

# EC News

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# Designating an Effective Emergency Coordinator

**STRONG SUPPORT FROM SENIOR LEADERSHIP IS CRUCIAL TO EMPOWERING A RESPECTED EMERGENCY MANAGEMENT LEAD AND CREATING AND MAINTAINING A ROBUST INTERDISCIPLINARY GROUP OF STAFF WHO ARE WELL PREPARED FOR A VARIETY OF EMERGENCIES**

The twists and turns of navigating the COVID-19 pandemic have pushed emergency management strategies to the forefront at health care organizations. From mitigation and preparedness to response and recovery, the value of effective, creative emergency management is clear as hospitals and other health care facilities continue to confront the evolving coronavirus situation.

Ideally, the lessons of the pandemic will inspire health care administrators to ramp up their emergency management teams to ensure that they're ready for a wide range of possible disasters, says Eric R. Alberts, CEM, CHPP, CEDP, CCMC, CHEP, SEM, Corporate Director—Emergency Preparedness for Orlando Health in Orlando, Florida. “Emergency management means being prepared for *all hazards*,” he emphasizes. “It’s so much more than a pandemic. It’s dealing with a lot of things you may know you have to think about—and those you don’t.”

Besides disasters such as wildfires, tornadoes, and hurricanes, emergencies include seemingly minor events that can escalate. “We tend to think of emergency management as the hospital catching on fire or an internal utility disaster such as a broken sprinkler pipe causing flooding. And it is that,” says Marisa Voelkel, CHSP, CHEP, CHEC III, an engineer in The Joint Commission’s Standards Interpretation Group. “But it’s also that snowstorm that turns into a three-day blizzard, and you can’t get staff.” (See [page 7](#) for an article on preparing for temperature extremes.)

Emergency readiness requires the flexibility to deal with limitless possibilities while also prioritizing the risks that are most likely to occur. It is no easy task, which is why The Joint Commission recommends that every health care organization—not just hospitals and large health systems—designate an emergency management coordinator or other individual to ensure compliance with The Joint Commission’s “Emergency Management” (EM) chapter and to champion continuous preparedness for the broad spectrum of incidents that could befall a facility. At smaller organizations, this position can be part time, with the individual serving in other roles, but it needs to be a priority. (Please note that at this time, The Joint Commission does *not* require that a health care organization designate an emergency management coordinator or leader, but it is considered a best practice—hence the recommendation.)

“We have observed that when someone ‘owns the EM chapter,’ there are fewer findings during the triennial survey and the program is very comprehensive,” points out James Kendig, MS, CHSP, HEM, Field Director—Surveyor Management and Development for The Joint Commission.

The emergency management coordinator or individual assigned to the EM chapter would ensure compliance with The Joint Commission's EM standards, including but not limited to planning, scheduling, and documenting the required EM exercises; spearheading the biennial hazard vulnerability analysis and review of the Emergency Operations Plan (EOP)\*; and organizing staff training in emergency preparedness and response. This role should not be confused with that of the incident commander, who takes charge during an emergency once the EOP is activated. (However, the two roles could be fulfilled by the same person.)

But having an emergency coordinator isn't enough, insist experts in the field. "The biggest mistake in most organizations is that they designate someone for emergency management and then don't follow up with resources to support that person," notes Shan Largoza, MBA, CHFM, CHEP, CHSP, Vice President, WellMed Medical Management Inc., an ambulatory care network based in San Antonio, Texas. A common scenario, according to Largoza, is an administrator cavalierly delegating responsibility: "Hey, you, put the plan together, and call me if you need me."

### **Leading the charge**

A strong EM program is vital to any health care organization, as the EM chapter makes clear. An EM program and the required written EOP provide a structure for handling whatever internal or external incidents arise. But without the buy-in of top management, the best-laid emergency plans can go awry.

The efforts required to stay on top of day-to-day health care functions can tempt senior leadership to push emergency management programs to the sidelines, Voelkel explains. "We're trying to get leaders to think outside crisis-only mode and move into constant readiness," she says. "It's a challenge because it's another thing on their plate that they can delegate and think it's covered; they may rely on the emergency management people only when they get a bomb threat or the boiler goes out."

That effect can trickle down to all levels of the health care organization, says Alberts. "If senior leaders don't take emergency management seriously, then the rest of the organization won't either," he observes.

The Joint Commission's EM standards acknowledge the crucial role of senior leaders. In fact, the first element of performance (EP) in the chapter addresses their responsibilities. In Standard EM.01.01.01, EP1 (the exact wording of which varies by manual), The Joint Commission requires the leadership of all accredited organizations to participate in planning activities prior to the development of the EOP. Similarly, Standard EM.02.01.01, EP 1, requires leaders to take part in the development of the written plan.

Appointing and championing a strong emergency coordinator (or manager or director, depending on the size of the organization) should also be a key responsibility of senior leadership. This means ensuring the coordinator's competency and providing the funds for ongoing training and professional development.

\*In certain Joint Commission accreditation programs, the written plan is known as an Emergency Management Plan (EMP).

To acquire “base knowledge,” a designated emergency coordinator at a health care organization should already have completed [online training courses](#) through the Federal Emergency Management Agency (FEMA) Center for Domestic Preparedness, says Voelkel. FEMA also offers an array of online and on-site courses via its [Emergency Management Institute](#) and its [National Incident Management System \(NIMS\) Training Program](#). (Again, at this time, these are best practices, not necessarily Joint Commission requirements.)

