About Joint Commission Resources

Joint Commission Resources (JCR) is a client-focused, expert resource for healthcare organizations. It partners with these organizations, providing consulting services, educational services, and publications to assist in improving the quality, safety, and efficiency of healthcare services, and to assist in meeting the accreditation standards of The Joint Commission. JCR is a subsidiary of The Joint Commission, but provides services independently and confidentially, disclosing no information about its clients to The Joint Commission or others. Visit our web site at: www.jcrinc.com.

Disclaimers

Joint Commission Resources educational programs and publications support, but are separate from, the accreditation activities of The Joint Commission. Attendees at Joint Commission Resources educational programs and purchasers of Joint Commission Resources publications receive no special consideration or treatment in, or confidential information about, the accreditation process.

The information in this Resource Guide has been compiled for educational purposes only and does not constitute any product, service, or process endorsement by The Joint Commission or organizations collaborating with The Joint Commission in the content of these programs.

NOTE: Interactivation Health Networks is the distributor of the Joint Commission Resources Quality & Safety Network series and has no influence on the content of the series.
# TABLE OF CONTENTS

- Program Summary ................................................................................................................................................. 4
- Program Outline ..................................................................................................................................................... 5
- Continuing Education (CE) Credit ........................................................................................................................ 6
- Top 10 Most Challenging Clinical Standards ................................................................................................. 7
- Ongoing Discovery of High-Level Disinfection of Endoscope Practices and the Use of
  Performance Improvement Methodologies to Improve Processes ................................................................. 15
- 5 Sure-Fire Methods: Complying with Standard PC.02.01.03 ............................................................................ 19
- Time to Close the Door on Medication Storage Challenges: How to Comply with MM.03.01.01 ............ 21
- Top 5 Most Challenging EC, LS Standards .................................................................................................... 24
- Tips for Succeeding During a Life Safety Building Tour .................................................................................. 29
- In the Clear: The Importance of Maintaining the Integrity of the Means of Egress ..................................... 32
- Appendix A: Additional Resources .................................................................................................................... 36
- Appendix B: Faculty Biographies ....................................................................................................................... 37
- Appendix C: Continuing Education (CE) Accrediting Bodies ......................................................................... 39
- Appendix D: Discipline Codes Instructions ....................................................................................................... 40
- Appendix E: Post-Test .......................................................................................................................................... 41
- Appendix F: JCRQSN Contact Information ....................................................................................................... 43
Program Summary

This page provides an overview of the program content and learning objectives. Please refer to the Table of Contents and Program Outline for a detailed list of the topics covered. The information included in this Resource Guide is intended to support but not duplicate the video presentation content. There may be additional information available online for this topic.

Program Description

Each year, The Joint Commission collects and analyzes standards compliance data to identify areas that accredited organizations and certified programs find most challenging. Equipped with these data, The Joint Commission can do the following:

- Identify trends.
- Focus education on these requirements.
- Update accreditation and certification manuals, as needed.
- Compare compliance data against data that it collects on standards inquiries from accredited or certified organizations to determine any correlation.

Through expert panel discussion and video case studies, this 60-minute program addresses the most recent challenging standards and provides examples of how your peer organizations are meeting these challenges.

Program Objectives

After completing this activity, the participant should be able to:

1. List The Joint Commission hospital standards identified as the most challenging for the field.
2. Implement practical solutions to help meet these challenges.
3. Create a work plan for implementing these solutions within your organization.

Target Audience

This activity is relevant to all healthcare leaders, medical staff, risk management professionals, performance improvement (PI) directors/Joint Commission coordinators, and nurse leaders.
Program Outline

Complying with the Most Challenging Joint Commission Standards
October 27, 2016

I. Introduction
   A. Program Content
   B. Objectives
   C. Faculty

II. Challenging Clinical Standards
   A. Identification of Challenging Standards
   B. Tips for Compliance Success

III. Challenging Environment of Care and Life Safety Standards
   A. Identification of Challenging Standards
   B. Tips for Compliance Success

IV. Conclusion

V. Post-Program Live Question and Answer Session
   A. Audio only telephone seminar with program faculty – for 30 minutes following the program.
   B. Call 1-888-206-0090; enter conference code: 7925428.
      Or e-mail your questions or comments to: Questions@jcrqsn.com

<table>
<thead>
<tr>
<th>Program Broadcast Time</th>
<th>Eastern:</th>
<th>Central:</th>
<th>Mountain:</th>
<th>Pacific:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2:00 p.m. to 3:00 p.m.</td>
<td>1:00 p.m. to 2:00 p.m.</td>
<td>12:00 p.m. to 1:00 p.m.</td>
<td>11:00 a.m. to 12:00 p.m.</td>
</tr>
</tbody>
</table>

Program Question and Answer Session

During the live airing of this program on October 27, 2016, you may be able to talk directly with the faculty when prompted by the program’s host. After this date, your message will be forwarded to the appropriate personnel.

Immediately following the program, we invite you to join in a live discussion with the program presenters. Call 1-888-206-0090 and enter Conference Code: 7925428 to be included in the teleconference.

To submit your question ahead of time or for additional details, please send an e-mail to questions@jcrqsn.com. If you submit your questions after this date, your message will be forwarded to the appropriate personnel.

You can also receive answers to your questions by calling The Joint Commission’s Standards Interpretation Hotline at 630-792-5900, option 6.
Continuing Education (CE) Credit

After viewing the JCR Quality & Safety Network presentation and reading this Resource Guide, please complete the required online CE/CME credit activities (test and feedback form). The test measures knowledge gained and/or provides a means of self-assessment on a specific topic. The feedback form provides us with valuable information regarding your thoughts on the activity’s quality and effectiveness.

NOTE: Effective April 1, 2012, the Learning Management System web site URL changed as noted below.

Prior to the Program Presentation Day
1. Login to the JCRQSN Learning Management System web site at http://twnlms.com/
2. Enroll yourself into the program
   Note: Your administrator may have already enrolled you in the program
   • Select All Courses from the courses menu.
   • Select the course category for the current year, 2016 Programs.
   • Select the course for this program, Complying with the Most Challenging Joint Commission Standards
   • When prompted, choose Yes to confirm that you would like to enroll yourself.
3. Display and print the desire documents (Resource Guide, etc.).

Online Process for CE/CME Credit
1. Read the course materials and view the entire presentation.
2. Login to the JCRQSN Learning Management System web site at http://twnlms.com/
3. Select Complying with the Most Challenging Joint Commission Standards from the courses menu block.
   Note: This assumes you have already been enrolled in the program as described above.
4. If you didn’t view the broadcast video presentation, view it online.
5. Complete the online post test (see Appendix E).
   • You have up to three attempts to successfully complete the test with a minimum passing score of 80%.
   • Physicians must take the post test to obtain credit.
6. Complete the program feedback form.
7. On the top right corner of the main course page, you will see your completion status in the Status block.
8. Select Print Certificate from within the Status block to print your completion certificate.
Top 10 Most Challenging Clinical Standards

Standard IC.02.02.01
The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Elements of Performance for IC.02.02.01
The hospital implements infection prevention and control activities when doing the following:

1. Cleaning and performing low-level disinfection of medical equipment, devices, and supplies.†
   
   Note: Low-level disinfection is used for items such as stethoscopes and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions.

2. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.‡ (See also EC.02.04.03, EP 4)
   
   Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.

3. Disposing of medical equipment, devices, and supplies.
4. Storing medical equipment, devices, and supplies.
5. When reprocessing single-use devices, the hospital implements infection prevention and control activities that are consistent with regulatory and professional standards.

