

The Environment of Care Compliance Manual

Sixth Edition



Thomas J. Huser, MS, CHSP, CHEP

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Downloadable materials (available at www.hcpro.com/downloads/13732): Management Plans, Chapter Files.



About the Author

Thomas J. Huser, MS, CHSP, CHEP

Thomas J. Huser, MS, CHSP, CHEP, brings more than 33 years of experience to bear on his position as safety coordinator, Emergency Management and Hazardous Materials, with Indiana University Health in Indianapolis. As the current safety officer for a physicians group with over 100 practices and with experience ranging from hospital management to emergency preparedness planning to fire safety instruction, Huser brings both administrative and real-world knowledge to his work in healthcare safety.

A master-level Certified Healthcare Safety Professional (CHSP) and a master-level Certified Healthcare Emergency Professional (CHEP), Huser is well versed in Environment of Care chapter sections, including safety, security, hazardous materials and wastes, fire prevention, medical equipment, and the functional environment. Huser also has expertise in the Emergency Management and Life Safety chapters of The Joint Commission's *Comprehensive Accreditation Manual for Hospitals*.

Before joining Indiana University Health, Huser worked for St. Vincent's Hospital in Indianapolis as the manager of health and safety for the hospital's organizational safety department and was a consultant for the St. Vincent Health-affiliated facilities. A volunteer firefighter for the past 37 years, Huser is a certified National Fire Protection Association (NFPA) fire instructor II/III and a state-certified hazardous materials instructor. He is currently a volunteer with the Cicero Indiana Volunteer Fire Department, where he has been a member since 2001. He was the healthcare representative on the Marion County, Indiana, Local Emergency Planning Committee and served as a hospital representative on numerous other planning groups.

Huser writes for the *Journal of Healthcare Security*. He has given presentations at such gatherings as the Ascension Health Safety Conference, the NFPA World Fire and Safety Conference, and the National Earthquake Conference.

About the Author

Huser holds a master's degree in health and safety management from Indiana State University, a bachelor's degree in business administration from Indiana Wesleyan University, and an associate's degree in applied fire science from Ivy Tech State College of Indiana.



Preface

It has been several years since the fifth edition of this manual was published. In this time, many things have changed, and many things have remained the same.

I have gone through two Joint Commission accreditation cycles. We are still planning for large-scale terrorist attacks, and we now must deal with emerging illnesses such as Ebola and Zika.

The Joint Commission for the Accreditation of Health Care Organizations changed its name to The Joint Commission. Congress passed the Affordable Care Act, which continues to turn health-care upside down. Physicians groups and smaller hospitals are either closing or merging with larger healthcare organizations. Medicaid and Medicare, along with insurance companies, are placing tighter constraints on the quality of outcomes, as well as greater emphasis on prevention. Patients themselves must now spend more of their own money on healthcare, prompting a consumer revolution in how they spend their healthcare dollars. All of this means that traditional healthcare has to become “lean and mean” to survive in the new healthcare environment.

For us, that translates to less money to spend on our programs. To get buy-in from leadership, we have to provide greater justification as well as clear returns on investment before studies for the implementation of projects and the hiring of personnel. I find that, as hospitals move to a “do more with less” response, more and more people who previously had little or no experience with the Environment of Care (EC) now have responsibilities in this area of compliance.

Not only is The Joint Commission making more demands for compliance, but so are governmental agencies. One such example is the Environmental Protection Agency’s enforcement of the Resource Conservation and Recovery Act (RCRA). Healthcare providers are now required to collect and properly dispose of their waste medications, which had previously gone down the drain or into the regular trash. Implementation of such programs can easily cost a 200-bed hospital \$90,000 annually or more depending on the program and amount of waste generated. The Joint Commission enforces this requirement when conducting surveys.

My involvement in the healthcare profession came via a nontraditional path. I worked first as a fire investigator for the Indiana Fire Marshal Department before taking on the role of security

supervisor/safety officer at St. Vincent Carmel (Indiana) Hospital, a 100-bed hospital that opened in 1985. My first experience with The Joint Commission came two years after my arrival at St. Vincent Carmel. At that time, The Joint Commission was still using the Plant Technology Safety Management (PTSM) method to conduct surveys. Following the PTSM method, individual areas were surveyed separately. Each section was vertically integrated, meaning that the requirements for compliance did not integrate with other sections of the chapter. Today, EC compliance requires cross-referencing and integration not only within areas of the EC chapter but also within areas such as Care of Patient and Human Resources. The survey was very much a learning experience. Prior to entering healthcare, I had never been involved in an accreditation survey. The closest that I had come was undergoing the Inspector General survey while I was in the military. The accreditation requirements were overwhelming at first, as was the documentation. Coming from a non-healthcare background, I found the reality of the compliance issues facing healthcare to be an eye-opening experience.