All emergency coordinators should be encouraged to take continuing education courses, participate in community training exercises, and pursue certifications such as [Certified Healthcare Emergency Professional \(CHEP\)](#) and [Certified Healthcare Emergency Coordinator \(CHEC\)](#). In addition, emergency coordinators should be able to attend professional conferences (in person and virtually) where they can network and share ideas with their peers. Proper continuing education for an emergency coordinator is a resource that senior leaders should provide.

### **Assembling the emergency management team**

A successful EM program requires not just a respected, supported, well-trained coordinator but also a robust EM team or committee representing multiple disciplines. “You really need the interdisciplinary structure to build an effective and realistic emergency management plan,” says Alberts. “You’ve got to build that collaboration with those different staff members—including members of the medical staff—before, during, and after an incident.” For smaller health care settings, such as ambulatory care facilities, nursing care centers and assisted living communities, and behavioral health care and human services organizations, the EM team will be smaller but can still represent key staff departments. Be sure to include representation from clinical staff, mental health, if available, and facilities, safety, or security.

The Joint Commission does not specify who should be on the EM team, but the hazard vulnerability analysis (HVA) can be used to determine the needed expertise. An HVA, which is required under Standard EM.01.01.01, EP 2, is a process for identifying potential emergency risks and their likelihood of occurrence, as well as the direct and indirect effects these hazards may have on the organization’s operations and the demand for its services.

Largoza recommends that the EM team include staff from facilities or engineering, safety and security, and both medical and nonmedical supply chain areas, along with a senior leader such as a chief operating officer. “You also need clinical ownership: What are your critical clinical services, and how can you represent those?” he says. “It’s best to have a clinical person (normally a nurse) and a



physician leader on there as well.” The team should also have representation from infection prevention and control, as the COVID-19 pandemic and previous infectious disease outbreaks have made abundantly clear.

The EM team’s second tier can include staff from human resources and patient services, as well as chaplains or grief counselors, Largoza suggests. “You need folks who can put emergency messaging out to staff and patients—a communications person who can put a flag on a web page to say we’re closed, a stress support team for your providers,” he says.

Critical access hospitals and nonhospital organizations, such as behavioral health care and human services facilities, assisted living communities, and home care organizations, will likely not have all the personnel described above. Such organizations should nevertheless have broad departmental representation on their emergency management teams. For example, a behavioral health care and human services facility might have a case manager as well as administrative, clinical, and facilities staff on the team. The point is for many perspectives to influence the development of the EOP and to have a well-represented and well-trained team ready to respond to emergencies.

Community organizations, local fire and police departments, and public health and emergency management agencies and regional coalitions should also be tapped for their insights and expertise, during both planning activities and emergency exercises. The emergency coordinator could, for example, arrange for local law enforcement officers to take part in emergency scenarios such as an active shooter drill, an infant abduction drill, or an “elopement” drill in which a child, a care recipient with dementia, or any patient without decisional capacity walks away from the facility.

## **Meeting expectations**

Regularly scheduled meetings are an important way for emergency management teams to maintain momentum and keep up with changes at the organization and in their local and regional area. “The minimum frequency to be meeting depends on the organization, its size, and how much is going on,” says Voelkel. When she worked as an emergency management director in health care, for example, the team met monthly unless there was a big change to be addressed, which increased the meeting frequency. The EM coordinator would then lead these regular meetings and ensure that any gaps or needs identified during the meetings were handled appropriately and promptly.

At Orlando Health, an EM council at each site meets at least four times a year, says Alberts. “Some meet almost every month, and our corporate [EM] council—40 leaders across the organization, including the emergency management chairs and vice chairs of the site councils—meets quarterly,” he says.

Meeting more often can help EM teams stay on track as they plan for future events, says Largoza, who recommends monthly meetings. “You need to be meeting regularly to be planning for the emergency drills required by your local authority. And you really need to be continually looking at what are the current emergency threats—a lot of which come with the changing seasons and weather.”

For example, observes Largoza, the Atlantic hurricane season runs from June through November. So during its May meeting, an East Coast or Gulf Coast organization's emergency management team should be addressing such questions as "Have we tested our emergency call rosters?" and "Do we have 96 hours of fuels, water, and medical supplies?" The specific questions will vary with the health care setting and part of the country. Many Florida and Gulf-based organizations start planning as early as January, adds Kendig, who previously served as a vice president of safety and security for a Florida health care organization.

Whether virtual or in person, team meetings should be well organized and run efficiently, Alberts emphasizes. "Having a structure is a big part of it—an agenda, a process, templates. That really brings [the team members] back," he says. "And the meeting should be a discussion, not just a readout on issues. Discussions bring up new things—construction is going to occur at a hospital, a new project is underway, there's new technology that can be used during an emergency. There are many ways that information can be used and leveraged by those on the team."

Meetings should also have a running follow-up list of items that need to be handled, including the who, what, and when. And the EM coordinator should be empowered to monitor and hold individuals accountable for fulfilling their obligations and responsibilities generated by the team in a timely way. The EM coordinator may also need to liaise with senior leadership to obtain any resources that the EM team identifies as necessary.

Kendig suggests inviting guest speakers with different areas of expertise to present on various issues during the meetings. Possible topics range from psychological first aid to child abduction response strategies to cybersecurity. When preparing for potentially devastating emergencies, the more ideas and insights considered, the better. 