NOTE: The R and D icons seen in this list indicate notes that relate to The Joint Commission's accreditation standards. For more specific information, please refer to the accreditation manuals.

†For further information regarding cleaning and performing low-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html.

‡For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Effective January 1, 2017
Standard PC.02.01.03

The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

Elements of Performance for PC.02.01.03

1. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.‡

   **Note:** Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:
   
   • Responsible for the care of the patient
   • Licensed to practice in the state where he or she provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements
   • Acting within his or her scope of practice under state law
   • Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services

7. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital provides care, treatment, and services using the most recent patient order(s).

20. Before taking action on a verbal order or verbal report of a critical test result, staff uses a record and “read back” process to verify the information.

Standard RC.01.01.01

The hospital maintains complete and accurate medical records for each individual patient.

Elements of Performance for RC.01.01.01

1. The hospital defines the components of a complete medical record.

5. The medical record contains the information needed to support the patient’s diagnosis and condition.

6. The medical record contains the information needed to justify the patient’s care, treatment, and services.

7. The medical record contains information that documents the course and result of the patient’s care, treatment, and services.

8. The medical record contains information about the patient’s care, treatment, or services that promotes continuity of care among providers.

   **Note:** **For hospitals that elect The Joint Commission Primary Care Medical Home option:** This requirement refers to care provided by both internal and external providers.

11. All entries in the medical record are dated.

19. **For hospitals that use Joint Commission accreditation for deemed status purposes:** All entries in the medical record, including all orders, are timed.

‡For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).
Standard PC.01.03.01
The hospital plans the patient’s care.

Elements of Performance for PC.01.03.01

1. The hospital plans the patient’s care, treatment, and services based on needs identified by the patient’s assessment, reassessment, and results of diagnostic testing. *(See also RC.02.01.01, EP 2; PC.01.02.13, EP 2)*

5. The written plan of care is based on the patient’s goals and the time frames, settings, and services required to meet those goals.

   **Note:** *For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient’s goals include both short- and long-term goals.*

6. **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** The written plan of care includes the following:
   - A substantiated diagnosis (The substantiated diagnosis is the diagnosis identified by the treatment team to be the primary focus upon which treatment planning will be based. It evolves from the synthesis of data from various disciplines. The substantiated diagnosis may be the same as the initial diagnosis or it may differ, based on new information and assessment.)
   - Documentation to justify the diagnosis and the treatment and rehabilitation activities carried out
   - Documentation that demonstrates all active therapeutic efforts are included
   - The specific treatment modalities used to treat the patient

22. Based on the goals established in the patient’s plan of care, staff evaluate the patient’s progress.

23. The hospital revises plans and goals for care, treatment, and services based on the patient’s needs. *(See also RC.02.01.01, EP 2)*

25. The hospital establishes or adopts diagnostic computed tomography (CT) imaging protocols based on current standards of practice, which address key criteria including clinical indication, contrast administration, age (to indicate whether the patient is pediatric or an adult), patient size and body habitus, and the expected radiation dose index range.

   **Note:** *This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.*

26. Diagnostic computed tomography (CT) imaging protocols are reviewed and kept current with input from an interpreting physician, medical physicist, and lead imaging technologist to make certain that they adhere to current standards of practice and account for changes in CT imaging equipment. These reviews are conducted at time frames identified by the hospital. (For hospitals that use Joint Commission accreditation for deemed status purposes, refer to MS.06.01.03, EP 9 for supervision of radiologic services)

   **Note:** *This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.*

43. **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** The plan of care includes the responsibilities of each member of the treatment team.

44. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** Patient self-management goals are identified, agreed upon with the patient, and incorporated into the patient’s treatment plan. *(Refer to RI.01.02.01, EP 1)*
45. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses clinical decision support tools to guide decision making. (Refer to LD.04.04.07, EPs 1-5)

**Standard LD.01.03.01**

The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

**Elements of Performance for LD.01.03.01**

1. The governing body defines in writing its responsibilities.
2. The governing body provides for organization management and planning.
3. The governing body approves the hospital’s written scope of services. (See also PC.01.01.01, EP 7)

   **Note:** For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to the “Medicare Requirements for Hospitals” appendix.

4. The governing body selects the chief executive responsible for managing the hospital.
5. The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. (See also NR.01.01.01, EP 3)
6. The governing body works with the senior managers and leaders of the organized medical staff to annually evaluate the hospital’s performance in relation to its mission, vision, and goals.
7. The governing body provides the organized medical staff with the opportunity to participate in governance.
8. The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff.
9. Organized medical staff members are eligible for full membership in the hospital’s governing body, unless legally prohibited.

20. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home evaluates the effectiveness of how the primary care clinician and the interdisciplinary team partner with the patient to support continuity of care and comprehensive, coordinated care.

21. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The governing body is responsible for making sure that performance improvement activities reflect the complexity of the hospital’s organization and services, involve all departments and services, and include services provided under contract. (For more information on contracted services, see Standard LD.04.03.09)

**Standard MM.04.01.01**

Medication orders are clear and accurate.

**Elements of Performance for MM.04.01.01**

1. The hospital has a written policy that identifies the specific types of medication orders that it deems acceptable for use.

   **Note:** There are several different types of medication orders. Medication orders commonly used include the following:
   - As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom
• Standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances
• Automatic stop orders: Orders that include a date or time to discontinue a medication
• Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient’s status
• Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval
• Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient’s status
• Orders for compounded drugs or drug mixtures not commercially available
• Orders for medication-related devices (for example, nebulizers, catheters)
• Orders for investigational medications
• Orders for herbal products
• Orders for medications at discharge or transfer

The hospital has a written policy that defines the following:

2. The required elements of a complete medication order.
3. When indication for use is required on a medication order.
4. The precautions for ordering medications with look-alike or sound-alike names.
5. Actions to take when medication orders are incomplete, illegible, or unclear.
6. The hospital minimizes the use of verbal and telephone medication orders.
7. The hospital reviews and updates preprinted order sheets, within time frames it identifies or sooner if necessary, based on current evidence and practice.
8. The hospital prohibits summary (blanket) orders to resume previous medications.
9. A diagnosis, condition, or indication for use exists for each medication ordered.

Note: This information can be anywhere in the medical record and need not be on the order itself. For example, it might be part of the medical history.

10. The hospital defines, in writing, the circumstances for which weight-based dosing is required for pediatric populations. (See also MM.01.01.01, EP 1)

Note: This element of performance is also applicable to sample medications.

13. The hospital implements its policies for medication orders.

14. The hospital requires an order from a doctor of medicine or osteopathy or, as permitted by law and regulation, a hospital-specific protocol(s) approved by a doctor of medicine or osteopathy to administer influenza and pneumococcal vaccines.

15. For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following:
• Review and approval of standing orders and protocols by the medical staff and the hospital’s nursing and pharmacy leadership
• Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines
• Regular review of such standing orders and protocols by the medical staff and the hospital’s nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols

• Dating, timing, and authenticating of standing orders and protocols by the ordering practitioner or another practitioner responsible for the patient’s care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.

21. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses an electronic prescribing process.

Standard IC.02.01.01
The hospital implements its infection prevention and control plan.

Elements of Performance for IC.02.01.01
1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

2. The hospital uses standard precautions, including the use of personal protective equipment, to reduce the risk of infection. (See also EC.02.02.01, EP 4)

Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients.

3. The hospital implements transmission-based precautions in response to the pathogens that are suspected or identified within the hospital’s service setting and community.

Note: Transmission-based precautions are infection prevention and control measures to protect against exposure to a suspected or identified pathogen. These precautions are specific and based on the way the pathogen is transmitted. Categories include contact, droplet, airborne, or a combination of these precautions.