I now have more than 33 years' experience working in the healthcare field. Over that time, I have witnessed many changes in The Joint Commission's survey process. Gone are the silos, now replaced by the laterally aligned EC. With the implementation of the EC in 1995, a major shake-up occurred in the way hospitals were surveyed. Higher expectations were placed on medical facilities to meet the demands of EC. For example, cooperation with other areas of the hospital became important to ensure that the necessary training was completed and to determine the competency of the staff. Traditional requirements, such as fire drills, disaster drills, and compliance with National Fire Protection Association (NFPA) and Occupational Health and Safety Administration (OSHA) rules remained in place. However, we also have new and ever-changing demands placed upon us. Currently, OSHA is beginning to enforce its voluntary requirements in the same manner as its mandatory requirements. Recent articles have indicated that the Ergonomic Standard, which is currently voluntary, will be enforced as a mandatory regulation. This means that hospitals will need to implement an ergonomic program or risk a citation from OSHA. This also applies to other voluntary standards such as the workplace violence program. Another example is the *Statement of Conditions*TM. This requires hospitals to conduct a thorough inventory as to their compliance with the National Fire Protection Association's (NFPA) *Life Safety Code*[®] and document the deficiencies and the repairs.

This book will assist you in navigating through the ever-changing EC requirements. As you will read in Chapter 1, The Joint Commission continues to evolve the EC. Initially, the changes may seem minor; however, they can have a significant impact on your program and your organization. New and updated sample forms are also provided to aid you in compliance, including completed revised management plans for all seven primary sections of the EC: Safety, Security, Hazardous Materials and Wastes, Emergency Management (formerly Disaster Preparedness), Fire Prevention, Medical Equipment, and Utilities. An eighth EC chapter requires proof that you have put into practice all of the aforementioned sections—and that you are working for continuous improvement. In order to comply with the EC, you must also be familiar with NFPA and OSHA

recommendations and regulations. This book will also help you to understand how both the NFPA and OSHA requirements have become part of The Joint Commission's requirements.

Chapters 2 through 8 detail each of the EC management plans, from planning through implementation. Chapter 9 reviews methods for providing documentation that your organization has implemented the seven management plans. Chapter 10 assesses the latest hot spots in the EC chapter, including details on pitfalls suffered by other organizations and what surveyors will be looking for when they come calling. This chapter and the "Survey Hot Spots" listed after each chapter, have been updated to reflect changes in survey emphasis.

Share this EC information with anyone in your facility—from the CEO on down—who has responsibility for compliance so they can better understand The Joint Commission's expectations and find support for fulfilling these obligations.

This book will assist you and your organization in assessing where your facility stands in terms of compliance with the EC chapter. It will also give you direction on how to improve your compliance and how to attain compliance in areas where you may be deficient; the book also provides sample forms to help you prepare for your next survey.

Creating an effective EC program can be challenging. Given that, it should not be undertaken by just one or two staff members. The EC process is a team effort that requires support from the board of directors on down to all employees. The EC also extends past the walls of the hospital to all locations the hospital owns, including those that do not involve patient care.

My hope is that this book makes the EC process more easily understood, especially by those who now find themselves involved for the first time, so that you comply with The Joint Commission's standards. I wish you the best of luck with your next survey.



Strategies for the Environment of Care

In the evolution of the Environment of Care (EC) chapter, The Joint Commission is taking a closer look at methods of survey preparation and reporting, as well as the integration of personnel in meeting accreditation imperatives.

The goal of EC management, according to The Joint Commission, is to “provide a safe, functional, supportive, and effective environment” to ensure quality, safety, and care of buildings, equipment, and people.

A Brief History of PTSM and EC Function

Before 1995, The Joint Commission separated the Plant Technology Safety Management (PTSM) requirements into four sections: utilities and preventive maintenance; fire prevention; disaster preparedness (now known as emergency management); and safety, which included the subcategory of hazardous materials and infectious waste. These standards were independent of each other and could function in silos, or independent units. Thus, the person in charge of the utility program did not necessarily have to share information with the person heading the safety program.

