a critical care area.
- ▶ Patient-care-related electrical equipment is defined in section 3.3.137 as electrical equipment that is intended to be used for diagnostic, therapeutic, or monitoring purposes in the patient care vicinity;
- ▶ Patient care room is defined in section 3.3.138 as any room of a health care facility wherein patients are intended to be examined or treated. Note that this term replaces the term “patient care area” used in the 1999 NFPA 99, but the definition has not changed.
- ▶ Patient care vicinity is defined in section 3.3.139 as a space, within a location intended for the examination and treatment of patients (i.e., patient care room) extending 6 ft. beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extends vertically 7 ft. 6 in. above the floor.

# Requirements

Power strips may be used in a patient care vicinity to power rack-, table-, pedestal- or cart-mounted patient care-related electrical equipment assemblies, provided *all* of the following conditions are met, as required by section 10.2.3.6:

- ❑ The receptacles are permanently attached to the equipment assembly.
- ❑ The sum of the ampacity of all appliances connected to the receptacles shall not exceed 75 percent of the ampacity of the flexible cord supplying the receptacles.
- ❑ The ampacity of the flexible cord is suitable in accordance with the current edition of NFPA 70, National Electric Code.
- ❑ The electrical and mechanical integrity of the assembly is regularly verified and documented through an ongoing maintenance program.
- ❑ Means are employed to ensure that additional devices or nonmedical equipment cannot be connected to the multiple outlet extension cord after leakage currents have been verified as safe.

# Requirements

- ▶ Patient bed locations in new health care facilities, or in existing facilities that undergo renovation or a change in occupancy, shall be provided with the minimum number of receptacles as required by section 6.3.2.2.6.2.
- ▶ Power strips providing power to rack-, table-, pedestal-, or cart-mounted patient care-related electrical equipment assemblies are **not** required to be an integral component of manufacturer tested equipment.
  - ❑ Power strips may be permanently attached to mounted equipment assemblies by personnel who are qualified to ensure compliance with section 10.2.3.6.

# Requirements

- ▶ Power strips may **not** be used in a patient care vicinity to power non-patient care-related electrical equipment (e.g., personal electronics).
- ▶ Power strips **may** be used outside of the patient care vicinity for both patient care-related electrical equipment & non-patient-care-related electrical equipment.
- ▶ Power strips providing power to patient care-related electrical equipment must be Special-Purpose Relocatable Power Taps (SPRPT) listed as UL 1363A or UL 60601-1.
- ▶ Power strips providing power to non- patient-care-related electrical equipment must be Relocatable Power Taps (RPT) listed as UL 1363.

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- ▶ Power strips providing power to non- patient-care-related electrical equipment must be Relocatable Power Taps (RPT) listed as UL 1363.



# Questions?



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