5. The hospital investigates outbreaks of infectious disease. (See also IC.01.05.01, EP 5)

6. The hospital minimizes the risk of infection when storing and disposing of infectious waste. (See also EC.02.02.01, EPs 1 and 12)

7. The hospital implements its methods to communicate responsibilities for preventing and controlling infection to licensed independent practitioners, staff, visitors, patients, and families. Information for visitors, patients, and families includes hand and respiratory hygiene practices. (See also HR.01.04.01, EP 4)

Note: Information may have different forms of media, such as posters or pamphlets.

8. The hospital reports infection surveillance, prevention, and control information to the appropriate staff within the hospital.

9. The hospital reports infection surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with law and regulation.

10. When the hospital becomes aware that it transferred a patient who has an infection requiring monitoring, treatment, and/or isolation, it informs the receiving organization.

†For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).

‡For further information regarding transmission-based precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).
11. When the hospital becomes aware that it received a patient from another organization who has an infection requiring action, and the infection was not communicated by the referring organization, it informs the referring organization.

**Note:** Infections requiring action include those that require isolation and/or public health reporting or those that may aid in the referring organization’s surveillance.

**Standard PC.02.01.11**

Resuscitation services are available throughout the hospital.

**Elements of Performance for PC.02.01.11**

1. Resuscitation services are provided to the patient according to the hospital’s policies, procedures, or protocols.

2. Resuscitation equipment is available for use based on the needs of the population served.

   **Note:** For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)

4. An evidence-based training program(s) is used to train staff to recognize the need for and use of resuscitation equipment and techniques.

**Standard MM.03.01.01**

The hospital safely stores medications.

**Elements of Performance for MM.03.01.01**

2. The hospital stores medications according to the manufacturers’ recommendations or, in the absence of such recommendations, according to a pharmacist’s instructions.

   **Note:** This element of performance is also applicable to sample medications.

3. The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation.

   **Note 1:** Scheduled medications include those listed in Schedules II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

   **Note 2:** This element of performance is also applicable to sample medications.

4. The hospital has a written policy addressing the control of medication between receipt by an individual health care provider and administration of the medication, including safe storage, handling, security, disposition, and return to storage.

   **Note:** This element of performance is also applicable to sample medications.

5. The hospital implements its policy addressing the control of medication between receipt by an individual health care provider and its administration.

   **Note:** This element of performance is also applicable to sample medications.

6. The hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.

   **Note:** This element of performance is also applicable to sample medications.
7. All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.

Note: This element of performance is also applicable to sample medications.

8. The hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration.

Note: This element of performance is also applicable to sample medications.

9. The hospital keeps concentrated electrolytes present in patient care areas only when patient safety necessitates their immediate use, and precautions are used to prevent inadvertent administration. (See also MM.01.01.03, EP 2)

18. The hospital periodically inspects all medication storage areas.

Note: This element of performance is also applicable to sample medications.

19. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a pharmacy directed by a registered pharmacist or a supervised drug storage area, in accordance with law and regulation.

Note: This element of performance is also applicable to sample medications.

24. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains records of the receipt and disposition of radiopharmaceuticals.

Standard PC.02.02.03

The hospital makes food and nutrition products available to its patients.

Elements of Performance for PC.02.02.03

6. The hospital prepares food and nutrition products using proper sanitation, temperature, light, moisture, ventilation, and security.

7. Food and nutrition products are consistent with each patient’s care, treatment, and services.

9. When possible, the hospital accommodates the patient’s cultural, religious, or ethnic food and nutrition preferences, unless contraindicated.

11. The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.

22. For hospitals that use Joint Commission accreditation for deemed status purposes: A current therapeutic diet manual approved by the dietitian and medical staff is available to all medical, nursing, and food service staff.
Ongoing Discovery of High-Level Disinfection of Endoscope Practices and the Use of Performance Improvement Methodologies to Improve Processes

Donna Armellino, RN, DNP, CIC

Preventing health care-associated infections, regardless of the setting (hospital, ambulatory, office-based), has become a priority. This focused attention can be attributed to leaders motivated to improve the quality of care with highly reliable, repetitive, evidence-based process practices; patient expectations of an uncomplicated health care experience; increased awareness of reported infections; and financial implications (positive and negative) to the organization. A topic that has recently become a main concern is high-level disinfection (HLD) and endoscopes used for endoscopic retrograde cholangiopancreatography (ERCP) procedures, as represented in the Food and Drug Administration (FDA) Safety Communication in February 2015.¹ Increased infection risk may reflect the complexity of the endoscope device, which contains many small working parts with hidden, often difficult to reach, crevices, and/or reprocessing errors, which can occur during any of the steps for precleaning, manual cleaning, HLD process, and endoscope storage.

An endoscope can be rendered free of harmful pathogens when the endoscope’s manufacturer guidelines are adhered to, HLD instructions for use are followed, and the endoscope is managed in ways that impede achieving a pathogen-free endoscope can include competency of those who perform HLD, as well as their adherence to the manufacturer’s multistep manual-cleaning guidelines for each scope and/or the HLD’s instructions for use (for example, temperature parameters and minimal effective concentration), plus the environment in which HLD is performed and endoscopes are stored.⁴ ⁵ The use of performance improvement methodologies and expert guidance from the literature and other organizations can facilitate the identification of HLD practice gaps that contribute to failures that lead to endoscope-associated infections and subsequent movement toward optimal practices to minimize the risk of cross contamination.

In their article, “Assessment of Endoscope Reprocessing Using Peer-to-Peer Assessment Through a Clinical Community,” in this issue of The Joint Commission Journal on Quality and Patient Safety, Teter and colleagues report on an assessment of HLD practices of endoscopes to guide improvement.⁶ Tapping into existing resources and following a peer-to-peer nonpunitive collaborative approach, the authors used a survey and tracer tool at 15 ambulatory practices to collect data on the current state of HLD and endoscope use. They aggregated the data to identify practice gaps and fed back the data to the practices, which were ranked by deficiency, and then conducted group discussions to develop improvement strategies. Lack of education/training and standardized processes ranked as the two predominant issues. These issues can contribute to inadequate HLD, possibly resulting in a contaminated endoscope and pathogen transmission, because transmission of infections can occur if inadequate cleaning is performed and recommended guidelines are not followed.⁴ ⁵ The fact that this process was implemented before the FDA Safety Communication¹ (and the ERCP infections that prompted the FDA action) is impressive.

For physicians, nurses, technicians, and administrators responsible for conducting or overseeing HLD, the article identifies possible issues that could contribute to an undesirable outcome—a contaminated endoscope linked to a patient infection. The approach taken by the authors can assist others in conducting an evaluation to prioritize an improvement approach, and their assessment findings can be used as the starting point to standardize processes as per endoscope manufacturer guidelines, HLD instructions for use, and external guidelines.² After an HLD standard is developed, education and training can be conducted, followed by ongoing assessment in terms of standard measurements that are aggregated to provide data on progress, feedback of the data to those conducting and overseeing the process, and the implementation of ongoing data-based changes to comply with practice standards and sustain performance. The peer-to-peer
assessment reported by Teter et al. is similar to the approach taken at Northwell Health early in 2015 following the release of the FDA’s Safety Communication of infections following ERCP procedures.¹

At Northwell Health (formally known as the North Shore-LIJ Health System), a health system with 21 hospitals, long term care facilities, and more than 450 ambulatory practices, we conducted an assessment, which in each case was completed by the site-specific infection preventionist and HLD area-specific management, and then implemented changes on the basis of the evaluation of practices in HLD locations in which reprocessed endoscopes were identified. Our own intervention also predated the alarm accompanying news of the ERCP infections, which allowed us to react proactively when it was announced. In summary, the following actions were taken:

- All HLD locations and endoscopes reprocessed were identified.
- Compatibility letters for each endoscope and method of HLD or sterilization were validated.
- HLD policies and procedures were reviewed and standardized to create a set of HLD procedural reference documents for all HLD areas within the health system.
- Competencies, based on manufacturer instructions for cleaning and reprocessing, were written, and all health care personnel (HCP) performing HLD was deemed competent through direct observation.
- HLD procedures and products (for example, automated endoscope reprocessors [AERs], flushing devices, magnification mirrors) were standardized.
- Endoscope tracers from precleaning to storage were conducted to identify variances from approved policies and procedures by health system resources. Just-in-time training and practice modifications were introduced as issues were identified.
- An environmental assessment of the HLD reprocessing areas was conducted and work-flow modifications were made to support a one-way flow to minimize cross contamination.
- A point-of-use test for ERCP endoscopes was introduced to support a clean endoscope after manual cleaning and before receiving HLD.
- All ERCP endoscopes were cultured once, and negative microbiology results were reported.
- An RN was reallocated to perioperative corporate services to support endoscopic practices and lead continuous HLD process improvement.
- Monthly meetings with those who oversee HLD were coordinated by the RN from perioperative corporate services to discuss and implement meticulous cleaning of the elevator with an enzymatic cleaner and specific brush, proper-positioning angle (45°) of the ERCP elevator during reprocessing, flushing the scope with isopropyl alcohol after reprocessing, hanging the endoscope in a horizontal vented cabinet between use, reprocessing scopes every 14 days, and tagging clean scopes as “clean” following HLD. The group continues to meet to discuss and implement best practices based on practice discoveries within their practice environment, published in the literature, and/or from expert guidance.

We also explored the use of remote video auditing (RVA) technology to assess the multistep manual cleaning of ERCP endoscopes, which is undertaken before HLD. In October 2015 a Northwell Health hospital committed to ensuring adherence to the ERCP endoscope manual-cleaning steps, as outlined by the endoscope manufacturer and external resources.²,³ Cameras were placed within the endoscope reprocessing area with a feed into a digital video recorder that was accessed by a third-party auditing company. The recorded activity provided the auditors with a high-resolution complete view of the sinks used to manually clean the endoscopes before they were placed into the AER. Trained auditors, located external to the facility, viewed video of the activity, including the ability to zoom into close-up video imagery of precise reprocessing processes, such as proper cleaning of the scope tip elevator. After the auditors observed an ERCP endoscope
being placed in the reprocessing sink by the HCP, his or her compliance with each item on the checklist, as well as the total duration of cleaning, were recorded. The auditors assigned a Pass to each item on the checklist when the HCP completed each task and the amount of time spent to complete the entire checklist was recorded. Conversely, auditors indicated a Fail when an HCP missed tasks on the checklist. What we learned is that the 41-item manual-cleaning ERCP checklist can be viewed and scored with the use of RVA. Monitoring, feedback, and reeducation with the support of leadership have increased audit compliance results from less than 50% to greater than 90%, which is similar to findings reported in other studies using RVA.7-9 The success of RVA and ERCP endoscope cleaning has led to their expansion to other Northwell Health hospitals.

To continue the health system’s improvement journey, the Joint Commission High-Level Disinfection (HLD) and Sterilization BoosterPak™ (BoosterPak), which is intended “to ensure practices are carried out following regulatory standards and evidence-based guidelines for HLD and sterilization in order to minimize the potential risk of infection transmission to patients,” became the basis for the development of a health system tool, “High-Level Disinfection (HLD) of Semi-Critical Devices Assessment.”10 This tool has two components to the risk assessment. The first section identifies HLD areas, HCP training and competencies, reprocessing environment, HLD practices based on endoscope manufacturer guidelines, HLD instructions for use, and health system HLD policies and procedures.** The second section is an HLD observation tool used to assess current practice and quantify near misses and/or practice variations. The observation tool guides observation of practices, and when observation does not align with outlined standards, immediate actions, which may include just-in-time training and practice modifications to avoid potential HLD failures, are taken. Examples of observations and changes based on standardized policies and procedures include precleaning at point of use prior to transporting the endoscope to the reprocessing area, endoscope manual cleaning within an hour of use, removal of tip protectors on stored endoscopes, wearing clean gloves when handling disinfected endoscopes, and keeping accessories with the endoscope or conversion to disposable accessories. What we have learned is that the BoosterPak, coupled with improvement methodologies, can lead to improved practice advancements and quality. The ongoing cyclical evaluation of performance measurement data, which are analyzed to identify improvement or maintain optimal practice, supports reliability through subsequent elimination of error.11 In this improvement process, near misses and practice variations (attributed to drift from the ideal state, shortcuts taken to complete the task, or deficits in knowledge due to lack of training or the relative infrequency of the task being performed) can be identified.11 We, as leaders in the health care delivery system, are responsible for the care we deliver and have to always remember that associated with every infection is a patient (and family) who expected high-quality care and services, not harm. Patient safety improvements focused on HLD do not necessarily require large investments; reallocation of organizational resources, accountability, and ongoing assessment to ensure process reliability should continue to evolve HLD processes to optimize patient safety.

* A Standards BoosterPak™ is a searchable document intended to provide detailed information about a single standard or topic area that has been associated with a high volume of inquiries or noncompliance scores in the health care field. Booster-Paks are available on the secure Joint Commission Connect™ extranet to organizations accredited and certified by The Joint Commission.

**The risk assessment can be requested from the author at darmelli@northwell.edu.
References


5 Sure-Fire Methods: Complying with Standard PC.02.01.03

Joint Commission Provision of Care, Treatment, and Services (PC) Standard **PC.02.01.03** requires that organizations provide care, treatment, and services as ordered or prescribed, and in accordance with law and regulation (see the sidebar below for the entire standard). This was one of the most challenging standards for hospitals during 2015, with 40% of those surveyed found to be noncompliant.

According to Heather Martin, RN, MSN, MBA, associate project director, Department of Standards and Survey Methods, The Joint Commission, one of the reasons why hospitals are having difficulty with compliance is that there seems to be a misunderstanding about key elements of the standard. “For example, protocols sometimes are considered orders, but the medical record must contain an order to implement the protocol, as well as the protocol itself,” she says.

Melissa Hager, RN, CMS consultant, Joint Commission Resources, says that this standard can be particularly difficult for hospitals that are providing outpatient services to patients whose physicians do not have privileges at the hospital. “The hospital and the governing medical staff have to have methods to ensure that the physician who has written the order is licensed in the state in which the patient is receiving care, is responsible for the patient, is practicing within his or her scope of practice, and is authorized by state law and organizational policies to order the care, treatment, or service,” she says.

**Organizations have a responsibility to ensure that health care providers operate within their scope of practice, licensure, and clinical privileges.**

Lack of compliance on the part of the practitioner can also contribute to noncompliance with Standard PC.02.01.03. “Element of Performance (EP) 1 states that hospitals must obtain or renew orders from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. **Note:** Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:

- Responsible for the care of the patient

### Related Requirements

**Standard PC.02.01.03**
The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

**Elements of Performance for PC.02.01.03**

1. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.

**Note:** Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:

- Responsible for the care of the patient

- Licensed to practice in the state where he or she provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements

- Acting within his or her scope of practice under state law

- Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services

7. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital provides care, treatment, and services using the most recent patient order(s).

20. Before taking action on a verbal order or verbal report of a critical test result, staff uses a record and “read back” process to verify the information.
staff bylaws, rules, and regulation,” Martin says. “That can sometimes be challenging for organizations that don’t have standardized processes.”