This changed in 1995, under the new direction of Ode Keil, The Joint Commission’s PTSM director. Keil’s responsibilities involved overseeing and creating surveys and standards, which comprised standards development, survey process development, and surveyor education. Under Keil, The Joint Commission implemented a radical change: the alteration of the PTSM to the EC chapter. The changes included the expansion of EC sections, continued emphasis on emergency management, renewed focus on patient safety, and different survey methodologies.

Expansion of EC sections

The four PTSM chapters were expanded to eight sections: safety, security, hazardous materials and wastes, emergency management (formerly disaster preparedness), fire prevention, medical equipment, utilities management, and the newest section, functional environment (formerly

appropriate environment). That final chapter requires facilities to document adherence to the aforementioned requirements and demonstrate efforts toward continuous improvement. This includes employee orientation and education, drills (to ensure knowledge and readiness), and testing and maintenance of operational components. The new section requires regular reporting, such as a comprehensive annual report to the board of directors, and the board's approval of performance improvement (PI) initiatives.

The expansion of the EC will continue in 2020, with the addition of 37 new EPs and changes in how EC is surveyed, mostly due to the changes required by CMS to maintain compliance. Gone are the days of looking for trends or having a management plan to demonstrate continuous compliance. All it takes is one fire door not closing properly or one missed fire extinguisher to earn a citation.

In 2017, four of the top nine elements of performance (EP) cited by The Joint Commission during surveys were from the EC chapter. The number one EP cited in 2017 was EC.02.05.01, which requires hospitals to control the risks associated with their utilities. In 2017, 80% of the hospitals surveyed were cited for noncompliance of one or more EPs in this section, which is an increase of 7% from the previous year. The other three top-cited sections for 2018 were:

- ▲ EC.02.06.01: Establishment and maintenance of a functional and safe environment was cited 72% of the time and was ranked #3
- ▲ EC.02.05.05: Requirement of the maintenance, testing, and inspection of the hospital's utility systems was cited 64% of the time and was ranked #7
- ▲ EC.02.02.01: Requirement of the hospital to manage the risks associated with hazardous materials was cited 61% of the time and was ranked #9

The other EPs in the top nine were from the Life Safety and Infection Control chapters of the accreditation manuals, including hospitals, critical access hospitals, nursing centers, and other Joint Commission-accredited facilities.

Continued emphasis on emergency management

The EC's continued emphasis on emergency management came at a time when these issues were brought to mainstream attention. Although it is generally understood that hurricanes Katrina and Rita did not initiate the revision of EC.4.20—the prevailing belief is that changes were in development for years—the catastrophic damage and subsequent controversy surrounding response to these events certainly contributed to a new examination of the emergency management section and, to a lesser degree, utilities management.

Adding to this continued emphasis were the new requirements from CMS that became effective in November 2017. These requirements have far-reaching effects on all healthcare entities, including inpatient and outpatient care facilities, and including hospitals.

Because of the increasing importance of emergency preparedness in our world today, The Joint Commission has completely removed the emergency management section from the EC chapter and placed it in its own chapter of the compliance manual. Because of this change, I will not discuss the expectations for emergency management in this manual. As superstorm Sandy demonstrated in 2012, while hospitals and governments have put into place corrective actions in response to some of the mistakes learned from Katrina, there is still significant progress that can be made. Further demonstration of this can be found in the aftermath of the F-5 tornado that wiped out a hospital in Joplin, Missouri, as well as the impact of other natural disasters.

Continued emphasis on patient safety

These experiences also brought to the fore concerns about patient safety from all sides and from all sources—from extreme natural disasters to the more common train derailments, bus crashes, subway fires, mass shooting events, and increased risk of terrorism across the globe.

Since the last edition, we have experienced the H1N1 worldwide pandemic, which tested the ability of many facilities to provide proper personal protective equipment for staff for an extended period of time. The world also witnessed the Ebola outbreak in Africa, which brought to light the lack of planning for such epidemics in the United States and across the globe. Fortunately, the world mobilized and was able to contain the illness mostly to the countries of origin.

Patient safety challenges are not limited to illnesses, however. Hospitals, which at one time were sanctuaries, are also facing an increase in violence within their walls. Crime—especially assaults and in some instances shootings—has now entered, threatening both patients and staff.