# Is Your Organization Prepared for Temperature Extremes?

HEALTH CARE ORGANIZATIONS WITH INPATIENT OR RESIDENTIAL SETTINGS SHOULD ADDRESS THE RISKS OF EXCESSIVE HEAT AND BRUTAL COLD IN THEIR HAZARD VULNERABILITY ANALYSIS AND EMERGENCY OPERATIONS PLAN AND IMPLEMENT MITIGATION AND PREPAREDNESS STRATEGIES ACCORDINGLY

Heat is one of the most dangerous weather-related killers in the United States, causing hundreds of deaths every year. During the heat wave of 1980, for example, more than 1,250 people perished. During the summer of 1995, more than 700 people in the Chicago area died due to excessive heat and humidity, making that heat wave the deadliest weather event in the history of the city.<sup>1</sup>



By Angela Murray, MSN, RN, Project Director, The Joint Commission's Department of Standards and Survey Methods

Extreme cold can also cause deaths, especially in areas of the country where buildings and systems are not designed for such temperatures. During the February 2021 winter storm that hit Texas, the state experienced widespread power outages that resulted in 111 weather-related deaths. Lack of heat and water forced patient evacuations at several Texas hospitals and other care centers.

## Impact of temperature extremes

Power outages and stress on power grid systems can be caused by both high and low temperature extremes. During very high temperatures or heat waves, increased electricity consumption leads to power outages. During high heat, people naturally increase their use of air-conditioning, which requires more electricity and strains the transmission lines. In hot weather, these transmission lines have a lower capacity, and the increased demand for electricity to run air-conditioners can force a line to droop and potentially short-circuit. If this happens enough, then power will go out because there aren't enough transmission lines to carry the electricity needed.<sup>2</sup>

During the Texas winter storm, the state reached historically low temperatures of single digits for the first time in more than 30 years. Hospitals across Texas faced several operational challenges due to the catastrophic winter storm that disrupted power, water, and food supplies. For example, burst pipes were a big problem in some health care facilities, limiting the availability of potable water. In addition, many inpatients could not be discharged safely to their homes. At the same time, critical outpatient facilities such as dialysis centers were closed, which increased the patient load at local hospitals.

The storm put a significant strain on the Electric Reliability Council of Texas, which manages the state's main power grid, representing 90% of the state's electric load and serving more than 26 million customers. Texans were told to prepare for short-term rolling power outages, but many buildings were without power for up to 42 hours.<sup>3</sup>

Snow and ice can also cause power outages due to the excessive weight on normally sturdy lines. Treacherous winter weather conditions can often prevent utility crews from accessing repair sites in a timely way.



## Regulatory and code requirements for health care

To prepare for temperature extremes—heat or cold—as well as storms, health care organizations need to assess the impact of a power outage and how the electrical grid system could affect their facilities. The likelihood and impact of temperature-related power outages should be addressed in the Joint Commission–required hazard vulnerability analysis (HVA). What follows are some considerations.

Joint Commission–accredited organizations must comply with the requirements set forth in state law and regulation as well as in the National Fire Protection Association (NFPA) *Health Care Facilities Code* (NFPA 99-2012). The requirements related to power outages, summarized and paraphrased here from NFPA 99-2012, provide a framework for risk assessment and preparedness strategies:

- ▶ **12.5.3.3.6.5—Essential Utilities.** The essential utilities list includes electricity and heating, ventilation, and air-conditioning (HVAC), among other items. Prior to declaring any emergency, an organization must assess whether it has the infrastructure to support the essential utilities.
- ▶ **12.5.3.3.6.6—Exterior Connections.** For essential utility systems in Category 1 facilities\* only—and based on the facility's HVA—an organization must consider the installation of exterior building connectors to allow for the attachment of portable emergency utility modules.
- ▶ **15.5.1.3—Emergency Generators and Standby Power Systems.** Emergency generators and standby power systems, where required for compliance with NFPA 99-2012, must be installed, tested, and maintained in accordance with NFPA 110, *Standard for Emergency and Standby Power Systems*.
- ▶ **15.5.1.4—Stored Electrical Energy Systems.** Stored electrical energy systems must be installed, tested, and maintained in accordance with NFPA 111, *Standard on Stored Electrical Energy Emergency and Standby Power Systems*.
- ▶ **B.12.3.2.5—Power Loss.** In getting a facility up and running after a power loss, the first operational priority is clinical care, and the second is infrastructure.

\*According to the National Fire Protection Association (NFPA) *Health Care Facilities Code* (NFPA 99-2012), Category 1 refers to systems or equipment for which failure would likely cause major injury or death. Category 1 facilities house Category 1 systems and equipment.

When ordering backup generators, it is important to know the size needed and the method to be used to connect the generators to the facility.

- ▶ **B.12.3.4—Activation of Emergency Utility Resources.** Planning for a loss of utilities is essential. Organizations should evaluate their ability to be self-sufficient over a period of at least 96 hours, including the fuel they have on hand. An organization that has backup generators must establish how long it can operate on those generators if it loses electricity.