Such challenges can have repercussions for the organization as well as patients. For those hospitals that use Joint Commission accreditation for deemed status purposes, failure to comply with Standard PC.02.01.03, EPs 1 and 7 can also affect Medicare status in the following ways:

- If a Medicare Condition of Participation (CoP) is cited as a standard level finding, it will result in the need to submit Evidence of Standards Compliance (ESC) before a recommendation for Medicare certification can be made.
- If a CoP is cited as a condition-level finding, it will result in a Medicare deficiency follow-up survey for organizations that are already Medicare certified, and in a new initial Medicare survey for organizations that are not currently Medicare certified.

Martin and Hager offer the following five strategies to help hospitals to better comply with Standard PC.02.01.03:

1. **Develop standardized policies for practitioner orders.** “Policies should include how the organization will handle orders for outpatient services by non-privileged practitioners and also how verbal orders will be handled,” says Hager. “Verbal orders, including telephone orders, should only be used for emergencies.” Martin adds, “Policies and procedures regarding ordering and prescribing and verbal and/or written orders need to be clearly communicated to practitioners and staff.”

2. **Conduct randomized audits.** “Use post-audit data tools and communicate results to practitioners and staff,” Martin says. “It’s up to you to create tools that will work for your organization, but you might be able to find information that will help by looking at state guidelines, nursing association guidelines, medical association websites, and The Joint Commission’s Leading Practice Library.”

3. **Outline a process for dealing with staff who are found noncompliant.** “Develop a standardized policy for disciplinary procedures if your organizational policy is not being met,” says Martin. “Your risk management and human resources departments should be able to help you determine what actions will be taken.”

4. **Develop a multidisciplinary medical records task force.** “The task force should meet regularly to discuss current issues related to documentation within your organization,” Martin says. “It’s important that the team be multidisciplinary because your policies will affect multiple practitioners, such as physicians, nurses, and data entry staff.”

5. **When migrating to an electronic medical record, conduct a risk assessment.** “Use the risk assessment to determine how your protocols will be associated within the individual patient medical record,” says Martin. “This should include how the protocols will be signed, dated, and timed.”

Copyright 2016 The Joint Commission
The Source, May, Volume 14, Issue 5
Time to Close the Door on Medication Storage Challenges: How to Comply with MM.03.01.01

Refrigerated medications, controlled substances, sample medications, and emergency medications—all these types of medications, along with any others dispensed in your health care organization, must be properly stored to maintain medication integrity, keep medications available, minimize the risk of medication diversion, and reduce potential dispensing errors.

Despite the importance of safe medication storage, many organizations still struggle with this concept. Joint Commission data from the first six months of 2010 show that 31% of hospitals, 27% of critical access hospitals, 25% of ambulatory care organizations, 19% of office-based surgery practices, 14% of long term care organizations, and 12% of behavioral health care organizations were not compliant with Medication Management (MM) Standard MM.03.01.01, which requires organizations to safely store medications.

Why does safe medication storage continue to be a challenge for many health care organizations?

There are 18 elements of performance (EPs) for MM.03.01.01 across the multiple accreditation programs, and noncompliance with one EP means an organization can be scored not compliant with the standard. Sometimes staff members responsible for medication storage and security are unfamiliar with or are unclear about all of the standard’s requirements. Those EPs cover the following areas:

- Ensuring appropriate conditions for medication storage
- Securing controlled substances
- Requiring policies that pertain to handling, storage, security, and return of medications from provision/dispensing by the pharmacy until administration to the patient
- Labeling stored medications
- Inspecting medication areas
- Handling expired medications

Here are some suggestions from Joint Commission experts on how various types of health care organizations can improve their compliance with safe medication storage:

**TIP Do a comprehensive assessment of current practice.** Your organization needs to determine its specific policies and procedures related to medication storage as well as your actual practice and where there are holes. “Often, organizations think they are performing this function well when they actually aren’t,” says Donna Tiberi Blaszczyk, R.N., associate director, Standards Interpretation Group, The Joint Commission. “Closely examining the medications an organization stores, how it stores them, and whether practices reflect Joint Commission requirements is critical to determine areas of success and areas that need improvement.” For example, The Joint Commission requires organizations to follow manufacturers’ recommendations when storing medications, in effect turning those recommendations into requirements. Ensuring that storage procedures follow manufacturers’ recommendations should be part of any assessment.

**TIP Review law and regulation.** Every state has specific laws and regulations that relate to medication storage. Your organization should review current laws and regulations and have a process for receiving any updates to these laws and regulations. “If an organization, such as a long term care organization, has many facilities across several states, the organization may want to consider using the strictest state’s laws and regulations to govern the medication storage at all its facilities,” says Lynette Foster, R.N., associate director, Standards Interpretation Group, The Joint Commission. “This ensures that every facility complies with law and regulation.”

**TIP Consult with the pharmacy or a pharmacist.** Pharmacists can be a key resource when designing effective medication storage programs. In a hospital, pharmacists are most likely on site and can easily participate in improvement projects targeting medication storage. In long term care and ambulatory care organizations, this is a little more challenging; however, consulting pharmacies, nearby hospital
“Pharmacists can help not only with determining the best ways to store medications but also with identifying any special storage needs and ensure that any recalled medications are removed from your organization,”

**Lynette Foster, R.N., associate director, Standards Interpretation Group, The Joint Commission.**

Pharmacists, and even commercial pharmacies can be valuable resources. “Pharmacists can help not only with determining the best ways to store medications but also with identifying any special storage needs and ensure that any recalled medications are removed from your organization,” says Foster.

**TIP Address controlled substances.** One key component of medication storage is the safety and security of controlled substances. This may involve locking—sometimes even double locking—and medications in a secure area and closely monitoring the use of those medications. Monitoring efforts may include the use of a log or other documentation that records when a particular substance is removed from storage, who removes it, how much is used, how much is wasted, and what is done with that waste. Your organization should consider monitoring these logs at least daily, and staff should be trained to recognize inappropriate use of controlled substances and possible drug diversion.

Because controlled substances can be considered a security risk, your organization may want to conduct a specific risk assessment on this aspect of medication storage to identify current procedures, possible risk points—including risks for diversion—and effective strategies for reducing risk. One strategy is to use a number lock instead of a keyed lock to prevent access to controlled medication. Only those individuals who should have access to the controlled substance are given the number, thus preventing individuals who should not have access from overcoming the lock.

**TIP Ensure proper temperature.** Many medications must be stored at a specific temperature. When that temperature can be reached only through refrigeration, you must have a valid and reliable way to measure temperature to ensure its consistency. “Some medications—such as vaccines—must be maintained at a constant temperature or they will break down,” says Foster. “It is critical in cases such as these that the organization has a temperature monitoring system and that the system is regularly checked. Staff should know how to check the monitoring system and what to do when a constant temperature is not maintained.”

There are a variety of ways to monitor temperature, and The Joint Commission does not require a specific method. For example, some organizations use an automated temperature monitoring system that has an alarm that sounds if the temperature drops below the required value. Other organizations use a thermometer that can show the temperature over the past 72 hours. With this type of system, staff can examine the temperature logs every morning to see if the temperature has remained constant throughout the past 24 hours.

For home care or hospice organizations, maintaining the proper temperature of medications can be particularly difficult. For example, if a nurse is visiting several patients in a day and brings their medications with him or her in the car, the nurse must ensure that he or she does not leave any medications requiring a controlled temperature in the car for too long. “Leaving a controlled-temperature medication in the car during extreme weather can destabilize the medication,” says Foster. Ideally, the nurse should deliver any refrigerated medications to patients early in the day, or, if that is not possible, have the medications delivered directly to the patient to avoid fluctuations in temperature.