Changes in method of survey

With the implementation of the EC in 1995, a major shake-up occurred in the way hospitals were surveyed. Higher expectations were placed on medical facilities to meet EC demands. Cooperation with other areas of the hospital became necessary to ensure that required training was completed and to determine the competency of the staff. Traditional requirements, such as fire drills, disaster drills, and compliance with standards and codes set out by the Occupational Safety and Health Administration (OSHA) and the National Fire Protection Association (NFPA), remained in place. Added to the new and updated requirements is the treatment of “voluntary” measures as mandatory, in areas involving, for example, workplace antiviolence programs and the filing of the Statement of Conditions (SOC). The SOC requires hospitals to conduct a thorough inventory of their compliance with the NFPA *Life Safety Code*®, as well as documentation of their deficiencies and repairs. Both the NFPA and OSHA codes and standards have become part of The Joint Commission’s requirements.

The Joint Commission Today: What to Expect in the Upcoming Year

With the 2018 overhaul of the EC chapter and the additions to the Life Safety and Emergency Management chapters, there is a lot to keep an eye on in the coming year, including the following:

- ▲ More multidisciplinary National Patient Safety Goals, covering topics such as alarm fatigue, which involves not just nursing but also clinical engineering, safety, security, and others to reduce the number of false alarms and thus lessen the potential for a real alarm to be missed by staff.
- ▲ Violence in the workplace, including plans for dealing with an active shooter and response to patient-on-staff and staff-on-staff violence. I know of a hospital that received a requirement for improvement for failing to have a written active shooter response policy. These are issues that must be addressed by strong multidisciplinary groups.
- ▲ Enforcement of the Environmental Protection Agency (EPA) Resource Conservation and Recovery Act (RCRA) standards, especially for the disposal of medications and medication waste from pharmacies. Although the RCRA standard has been in place since October 1976, with the exception of healthcare's bulk hazardous waste, hospitals had been overlooked. The EPA and The Joint Commission are now looking more closely at hospitals and how they dispose of all wastes.

The Key to EC Compliance: Strong Team, Strong Plan

Successful EC compliance hinges on a well-planned, well-executed team approach that has the support of the administration and the staff.

The plan

Each section of the EC requires a management plan, which gives the surveyor an overview of the way the facility is addressing the requirements of each standard. All management plans need to be identical in format to show the surveyor that the people responsible for the EC chapter work as a team and communicate well with each other. This also shows the surveyor what processes your facility uses to ensure compliance with each section of the EC chapter.

For safety and security, you have the option of having one plan for both or separate plans for each. How you choose to implement the plan(s) is up to you; there is no right or wrong. I suggest letting the size and complexity of the facility dictate whether they are separate or together: The larger and more complex your facility and program, the greater the need for separate plans. Inversely, the smaller and less complex the facility, the greater the justification for only one plan. The same goes for your committees: You can have one all-encompassing committee or divide

committees by functionality and/or reporting within the facility. In some places, it might make sense to combine the medical equipment and utilities committees, while at other larger and more complex facilities, these need to be separated.

When creating or updating your management plans, it is advisable to not include direct chapter and EP numbers, as these are subject to change and you would then need to revise your plans to match the current numbering system. Also pay attention to the numbering of your policies. For example, in a recent review in our hospital, some surveyors were confused because our EC policies carried an “EC” designation to denote that they affected the EC—titled “EC 1.XX,” “EC 2.XX,” etc. Rather than changing all of our policy numbers, we added the word “policy” to all such references, so they now read “Policy EC 1.XX,” “Policy EC 2.XX,” etc. The easier it is for the surveyors to discern what you have done, the easier the survey will go for you, as well.

Completely updated management plans for each of the sections are available as downloads with this book.

The team

The EC chapter should not be administered by just one or two people, especially with the advent of the unannounced survey. One facility I know of has chapter facilitators who are responsible for ensuring compliance with a particular chapter and for providing support personnel who assist in ensuring compliance. For example, the director of facilities and security is responsible for the utilities management section. He has support from various managers and supervisors and is also cofacilitator for the chapter. Another example is the director of clinical engineering. Numerous staff members support the reporting and activities in the maintenance of this section. Because of the size of this facility, 15 people directly assist the chapter facilitators. And this does not begin to encompass members of the support staff, who conduct the day-to-day activities related to the EC.

The number of people on your team will vary depending upon the size of your facility. Some suggested team members might include people from senior management, facilities/engineering services, safety, security (if applicable), clinical engineering/biomedical, infection control, nursing administration, and off-site locations, along with any “facilities” within your facility.