Besides the above requirements, health care organizations should consider guidance (not a regulation) from the Occupational Safety and Health Administration (OSHA). To optimize the comfort of building occupants, OSHA's Standard 1910.1000 recommends temperature control settings in the range of 68°–76° F and relative humidity control settings in the range of 20%–60%.<sup>4</sup>

### **Emergency management and The Joint Commission's standards**

In The Joint Commission's "Emergency Management" chapter, Emergency Management (EM) Standard EM.02.02.09 states: As part of its Emergency Operations Plan, the [organization] identifies alternative means of providing the following<sup>†</sup>:

- Electricity and lighting
- Water needed for consumption and essential care activities
- Water needed for equipment/sanitary purposes
- Fuel required for building operations, generators, and so on
- Medical gas/vacuum systems
- Utility systems that the [organization] defines as essential (for example, heating and cooling systems)

**Note:** *The essential utility systems include mechanisms for maintaining temperatures at a level that protects patient health and safety and the safe and sanitary storage of provisions.*

There are alternative means of maintaining acceptable temperature and humidity levels, including the use of portable air-conditioning units, portable chillers, or portable heating units during an emergency when there is disruption to the internal power system or during an external power outage in the community. Additional generators may need to be used to supply electricity to these additional utility modules.

Per the NFPA, primary backup generators are not required to supply electricity to the HVAC system but only to critical areas, as defined in the code. Alternative means for providing continuous thermal comfort (heating and/or cooling) for some organizations may simply consist of evacuating and/or relocating patients and staff and suspending services.

<sup>†</sup>The pertinent elements of performance in this standard are paraphrased here.

## Planning for temperature extremes

As part of its planning activities, a health care organization’s emergency management team should prepare for temperature extremes. The following checklist can be used to quickly assess or improve an organization’s preparedness.

### Mitigation and Preparedness Checklist for Temperature Extremes

Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you addressed temperature extremes in your organization’s Emergency Operations Plan (EOP)?
	Have you considered the following?
Yes <input type="checkbox"/> No <input type="checkbox"/>	A risk assessment related to extreme temperatures that could affect patients, staff, and visitors
Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitigating strategies related to temperature-extreme risks identified in your organization’s hazard vulnerability analysis (HVA)
Yes <input type="checkbox"/> No <input type="checkbox"/>	Installation of exterior connectors or adapters for the attachment of portable emergency utility modules
Yes <input type="checkbox"/> No <input type="checkbox"/>	Monitoring protocols related to weather forecasts and projections
Yes <input type="checkbox"/> No <input type="checkbox"/>	Coordination with local public safety or emergency management officials to address extreme temperature–related emergencies and alternative sources of power
Yes <input type="checkbox"/> No <input type="checkbox"/>	Pre-identified locations within the organization capable of providing continuous thermal comfort (heating and/or cooling)
Yes <input type="checkbox"/> No <input type="checkbox"/>	Processes for transfer or relocation of patients to areas capable of providing thermal comfort and, if necessary, evacuation
Yes <input type="checkbox"/> No <input type="checkbox"/>	Strategies for maintaining essential utilities such as electricity and HVAC during and after the temperature extremes
Yes <input type="checkbox"/> No <input type="checkbox"/>	Protocols for monitoring air temperature, humidity, and air movement during or after the temperature extremes
Yes <input type="checkbox"/> No <input type="checkbox"/>	Agreements with contractors for equipment such as backup emergency generators, portable air-conditioning units, portable heating units, and so on

## Conclusion

This article summarizes the impact of extreme temperatures on health care organizations and organizations’ ability to continue to provide essential utilities using emergency generators and alternate emergency utility modules. The inability to maintain or provide essential utilities, such as electricity and heating or cooling, can lead to devastating effects, including severe illness and even death—especially during extended power outages.

The importance of comfort to patients' well-being cannot be overstated. A review article in *BMC Public Health* in late 2020 indicated that when HVAC is in use, patients have positive outcomes such as improved vital signs, reduced cardiac stress, and shorter hospital stays.<sup>5</sup> 

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3. Bohra N. [Almost 70% of ERCOT customers lost power during winter storm, study finds](#). *The Texas Tribune*. Mar 29, 2021. Accessed Jun 21, 2021.
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APPLICABLE PROGRAM: CAH

# Critical Access Hospitals Face EC, LS, and EM Compliance Challenges

FOUR OF THE TOP 10 MOST FREQUENTLY CITED HIGH-RISK ELEMENTS OF PERFORMANCE (EPS) INVOLVE THE HEALTH CARE PHYSICAL ENVIRONMENT

Critical access hospitals provide vital health care services to rural and other medically underserved areas. With their limited staffing and focus on clinical care, it's not surprising that critical access hospitals may struggle to comply with a number of The Joint Commission's Environment of Care (EC) and Life Safety (LS) standards and elements of performance (EPs).

"My observation is that critical access hospitals tend to have scarce resources," says Herman A. McKenzie, MBA, CHSP, The Joint Commission's Director of Engineering. "The facilities person is wearing many hats and prioritizes the maintenance issues requiring immediate attention."

James Kendig, MS, CHSP, HEM, Field Director—Surveyor Management and Development for The Joint Commission, agrees, adding that the community served is likely to have a volunteer fire department and protection from county or state police instead of a municipal police department. What's more, the resources of the [Office of the Assistant Secretary for Preparedness and Response \(ASPR\)](#) may be some distance away.

What often doesn't get prioritized in critical access hospitals are some of The Joint Commission's required risk management, inspection, testing, and preventive maintenance activities. As a result, in full-year 2020—a year in which critical access hospitals were dealing with COVID-19 and at times operating beyond their normal 25-bed, 96-hour inpatient limit—the noncompliance rates were high for the most frequently cited EC and LS standards.

As Figure 1 on page 13 shows, the noncompliance percentages for the top 10–cited EC and LS standards ranged from nearly 80% to just over 42%. These standards address fire-extinguishing systems and other fire safety equipment and building features; utility system risk management and inspection, testing, and maintenance (ITM); handling and disposal of hazardous materials and waste; and general maintenance of a safe, functional environment.