**TIP Have a contingency plan for temperature system failure.** Even if your organization has state-of-the-art refrigeration equipment, that equipment may fail, or the power may be disrupted, thereby disabling the system. Your organization therefore needs a backup plan. The plan should be clearly defined, and staff should be familiar with it. For example, if the refrigeration unit fails, staff should know whom to call—typically the supervisor.
and the facility maintenance department—and how to ensure the safety of the medication. If the refrigerator is connected to emergency backup power, leaving the medication in place may be appropriate. In other cases, disposing of the medication or putting it on dry ice and delivering it to another unit, department, or facility may be the best course. Enlisting pharmacists’ assistance in these situations is critical in determining the continued usability of the medication.

**TIP Store medications by use.** One frequent problem with medication storage involves look-alike, sound-alike medications. “To avoid inadvertent mix-ups, organizations should refrain from storing medications alphabetically,” says Blaszczyk. “Instead, they should consider storing them by use, for example, putting all the asthma medications together and all the diabetes medications together.”

Your organizations should also examine the packaging of medications to ensure that those with similar packaging are not stored next to each other.

**TIP Label high-alert medications.** Identify any high-alert medications, such as heparin and epinephrine, through the use of stickers or special labels. Such careful identification shows staff that the medication is high alert and must be handled with care.

**TIP Don’t forget sample medications.** The storage of sample medications, just like that of any other medications, is governed by law and regulation and manufacturers’ instructions. Organizations that store a large amount of sample medications—such as ambulatory care organizations—should include them in their overall assessment of medication storage and address any risk points.
Top 5 Most Challenging EC, LS Standards

#1: EC.02.06.01
• **EP 13 (challenging):** The organization maintains ventilation, temperature and humidity levels suitable for the care, treatment and services provided
  – Issues with Ventilation
    ➢ e.g., doors held open by air pressure; odors
  – Issues with Temperature
    ➢ Hot/Cold calls
  – Issues with Humidity
  – Primary concern is for areas >60%RH
    ➢ Mold growth is possible
• **EP 20 (also a challenge):** Patient care areas are clean and free of offensive odors

Issues Observed with Oxygen Cylinders

#2: EC.02.05.01
• **EP 15 (challenging):** In 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, relative humidity, and temperature
• FYI – Room Pressure
  – Supply brings air into a room
  – Exhaust removes air from a room
    ➢ Whichever is greater determines the room pressure
• FYI: Air Changes per Hour (ACH)
  – Air change is how many times the air enters and exits a room from the HVAC system in one hour
Tools for Testing Air Pressure Relationships

Screening for Air Pressure Relationships
- **Tissue test**: only to be used as a pre-screening tool to evaluate if further investigation needs to occur
  - To perform the flutter test take a tissue and let it hang just off the floor near the bottom edge of a door
  - If the tissue indicates incorrect air flow, stabilize the area by closing doors and windows, wait a few minutes and re-test
  - If the organization presents a Testing & Balancing report the following questions should be asked
    - When was the balancing done (seasonal issues)
    - Are any specific requirements (such as keeping a door closed) needed to achieve satisfactory results

Survey Process as Related to EC.02.05.01, EP 15
- Deficiencies will generate a CLD
  - If the organization can repair the process that led to non-compliance, the LSCS may review
  - Following LSCS review, the LSCS may contact the Central Office to discuss the possibility of reducing the CLD to SLD, with no change to the finding
  - Resolution should include the area affected by the equipment identified as non-compliant, not just the identified room/area
#3: LS.02.01.20

- **EP 1 (challenging):** Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side
  - Exception: locking based on clinical needs of patients requiring security measures for their safety
    - Staff must be able to readily unlock such doors
  - Exception 2 & 3: delayed and access controlled doors allowed

- **EP 13 (challenging):** Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice
- FYI – Anything in the egress corridor more than 30 minutes is storage
- FYI – Dead end corridors may be used for storage

**LS.02.01.20, EP 13**

- FYI – Carts Allowed:
  - Crash Carts
  - Isolation Carts
  - Chemo Carts

- FYI – Allowed by 2012 LSC:
  - Fixed Furnishings
  - Transport Equipment
    - Wheel Chairs
    - Lifts

**Non-Compliant Exit**
Example of Corridor Clutter

#4: LS.02.01.30

- **EP 2 (challenging):** All hazardous areas are protected by walls and doors in accordance with NFPA 101-2000….
  - FYI – Primarily door issues related to above
- **EP 11 (challenging):** Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.

Examples of Door Issues
#5: **LS.02.01.10**

- **EP 5 (challenging):** Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch.

- **EP 9 (challenging):** The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.

**Self Closing Rated Door Should Not be Propped Open**

**Lack of Fire-Rated Material Around Pipe**

**Top Five EC, LS Findings Comparison**

<table>
<thead>
<tr>
<th>Standard</th>
<th>2015% Noncompliance</th>
<th>2016% Noncompliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC.02.06.01</td>
<td>56%</td>
<td>62%</td>
</tr>
<tr>
<td>EC.02.05.01</td>
<td>53%</td>
<td>58%</td>
</tr>
<tr>
<td>LS.02.01.20</td>
<td>50%</td>
<td>51%</td>
</tr>
<tr>
<td>LS.02.01.30</td>
<td>43%</td>
<td>50%</td>
</tr>
<tr>
<td>LS.02.01.10</td>
<td>46%</td>
<td>46%</td>
</tr>
</tbody>
</table>
Tips for Succeeding During a Life Safety Building Tour

Joint Commission surveys can be a challenging experience for any facility manager. “Sitting down with the Life Safety Code®* surveyor to review the documents is one thing, but then the building tour has always been my biggest concern,” says Mark Kaldahl, facility support director at Carilion Franklin Memorial Hospital (CFMH). CFMH is a 37-bed, 66,605 square foot hospital located in Rocky Mount, Virginia. “Having gone through several surveys over the years, the most recent one being in June 2015, I’ve learned facility managers can lessen the stress of the building tour by putting these simple practices in place,” Kaldahl says.

Kaldahl recommends the following strategies to help prepare:

1. **Be sure your life safety drawings are up to date.** Before the life safety surveyor begins the building tour, she or he is going to want to review the life safety drawings. Drawings that are incomplete or missing information are going to send up a red flag before the building tour ever begins.

2. **Be sure the person(s) responsible for the environment of care has a good knowledge of the “Environment of Care,” “Emergency Management,” and “Life Safety” standards.** “During my recent survey the life safety surveyor told me you’d be surprised at how many facilities we go into where the person responsible for the environment of care doesn’t even have a copy of what those standards are,” says Kaldahl. It isn’t surprising that facilities don’t do well during the survey when those responsible for maintaining the building don’t even know what the life safety engineer is looking for. But it doesn’t have to be that way. To stay proficient with environment of care management, Kaldahl advises facilities personnel to take advantage of the resources and training opportunities available to them from organizations such as The Joint Commission, Joint Commission Resources, and the American Society of Healthcare Engineers.

3. **Conduct your own building tour.** The “Environment of Care” standards require environmental rounds be conducted in all patient care areas every 6 months and all other non-patient care areas annually to minimize or eliminate risks in the environment. Environmental rounds are designed to identify and correct environmental issues on a regular basis so as to keep the facility in a constant state of readiness should an outside agency stop by to inspect the facility (for example, Fire Marshal, the US Centers for Medicare & Medicaid Services, Property Insurance Carrier, or The Joint Commission). The key to obtaining positive results from these rounds is the thoroughness of those doing the rounds. “Those making the rounds must be dedicated to improving the environment,” says Kaldahl. More often than not, rounds become ineffective because they fail to document those opportunities for improvement for fear of making that area leader look bad in front of his/her peers. “But the more thorough these environmental rounds are, the better prepared the facility will be when The Joint Commission walks through the front door,” says Kaldahl.