Make sure that all players come together on a regular basis, not just before a survey. They must be familiar with their roles during a survey and be comfortable discussing issues and processes with the surveyor. Holding regular meetings also allows new members to become familiar with the survey process and to see how your facility responds to survey questions. The week before a survey is not the time to get everyone together for the first time—rather, such meetings should be part of the ongoing EC process.

The support

The team can't make anything happen without support from the top brass. The success of the EC program depends upon the support of senior management, up to and including the board of directors. This support is needed for many reasons, the most important being financial—when compared with other Joint Commission chapters, the EC chapter is likely the most expensive with which to comply. However, it is not an overstatement to say that lives of patients and staff depend upon compliance with this chapter.

If you have any doubts as to the potential for disaster if compliance is not maintained, simply look at recent history. People are still dying in fires in healthcare facilities; people still die from inhalation of improper gases through the central gas-distribution system. Imagine what would happen to patients on life support if your facility lost power and the emergency generators failed. Likewise, the ramifications of improper maintenance of a defibrillator could be devastating. The Joint Commission requires that the board of directors be informed of all such deficient areas and of all actions being taken to correct them.

It is sometimes difficult to garner the support of leadership, especially in today's healthcare environment. Funds are tight, and it can be a challenge to justify spending money for a new generator, for example, when you have never had one fail—especially when a physician requests funding for a revenue-producing project.

The EC chapter deals in the area of “what-ifs”—what if something goes wrong? You might have a plan in place to deal with the world's what-ifs, but projects based on what-ifs are extremely hard to get approved—even if your facility has experienced similar failures or disasters. The “lightning never strikes twice” mindset shows itself here.

There is no clear-cut formula that will guarantee funding for your projects. It takes a time-proven, well-established working relationship between senior management and your EC team on all levels to make your program succeed.



Safety and Security

Standards covered under this chapter: EC.01.01.01, EC.02.01.01, EC.02.01.03

This chapter closely examines elements of performance (EP) for planning and implementation of the safety and security programs for your facility. Interestingly, some feel the safety and security compliance areas of the Environment of Care (EC) require full-time safety and security personnel, but none of the EC programs requires such a position. Instead, one staff member absorbs the role of “safety officer” or “security coordinator” into his or her responsibilities. New this year is the actual combination of the safety and security sections of the EC. This change will aid the small facility that does not have the resources or the need for personnel dedicated to these functions. However, the new standards do allow the option of separating these functions as evidenced by the continued requirement for individual management plans for safety and security.

If you work in a large or medium-size facility, you might have the resources to dedicate specific personnel to handle survey programs, but if you work in a hospital of just 16 beds, you probably employ a staff person to fill multiple roles to ensure compliance with standards set out by The Joint Commission. Whatever the size of your facility, you will want to establish as the basis for your safety program the Standards for General Industry (29 CFR 1910) set out by the Occupational Safety and Health Administration (OSHA). The Joint Commission now trains its surveyors on how to survey facilities for compliance with OSHA regulations.

Please note that The Joint Commission has changed the numbering of the standards and their associated EPs. I will follow each standard and the associated EP as I have in the previous editions of this handbook.

Did You Know

Chapters 2 through 8 of this book cover the individual sections of the EC chapter. The book also reviews the EC planning and implementation phases in addition to “hot-button” issues to make your survey process easier. Remember, the foundation of each program is the management plan discussed in Chapter 1 and designed for each section.

EC Scoring

The Joint Commission standards that require documentation as proof of compliance will have a “D” enclosed in a circle to the left of the EP. Throughout this book, each EP will have a string of letters that correspond to the prepublication scoring categories. Please refer to the following key, and be sure to review the final version when it becomes available:

Scoring Key	D	Requires at least 12 months of documentation to show compliance
	R	Indicates a patient safety risk
	CMS	Crosswalk
	ESP-1	The Element of Performance (EP) applies to Early Survey Option
	NEW	Indicates that this is a new or changed EP

Time frames

Timing frames for compliance were defined beginning in 2014. Previously, you could self-define “annual” by calendar year; now it is defined as being one year from the previous time, plus or minus 30 days. Below is a list of the acceptable intervals for purposes of compliance:

- ▲ Three years or every 36 months equals 36 months from the previous time, plus or minus 45 calendar days
- ▲ 12 months or annual, or yearly equals one year from the previous time, plus or minus 30 calendar days
- ▲ Six months or semi-annual equals six months from the previous time, plus or minus 20 calendar days
- ▲ Every quarter or quarterly equals three months from the previous time, plus or minus 10 calendar days
- ▲ Every month, monthly, or 30 days equals once each calendar month and 12 times per year
- ▲ Weekly equals each calendar week

EC.01.01.01: Minimizing EC Risks

What the standard says

The facility minimizes risks in the EC through planned activities.