**Figure 1. Top 10–Cited EC and LS Standards for Critical Access Hospitals in Full-Year 2020**

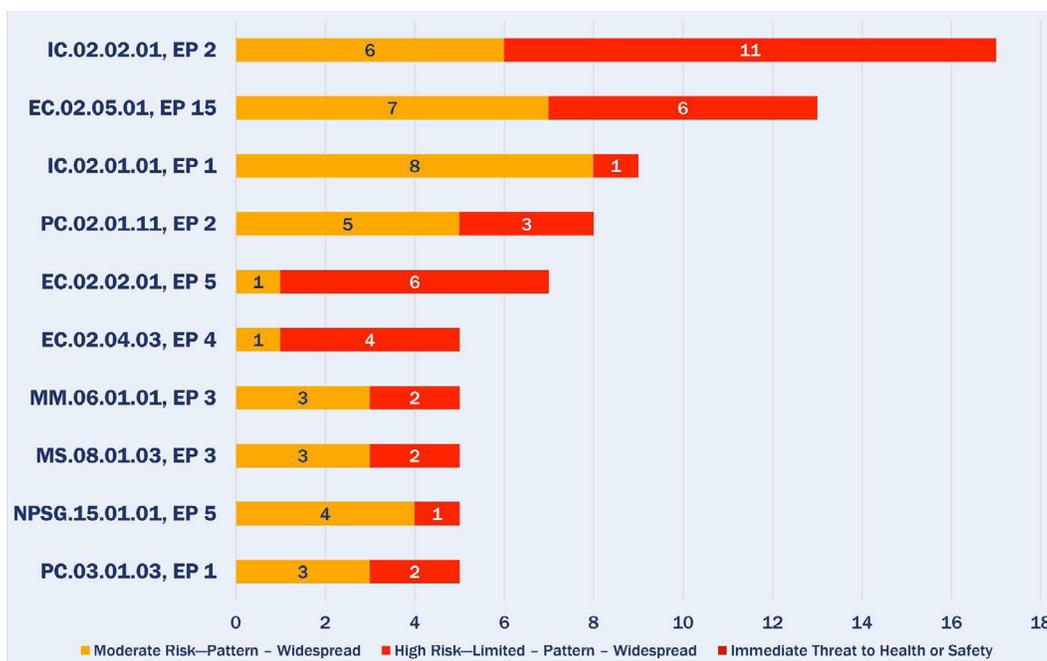
Standard Number	Standard Topic	Noncompliance Percentage
LS.02.01.35	Provides and maintains systems for extinguishing fires	79.69%
EC.02.05.01	Manages risks associated with its utility systems	68.75%
EC.02.03.05	Maintains fire safety equipment and fire safety building features	57.81%
LS.02.01.30	Provides and maintains building features to protect individuals from the hazards of fire and smoke	57.81%
EC.02.05.07	Inspects, tests, and maintains emergency power systems	56.25%
LS.02.01.10	Designs and maintains building and fire protection features to minimize the effects of fire, smoke, and heat	56.25%
EC.02.02.01	Manages risks related to hazardous materials and waste	51.56%
LS.02.01.20	Maintains the integrity of the means of egress	51.56%
EC.02.05.05	Inspects, tests, and maintains utility systems	48.44%
EC.02.06.01	Establishes and maintains a safe, functional environment	42.19%

In looking at the higher-hazard EPs across all the standards in the *Comprehensive Accreditation Manual for Critical Access Hospitals*, it is notable that physical environment deficiencies accounted for 4 of the 10 leading Requirements for Improvement (RFIs), as shown in Figure 2 on page 14:

- ▶ **EC.02.05.01, EP 15:** In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature, and humidity. For new and existing health care facilities or altered, renovated, or modernized portions of existing systems or individual components (constructed or plans approved on or after July 5, 2016), heating, cooling, and ventilation are in accordance with NFPA 99-2012, which includes 2008 ASHRAE 170, or state design requirements if more stringent.
- ▶ **EC.02.02.01, EP 5:** The critical access hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.
- ▶ **EC.02.04.03, EP 4:** The critical access hospital conducts performance testing of and maintains all sterilizers. These activities are documented. (*See also* IC.02.02.01, EP 2)

- ▶ National Patient Safety Goal (NPSG) **NPSG.15.01.01, EP 5**: Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following:
  - Training and competence assessment of staff who care for patients at risk for suicide
  - Guidelines for reassessment
  - Monitoring patients who are at high risk for suicide

**Figure 2. Most Frequently Cited EPs at Critical Access Hospitals for Full-Year 2020**



The orange and red portions of the bar graph refer to the *Survey Analysis for Evaluating Risk*® (SAFER®) Matrix, the color-coded framework used by Joint Commission surveyors to identify the likelihood to harm and scope of each finding. The requirements for improvement (RFIs) in the orange-colored section of a bar represent hazards that pose a moderate risk of causing harm, while the RFIs in the red section of a bar represent high-hazard deficiencies.

### Specific observations

*Life Safety Code*®\* Surveyor Narsimha Irrinki, MS, PE, CHFM, CPE, has noticed the following compliance problems while surveying critical access hospitals:

- ▶ Failure to implement an integrated utilities management program to manage risks and inspect, test, and maintain gas, vacuum, electrical, and heating, ventilation, and air conditioning (HVAC) equipment and systems. “The program did not address high-risk and non-high-risk utility operating components,” Irrinki notes. “And despite the complex nature of these systems and equipment, there were no competent personnel on site and no ongoing continuing education and training.”
- ▶ Failure to provide, inspect, test, and maintain fire suppression, protection, detection, and extinguishing systems.