4. **Encourage staff reporting.** Hospitals must have a process in place where staff can report building deficiencies and problems to the facilities/maintenance staff. Maintenance staff don’t typically go into every area of the hospital on a regular basis unless they are asked to do so (for example, surgery, patient rooms, ICU) but nursing and environmental services staff are in them every day. Encourage staff to report building problems through the work order system rather than just stopping one of the maintenance staff in the hall. Placing a work order in the system allows for a record to be made of the request and allows the request to be scheduled to get completed. Stopping and telling one of the maintenance workers in the hall may work at times, but more

---

*Life Safety Code®* is a registered trademark of the National Fire Protection Association, Quincy, MA.
often than not they are forgotten and never get addressed.

5. **Maintain structures for safety.** “In every hospital I’ve worked, we’ve had a program in place to maintain the integrity of everything above the ceiling tiles,” says Kaldahl. These programs included regular checks by the maintenance staff looking for penetrations, having above ceiling permits for contractors, and having agreements in place for cabling projects that ensure contractors maintain the integrity of the hospital’s fire walls during the project. “How is it then that with all these programs in place surveyors still find deficiencies above the ceilings during the building tour?” asks Kaldahl. The answer is simple: Lack of accountability.

**Conduct inspections**

“Two surveys ago I was working at a much larger facility that encompassed about 800,000 feet. It was during the last survey I participated in there that I learned the secret to surviving the life safety building tour,” says Kaldahl. During that building tour, the life safety engineer started down a long corridor on the ground floor of the hospital. By the time he inspected several smoke compartments, he told me to put the ladder away and that he was finished looking above the ceilings. His comment to me was there are so many deficiencies above the ceiling that I don’t need to look anywhere else (For example, penetrations in firewalls, ceiling grids, and lights supported by sprinkler pipes, and open junction boxes). Needless to say we received several findings on our survey from his inspection. “Although we had several programs/processes in place to ensure this didn’t happen, it did,” says Kaldahl. “I learned then, if you want to ensure the building stays in compliance, someone needs to be checking it to make sure that it is.” The old saying “you need to inspect what you expect” proved to me to be true.

With CFMH being a 66,605 feet² facility, it wasn’t very time consuming for me to do a thorough above ceiling inspection prior to our June 2015 visit by The Joint Commission. “For me it took about 18 hours,” says Kaldahl. During the inspection I filled all the fire wall penetrations I came across, installed covers on open electrical boxes, removed wires holding up lights and ceiling grids which were attached to sprinkler pipes, re-routed flexible conduit that had been wrapped around sprinkler pipes, and moved wires that were draped over sprinkler pipes with cable tie wraps. All of these things would have been found by the surveyor when s/he did the above ceiling inspection. “Much to my satisfaction, when the Life Safety Surveyor did his above ceiling inspection during our survey in June, he did not find any deficiencies in his above ceiling inspection,” says Kaldahl.

Some would say this would be easy to accomplish in a small facility like CFMH. But how do you stay on top of things in a much larger facility? “The answer is easy–divide the building into small areas, where over the course of a year you can get through the entire building,” says Kaldahl. In the large facility in which I worked, I divided the building into 12 areas. Then working with the Maintenance staff, we inspected one area per month, repairing all the deficiencies we found as we went along. We checked above ceilings, checked fire doors to ensure they closed and latched, and examined fire extinguishers to ensure they had been checked, just to name a few things on our list of things to review. By the end of the year we had gone through the entire building one time. The first cycle was very time consuming, but when we started over again the second year, the inspections were much quicker and very few repairs needed to be made.

The secret to these inspections is being thorough. “It’s important to remember that whoever is doing these inspections needs to know what to look for,” says Kaldahl. Anything short of that will result in deficiencies being found during the Life Safety Building Tour. This is where having a good knowledge of the Life Safety Standards comes into play. Many of the Life Safety elements of
performance point out things surveyors examine when doing an above ceiling inspection (For example, LS.02.01.10 EP 9, LS.02.01.30 EP 18, LS.02.01.35 EP 4). These can be used as a guide when doing above ceiling inspections.

“With all the work that was done here at CFMH preparing for our survey, I’m happy to report we didn’t receive any direct/indirect findings related to the Environment of Care,” says Kaldahl. So it can be done. Surveys don’t have to be painful. But it does take a team of dedicated individuals working together to make it happen. What’s more, someone in the facility must be accountable to make sure it all happens. But in the end it’s all worth it when you hear The Joint Commission survey team leader say “There were no direct/indirect findings to report related to the Environment of Care.” That’s what makes it all worthwhile,” says Kaldahl.
In the Clear: The Importance of Maintaining the Integrity of the Means of Egress

Patients are extremely vulnerable occupants inside a hospital, especially in the event of a fire or other emergency from which they may not be able to evacuate or relocate on their own. In an emergency situation in which the building systems fail and relocation of patients is required, staff must be able to move patients through the building. This means ensuring that corridors are free of clutter, egress doors are not locked in a manner that restricts safe passage, and ample exits are available.

Based on the 2000 edition of the National Fire Protection Association (NFPA) *Life Safety Code*, The Joint Commission’s “Life Safety” (LS) chapter includes Standard LS.02.01.20. This standard addresses the importance of maintaining the integrity of the means of egress, which applies potentially life-saving requirements in the form of 32 corresponding elements of performance (EPs).

The *Life Safety Code* defines means of egress as a continuous and unobstructed way of travel from any point in a building or structure to the public way, consisting of three separate and distinct parts:

1. The exit access
2. The exit
3. The exit discharge

The means of egress includes the doors and their hardware and fire rating; fire rating construction of the walls and ceiling enclosing the exit way and their integrity; illumination and signage identifying the pathway; and an adequate number of options for escape in case one is blocked by fire. Issues of noncompliance include obstruction of the pathway by stored or improper objects; noncompliant construction, signage, fire rating, and possible obstruction of stairs that are a part of the exit pathway; as well as points of potential confusion, such as mirrors or decorations obscuring exit doors or doors that appear to but do not lead to a continued exit pathway (for example, into an enclosed courtyard).

* *Life Safety Code®* is a registered trademark of the National Fire Protection Association, Quincy, MA.
In addition, LS.02.01.20 continues to be commonly cited by surveyors, ranking as the third-most-cited standard for hospitals during 2015, up from the fourth-most-cited standard in 2014. LS.02.01.20 ranked number one in 2013 and number two in both 2012 and 2011.

“The most problematic elements of performance (EPs) currently are numbers 13, 1, and 12 (ranked by highest to lowest survey results). Respectively, these require that exits, exit access, and exit discharges be clear of obstructions or impediments to the public way, such as clutter, construction material, and snow and ice; doors in a means of egress remain unlocked in the direction of egress; and corridor width is not obstructed by wall projections,” says John Maurer, SASHE, CHFM, CHSP, engineer with the Joint Commission’s Department of Engineering.

Corridor congestion remains a major concern, with empty beds, carts, medical equipment, mobile computer workstations (some with stationary chairs), and, in some situations, patients held in the corridor for more than 30 minutes all representing potential impediments. Keeping doors unlocked can certainly help prevent an obstructed means of egress. But for clinical or security reasons, some doors need to be locked, which can lead to deficiencies—especially when key-operated locks and electromechanical locks are involved.