Why the standard is important

EC.01.01.01 lays the foundation for your safety program with a mind toward the safety risks inherent in the operations of the facility in providing patient care, monitoring the staff's daily activities, and maintaining the facility's physical environment. You will need to establish a program that ensures that your safety policies cover the entire facility and consistently reflect your organization's mission, vision, and values. EC.01.01.01 also reinforces the need for support from your organization's leadership in meeting these goals.

New for 2009 is the inclusion of the six management plans needed to demonstrate compliance with The Joint Commission's standards. Previously, the requirement for a management plan was stated under each section. No more; the requirements for the management plans are now in EC.01.01.01, which clearly establishes this section as the foundation for the EC.

Although the wording is very concise, the standard conveys a great deal of meaning. It tells you to create a program that addresses the safety of patients, visitors, and employees. This may sound simple, but The Joint Commission and OSHA combined have numerous regulations and criteria for you to follow. The Joint Commission uses the following criteria to measure your facility's compliance with this section.

Elements of performance

SCORING: ESP-1 R CMS: 482.41(d)(2), 482.41(c)(1), 482.41(c)(2)	1. The facility identifies individuals designated by the leadership who are responsible for the development, implementation, and monitoring of the safety management program. Also see EC.01.01.01, EP 1.
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The Joint Commission leaves the selection of the safety officer to the discretion of your organization's leadership. This person need not possess a degree in safety management or safety engineering or any safety-related certifications. However, once you choose this person, you will have to defend his or her qualifications. A safety officer's tasks include development, implementation, and monitoring of safety plans for compliance. I have seen the role of safety officer filled by people with all types of backgrounds—nurses, maintenance personnel, and administrators. Your human resources department should develop a job description and job qualifications for this position.

SCORING:	2. Not used
-----------------	--------------------

Survey Hot Spots

- ▲ **Failure to maintain a management plan:** The management plan is the basis for the safety program, and without detailing methods of training, performance measurements, and improvements completed, your program cannot exist.
- ▲ **Failure to conduct safety assessments:** Conduct these assessments on a semiannual basis for patient care areas and annually for all other areas. The Joint Commission does not require that the safety officer conduct the assessments; it requires only that they are completed, that they are tracked, and that corrective actions are taken. It is just as important to track the completion rate of assessments.
- ▲ **Failure to keep a current Safety Officer Statement of Authority (SOA):** It is easy to allow the SOA document to get out of date. If your facility has frequent turnover in senior leadership, be sure the new leader signs the letter.
- ▲ **Failure to develop a practical smoking policy:** Do not set yourself up to fail. Be realistic about the policy requirements and their application.
- ▲ **Failure to conduct a safety evaluation every 12 months:** This evaluation provides a snapshot of your accomplishments and identifies other steps for compliance.
- ▲ **Failure to rely on personnel:** A well-organized safety program leads to Joint Commission compliance and meeting the requirements of OSHA, the state health department, and the U.S. Department of Labor. In addition, such programs help resolve workers' compensation cases—and, for that matter, lawsuits brought by any patient, visitor, or employee. Having a good safety program in place improves employee morale through high visibility and employee contact with the safety officer. It also demonstrates the facility's commitment to a safe working environment. The prevention of injuries to employees, patients, and visitors far outweighs the cost of adhering to all of the safety requirements.