\**Life Safety Code*® is a registered trademark of the National Fire Protection Association, Quincy, MA.

- ▶ Failure to develop and maintain an Emergency Operations Plan (EOP) that describes procedures to sustain resources to last 96 hours. “The program did not document strategies for implementing continuity of operations,” Irrinki remembers. “Also, there was no memorandum of understanding (MOU) with other hospitals and alternate care sites situated along all possible routes [for transferring or referring patients during the pandemic].”

Even though Emergency Management (EM) requirements did not rank among critical access hospitals’ top 10 EPs for noncompliance last year, Irrinki emphasizes that these hospitals need to improve their compliance with several standards in the EM chapter. Comprehensive emergency preparedness is particularly essential, given the critical access hospitals’ limited resources and more isolated geographic locations.

### Compliance tips

Irrinki offers the following tips to critical access hospitals:

- ▶ Review the EC, LS, and EM standards and keep up to date with any changes. Remember that *The Joint Commission Perspectives*<sup>®</sup>, The Joint Commission’s official newsletter, provides monthly updates on any changed or new standards, outside the twice-annual update cycle for accreditation standards.
- ▶ Establish standard work processes whenever and wherever possible. Document these processes and be sure to include them in new staff orientation.
- ▶ Conduct EC rounds to ensure continuous compliance. EC rounds are not required by The Joint Commission, but they are helpful.
- ▶ Manage EC issues—such as blocked or cluttered corridors, stained ceiling tiles, open junction boxes, and blocked doors—daily.
- ▶ Perform mock tracers with the regulatory readiness team.
- ▶ Update policies and procedures (P&Ps) according to a defined cycle. Always review your P&Ps when Joint Commission standards are updated or introduced to ensure ongoing compliance.
- ▶ Become familiar with the following resources—in addition to the *Comprehensive Accreditation Manual for Critical Access Hospitals* (or its E-dition<sup>®</sup> counterpart) and *EC News*:
  - The National Fire Protection Association (NFPA) *Life Safety Code* (NFPA 101-2012), Chapter 18/19
  - The NFPA *Health Care Facilities Code* (NFPA 99-2012), Chapters 4, 6, and 9 (related to utility systems such as gas, vacuum, electrical, and HVAC systems)

The Joint Commission recognizes that those in critical access hospitals can feel overwhelmed by EC, LS, and EM compliance expectations on top of their day-to-day operational challenges. Timothy Markijohn, MBA/MHA, CHFM, CHE, Field Director—Surveyor Management and Development for The Joint Commission, has observed what he considers to be a positive trend. “We are seeing more and more standalone critical access hospitals being acquired by larger health care systems,” Markijohn says. “This is beneficial because these small hospitals now have a big brother to lean on when needed.” 

APPLICABLE PROGRAMS: ALL

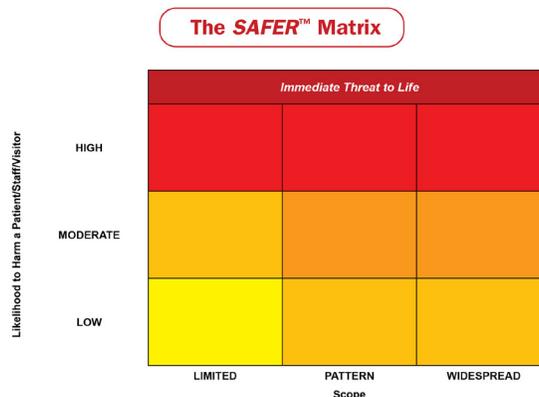
# Leverage the SAFER<sup>®</sup> Dashboard to Visualize Your Organization's Performance Metrics

THIS TOOL ENABLES ACCREDITED ORGANIZATIONS TO EASILY ANALYZE THEIR EC, LS, AND EM COMPLIANCE ISSUES; GENERATE A WEALTH OF CHARTS AND GRAPHS; AND COMPARE THEMSELVES TO SIMILAR ORGANIZATIONS NATIONALLY

By now, most Joint Commission–accredited organizations (except perhaps those new to accreditation) should be familiar with the *Survey Analysis for Evaluating Risk*<sup>®</sup> (SAFER<sup>®</sup>) Matrix—the color-coded grid framework used by surveyors to identify the risk level of a cited deficiency. Each survey finding is plotted on the SAFER Matrix based on its likelihood of causing harm and its scope or pervasiveness within a facility or organization. The level of risk ranges from “low harm, limited scope,” depicted by a bright yellow rectangle in the lower-left corner of the grid, to “high harm, widespread,” a red rectangle in the upper-right corner. (All high-harm deficiencies, even those of limited scope, are coded red.) A darker red band across the top of the grid represents “immediate threat to health or safety.” The grid also includes two shades of orange, the lighter hue representing “moderate harm, limited scope” and the darker hue, “moderate harm and pattern or widespread scope.”

Since its launch in June 2016, the SAFER Matrix has helped organizations to visualize and prioritize their Requirements for Improvement (RFIs), enabling them to focus on the more prevalent, higher-hazard deficiencies first—the goal being to have the greatest positive impact on safety in the shortest period of time. Debuting in April 2021, a new SAFER Matrix–related Joint Commission platform—the SAFER<sup>®</sup> Dashboard—empowers users to look at their survey performance data through multiple lenses. This data analytics tool is available free to accredited organizations via their Joint Commission Connect<sup>®</sup> extranet site.

Specifically, the SAFER Dashboard allows users to generate their own SAFER Matrix–coded bar graphs and charts, using their organization's aggregate survey data. Multisite organizations can view their survey findings across the enterprise and by location and program.\* The platform extends beyond the SAFER Matrix data set. For example, organizations that use their



\*Note that access to the SAFER<sup>®</sup> Dashboard is user based. Users will have access to data only for the organizations in which they're listed as designated SAFER Dashboard contacts.

Joint Commission accreditation for deemed status purposes can also create a range of charts and graphs related to their Medicare Condition-level deficiencies.

The new dashboard also allows users to drill down on individual standards chapters. Of special interest for readers of *EC News*, users can key in various parameters to filter their data to focus only on Environment of Care (EC), Life Safety (LS), and Emergency Management (EM) standards and elements of performance (EPs) or zero in on a single chapter. The data can also be parsed by specific survey or year. What's more, the *SAFER* Dashboard enables historical data since January 1, 2017, to be viewed in the aggregate or year by year—or filtered by program, location, manual chapter, and other factors. A wealth of EC, LS, and EM compliance data for your accredited organization is literally at your fingertips.

You can also look at how your organization compares nationally. Arguably one of the most valuable features of the *SAFER* Dashboard is the ability to compare your organization's performance metrics to comparably filtered national aggregate data, as can be seen in Figure 1 below and Figure 2 on page 18. Being able to see aggregate peer data provides important insights into a health care organization's relative strengths and weaknesses. This can be especially helpful when trying to assess one's compliance with EC and LS standards and EPs, as The Joint Commission's physical environment requirements tend to be among the most challenging for organizations.

**Figure 1. Sample SAFER® Dashboard Showing Top-Cited LS Elements of Performance**



This sample screenshot, displaying fictitious organizational data, shows a side-by-side comparison of the most frequently cited Life Safety (LS) elements of performance (EPs) nationally and at an individual facility.

**Figure 2. Sample SAFER® Dashboard Depicting an Aggregate SAFER Matrix Comparison**



This sample screenshot, also displaying fictitious organizational data, depicts the facility’s aggregate Environment of Care (EC) noncompliance data in a bold-face font right next to the national aggregate EC noncompliance data.

### Multiple perspectives

Organizations can use the SAFER Dashboard to generate graphs of the top 10–cited standards and EPs across the enterprise and see whether any EC, LS, and EM standards count among the most scored. Organizations can also take a granular approach and bring up the most frequently cited higher-hazard EC and LS requirements, including EPs, at particular facilities. The possibilities are boundless.

The synergy of multiple perspectives, from macro to micro, in data analysis can help an organization determine the most effective and efficient corrective measures and long-term action plans for performance improvement. Uncovering previously unseen patterns enables organizations to implement targeted, customized solutions.

If you have questions about the SAFER Dashboard, please contact your Account Executive at The Joint Commission. 

# What's Your Question?

## What's Your Solution?

Readers are invited to share their questions and solutions regarding common compliance challenges

Readers who seek best practice suggestions from other organizations or who would like to share their own solutions to common EC, LS, or EM challenges should email Carolyn Schierhorn, Executive Editor, at [cschierhorn@jcrinc.com](mailto:cschierhorn@jcrinc.com). Please put "What's Your Solution?" or "What's Your Question?" in the subject line of the email. The best questions and answers will be published in future issues of *EC News*.

**APPLICABLE PROGRAMS: AHC, CAH, HAP, NCC**

### **Q. What are The Joint Commission's requirements and recommendations regarding crash carts?**

**A.** Crash carts contain high-risk medical equipment, such as defibrillators and suction machines, so deficiencies would often be cited under either of the following Environment of Care (EC) standards:

- ▶ **EC.02.04.01:** The [organization] manages medical equipment risks.
- ▶ **EC.02.04.03:** The [organization] inspects, tests, and maintains medical equipment.

The equipment on crash carts should be addressed in the organization's written plan for managing medical equipment, required by EC.01.01.01, element of performance (EP) 8. The organization's written policy should detail the frequency of inspecting the contents of medical carts, checking for expired supplies and medications, restocking supplies and medications as needed, and testing and maintaining the equipment in accordance with the manufacturer's instructions for use or an alternative equipment maintenance program.

Crash carts are always considered to be "in use," so a crash cart along a corridor wall near patient or resident rooms will not be cited for blocking the means of egress.

The Joint Commission doesn't detail specific requirements for crash carts, also known as emergency carts, in the *Comprehensive Accreditation Manual* or its E-dition® counterpart. The "Provision of Care, Treatment, and Services" chapter states that resuscitation equipment and supplies should be based on the needs of the population served. The organization must be able to respond immediately

in the event that a patient or nursing care center resident has a life-threatening medical emergency.

The FAQ section of JointCommission.org, however, addresses a couple of issues pertaining to crash carts in the realms of battery power maintenance and medication security:

► **Are crash carts and defibrillators required to be plugged into emergency power receptacles?**

The Joint Commission does not require battery-powered emergency carts and defibrillators on standby for medical emergencies to be plugged into emergency power receptacles to maintain charging of the batteries; however, this is considered best practice. The Joint Commission does require that a process be in place to maintain the battery charge during a prolonged normal electrical power outage. Non-battery-powered emergency carts and defibrillators should be plugged into an emergency power receptacle during use. Also, be sure to follow the manufacturers' instructions for use.