Figure 2.1 The SOA Form

Safety Officer Statement of Authority	
<p>The Safety Officer and his/her designees are authorized on behalf of the Safety Committee, and with the support of hospital management, to initiate appropriate and immediate remedial action if failure to take such immediate action might result in personal injury to individuals or damage to equipment or to other property.</p> <p>The Safety Officer's authority to initiate remedial action shall be limited to cases of personal injury or damage to property and shall, when in the case of possible personal injury, be further limited to nonmedical and safety matters. The Safety Officer is not authorized to intervene in cases where treatment of the patient might be in question or when his or her education, training, and experience clearly do not qualify him/her to act.</p>	
<p>_____</p> <p>Chief Executive Officer</p>	<p>_____</p> <p>Chief of Medical Staff</p>
<p>_____</p> <p>Date</p>	<p>_____</p> <p>Date</p>
<p><i>Source: Thomas J. Huser. Reprinted with permission.</i></p>	

Figure 2.2 Blank Witness Statement Form

<p>Case #: _____ CAD#: _____</p>	
<p>Statement made by: _____ Date: _____</p>	
<div style="border: 1px solid black; min-height: 150px; padding: 10px;"> <p>Narrative:</p> </div>	
<p><i>Source: Thomas J. Huser. Reprinted with permission.</i></p>	

Figure 2.3 Blank Supplement Form

Case #: _____ CAD#: _____

Reported by: _____ Date: _____

Narrative:*Source: Thomas J. Huser. Reprinted with permission.***Figure 2.4** Injury Information Sheet**Visitor/Volunteer injury information statement**

If you are a visitor or volunteer who has fallen or has been injured while on (Hospital) premises, as a courtesy, (Hospital) offers an initial evaluation and physician examination in the appropriate (Hospital) emergency room. The evaluation includes initial first aid treatment and diagnostic x-rays and, if appropriate, initial evaluation for blood or body fluid exposures, including baseline infectious disease testing and testing of any identified source patient. An initial evaluation does not include prescribed drugs, therapies, vaccines, specialist fees, or treatment in addition to the initial evaluation.

You are not responsible for the cost of the initial evaluation. If you should receive a bill for the initial evaluation, please contact Hospital Administration at (phone number).

Any costs not related to your initial evaluation are your responsibility. If you choose not to have an initial evaluation, any future treatment will be at your expense.

Your signature on this statement does not waive any legal rights that you may have. It indicates that you have been informed of the availability of a courtesy initial evaluation, what is included in the initial evaluation, and what costs are covered in the initial evaluation.

- ☐ I have read and understand the above statement and would like an initial evaluation in the appropriate (Hospital) emergency department.
- ☐ I have read and understand the above statement and do not want an initial evaluation at the appropriate (Hospital) emergency department.

Chief Executive Officer_____
Chief of Medical Staff_____
Date_____
Date*Source: Thomas J. Huser. Reprinted with permission.*

Figure 2.5 Fall/Injury Report

Case #: _____ CAD#: _____

Officer: _____ Date: _____

Incident: ☐ Fall ☐ Injury**Status:** ☐ Patient ☐ Visitor ☐ Employee ☐ Other**Occurred:****Location of incident:****Reported:****Reported by:****Status:** ☐ Patient ☐ Visitor ☐ Employee ☐ Other**Address:****Telephone #:****Victim:****Status:** ☐ Patient ☐ Visitor ☐ Employee ☐ Other**Address:****Telephone:****DOB of victim:****Reason given for fall/injury:****Type of surface:****Condition of surface:** ☐ Wet ☐ Water ☐ Ice ☐ Other☐ Dry ☐ Smooth ☐ Rough—Rocks/Holes/Debris**Shoe type:** ☐ Flats ☐ Heels ☐ Other**Glasses:** ☐ Yes ☐ No**Was the victim wearing them?** ☐ Yes ☐ No**Nature of injury:** ☐ Bruise ☐ Laceration ☐ Sprain ☐ Fracture ☐ Burn ☐ Other**Complaint of pain:****Were there visible signs of injury?** ☐ Yes ☐ No**What visible signs of injury?****Location of injury:** ☐ Head ☐ Arm (☐ left ☐ right) ☐ Hand (☐ left ☐ right) ☐ Other☐ Leg (☐ left ☐ right) ☐ Foot (☐ left ☐ right)

The Environment of Care Compliance Manual

Sixth Edition

Thomas J. Huser, MS, CHSP, CHEP

The Environment of Care Compliance Manual, Sixth Edition, provides all the guidance safety officers need to comply with The Joint Commission's Environment of Care standards and corresponding CMS requirements. Author **Thomas J. Huser, MS, CHSP, CHEP**, discusses topics such as safety and security, hazardous materials and waste, fire prevention, medical equipment, life safety, utilities management, and management plans, delivering imperative information in a hassle-free format.

This valuable resource also includes policies and procedures, forms, and tools that can be easily downloaded and customized to use at your organization.

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