► **Can you clarify what is required for medication security on crash carts? Is the use of a breakaway tag that includes a numeric identification number and a defined process to monitor cart integrity considered an acceptable approach?**

The Joint Commission requires that medications be stored in a secure manner to prevent tampering, theft, or diversion in accordance with law and regulation. Considering the intended nature and use of emergency carts, organizations must balance security with the requirement that emergency medications and their associated supplies are readily available when needed.

While organizations are responsible for ensuring the security of the contents of an emergency cart, use of devices (such as padlocks) that could create delays or barriers to immediate access to emergency medications and supplies is discouraged and could potentially lead surveyors to interpret these carts as “not readily accessible for use.”

When a security device is used, the intent would be to use an appropriate device that allows the organization to detect tampering while not creating a barrier or delay in the staff's ability to access the emergency supplies in the cart. Use of a breakaway tag with a numeric identification number is acceptable, as long as there is a defined process to monitor the integrity of the breakaway lock.

It is recommended that organizations conduct a risk assessment of the various options available for securing emergency cart contents. The results of the risk assessment will enable leaders to make decisions and design processes that best serve the delivery of safe, quality emergency care while maintaining the integrity of emergency medications and supplies. Note that emergency carts containing medications located in departments that are not staffed 24/7 must be secured in a locked location.

## Common problems with crash carts

In 2017, The Joint Commission issued a *Quick Safety* bulletin titled “Crash Cart Preparedness,” which lists the following patient safety concerns, among others:

- Missing, expired, damaged, contaminated, and unavailable equipment or medications
- Empty oxygen tanks
- Drained batteries on equipment or equipment failure
- Unsecured carts or carts that have been tampered with
- Carts secured with heavy-duty tape and/or padlocks that prevent immediate access
- Carts not checked or inspected according to an organization’s policies and procedures
- Carts that can’t be located because they’re not in a specified location
- Staff unfamiliar with the items commonly stored on the crash cart or procedures for using the cart during a life-threatening emergency

Surveyors have also observed these issues with crash carts:

- Suction machines that don’t work or that lack critical accessories and supplies (such as connecting tubing, canisters, and suction catheters)
- Expired defibrillator pads
- Lack of documentation that a crash cart was checked per policy

## Best practice tips for crash carts

To improve patient safety when crash carts are needed, Joint Commission surveyors and the *Quick Safety* bulletin share a number of best practice solutions from the field:

- ▶ Conduct a risk assessment, identifying crash cart issues that have occurred or that potentially could occur.
- ▶ Label each drawer of the crash cart for contents, indicating the expiration dates of supplies, as applicable.
- ▶ Incorporate crash carts into emergency exercises and drills and simulate life-threatening medical emergencies such as cardiac or respiratory arrest.
- ▶ When training staff on how to use crash carts and the related equipment and supplies, validate their learning through return demonstration and hands-on practice.
- ▶ Reduce complexity through standardization and simplification; if possible, reduce the number of items on a cart that need to be checked.

- ▶ Maintain crash carts in locations that are easily accessible and make sure clinical staff know where they are.
- ▶ Create a process for restocking and replacing the contents of a crash cart and communicate that process to all applicable clinical staff.
- ▶ Make sure that your written policy or plan regarding crash carts addresses equipment, supplies, medications, inventory management, emergency protocols, training and competency of staff, emergency drills and simulation exercises, and assignment of responsibility for continued oversight of the process.

Because they contain high-risk medical equipment and emergency medications and are used to save lives, crash carts must be taken seriously. Systematizing the processes and procedures involving their use will go a long way toward championing safe, high-quality patient care. 

# Other Learning Opportunities from The Joint Commission and Joint Commission Resources

These resources will enhance your knowledge of the environment of care, life safety, and emergency management.

## 2021 Environment of Care/Life Safety Webinar Series

### ► Environment of Care/Life Safety: Compliance Issues in the Physical Environment

- Ligature Risks: What’s New—available September 15, 2021
- “Life Safety” Chapter Surveys—available December 15, 2021

## Live Virtual Conferences

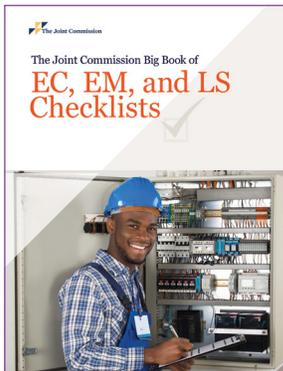
**Environment of Care and Life Safety Chapter for Ambulatory Care**—July 19–22, 2021

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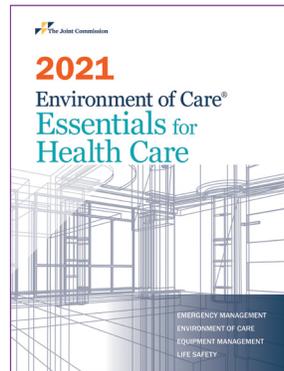
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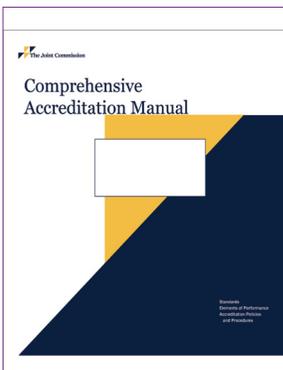
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Dozens of downloadable, sample policies and procedures required by Joint Commission standards, reviewed and approved by The Joint Commission. Four modules currently available:



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