Kendig says other commonly found compliance issues include unplanned or unknown openings in or damage to fire-rated egress path walls or enclosures as well as egress paths that lead to confined spaces or fail to lead to safety.

A clearer path from A to B
To resolve many of these issues and increase compliance, Maurer and Kendig recommend the following best practices:

• Implement regular and consistent environmental rounding by teams of knowledgeable personnel.

Take a Walk for Enhanced Safety

Conducting environmental rounds of the means of egress is a vital way to evaluate vulnerabilities along this imperative pathway. One approach to this process is a “Walk ‘Em Out,” suggested by James Kendig, CHSP, CHCM, HEM, field director of Life Safety Code Specialists, Survey Management and Development, which involves the following steps:

1. Choose a non-staff person, if possible, to perform this process in order to obtain an objective viewpoint.
2. Have this person walk the exit paths from their topmost point to the area of safety external to the building.
3. Be sure the integrity of walls and the function of doors and hardware are carefully examined and notes are taken on what needs attention. Be on the lookout for:
   a. Wrong turns
   b. Inadequate illumination
   c. Failed doors
   d. Damaged walls above and below the ceiling
   e. Obstruction
   f. Points of confusion or delay
   g. Locked doors or delayed systems that fail
   h. Exit sign chevrons are pointing in the right direction
For more information on this topic and further suggestions on complying with LS.02.01.20, check out these worthwhile online resources from The Joint Commission:

- Article on when to lock or not lock doors: [http://www.jcrinc.com/to-lock-or-not-to-lock/](http://www.jcrinc.com/to-lock-or-not-to-lock/)
- Leadership awareness article on LS.02.01.20, EPs 1 and 13: [http://www.jointcommission.org/assets/1/6/JCPEP_LS_0201_20_LD_Module_FINAL.pdf](http://www.jointcommission.org/assets/1/6/JCPEP_LS_0201_20_LD_Module_FINAL.pdf)

“Many of these issues result from wear and tear, temporary variance in the use of space, and other ongoing variables. Thus, regular and knowledgeable examination of the means of egress is warranted at proper intervals,” says Kendig, noting that some organizations conduct rounding on a daily, weekly or even monthly basis. (See “Take a Walk for Enhanced Safety,” page 33, for more rounding tips.)

- **Reduce clutter in the means of egress.** Some wheeled items are allowed to remain in corridors as long as they are “in use,” including equipment and carts used by hospital workers for periods less than 30 minutes. Crash carts can remain in the egress path as they are always considered “in use”; chemotherapy and isolation carts, when associated with patient care, can also be in the egress path as needed. In 2013, The Joint Commission and CMS began to allow a series of categorical waivers (CWs) based on the 2012 edition of the Life Safety Code (see November 2013 Perspectives and CMS S&C letter and CMS S&C letter 13-58-LSC). Included in the CWs is a provision to allow wheeled equipment, such as wheelchairs, portable lifts, and other patient transportation devices, in egress corridors. If the CW provision is used, the organization must ensure compliance with the conditions of the CW, document where it is applicable, and declare at the beginning of a survey where the CW is applied.
• Be sure all access-controlled egress doors and delayed-egress locks are properly installed. Doors within a means of egress are not permitted to be locked unless one of the three permissions are met, such as delayed-egress locks or access-controlled egress doors, or conditions where staff carry keys at all times.

“Means of egress affects everyone inside the facility.”
— John Maurer, SASHE, CHFM, CHSP, Joint Commission engineer

• Train and educate staff to be aware and observant of issues affecting the means of egress and implement an effective system for reporting these issues. Consider also reexamining policies, drills, and training programs to eliminate frequently found problems.

• Have a fire safety professional or architect and the local fire marshal responsible for building fire safety occasionally examine building egress paths. “While this may involve some cost, it can be important in identifying changes that may have impacted these egress paths, especially after renovation or construction projects as the means of egress may change,” Kendig adds.

• Assess and maintain locking and security mechanisms regularly to assure continuous correct and safe functioning. “Unintended locking of an egress path is one of the highest-risk situations that can occur in a health care environment,” says Kendig.

Reading the smoke signals
The fact that LS.02.01.20 continues to place high every year among The Joint Commission’s most commonly cited standards indicates that this topic needs to be regularly revisited.

“Means of egress affects everyone inside the facility,” says Maurer. “Applying Standard

<table>
<thead>
<tr>
<th>Most Cited Standards: 2011-2014</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>EC.02.06.01: Built environment</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>EC.02.05.01: Utility systems risks</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>LS.02.01.20: Means of egress</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>EC.02.03.05: Fire safety systems</td>
<td>11</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>LS.02.01.10: General building requirements</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>LS.02.01.35: Extinguishment</td>
<td>5</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>LS.02.01.30: Protection</td>
<td>4</td>
<td>9</td>
<td>6</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>EC.02.01.01: Hazmat and waste</td>
<td>7</td>
<td>10</td>
<td>11</td>
<td>11</td>
<td>15</td>
</tr>
</tbody>
</table>

This chart shows the most challenging Environment of Care (EC) and Life Safety (LS) standards for 2011 through 2015. The first column identifies the standard and the subsequent columns show where the standard ranked for noncompliance during each year. For example, LS.02.01.20 was the third-most-challenging standard during 2015, the fourth-most-challenging in 2014, and the most challenging in 2013.

LS.02.01.20 and its EPs is certainly important as part of a defend-in-place strategy and evacuation strategy used in a health care environment. It’s not just about complying with the Life Safety Code, Joint Commission, or CMS, though. Organizations also should include the means of egress in their fire response planning efforts with reinforcement through drills, and continuing education.”

Kendig agrees. “The use and effectiveness of the means of egress is critically dependent upon the practice and policies implemented by the hospital,” says Kendig. “Lastly, don’t overlook coordination and participation with local fire response officials and staff.”

References
Appendix A: Additional Resources

Print Resources

JCR periodical articles can be purchased on PubMed via Ingenta (http://www.ingentaconnect.com/).

Electronic Resources

The Joint Commission: http://www.jointcommission.org
Joint Commission Resources: http://www.jcrinc.com/

NOTE: The Internet is an ever-evolving environment and links are subject to change without notice.
Appendix B: Faculty Biographies

NOTE: These presenters do not have any financial arrangements or affiliations with corporate organizations that either provide educational grants to this program or may be referenced in this activity. These presenters have also attested that their discussions will not include any unapproved or off-label use of products.

Randy Blanchard, DNP, MBA, MHA, RN, NEA-BC, CJCP
Consultant
Joint Commission Resources

Dr. Randy Blanchard uses his experience in clinical operations, performance improvement, patient safety initiatives, and hospital leadership as a solid foundation in his role as a consultant. Dr. Blanchard's broad-based leadership experiences in both nursing and non-nursing services provide the basis for his ability to evaluate care delivery opportunities across the organization and to relate those opportunities to both hospital staff and leadership. His experiences provide the opportunity to relate standards to real-world scenarios and cross reference to evidence-based literature. As a consultant, he has been able to develop sound working relationships with clients in both short and long-term engagements. Dr. Blanchard is not only proficient in inpatient patient care services, but also has expertise in ambulatory care. He has demonstrated experience in delivering perioperative safety consulting services.

Dr. Blanchard's experience with health care facilities includes:
• Acute Inpatient as Chief Nursing Officer
• Ambulatory as Vice President of 212 ambulatory clinics
• Emergency as Nursing Director of a Level I Trauma Center
• Leadership

His professional affiliations and certifications include:
• American Organization of Nurse Executives, Member
• Nurse Executive Advanced-Board Certified
• Certified Joint Commission Professional

Dr. Blanchard received his bachelor's degree in nursing from Valdosta State University in Valdosta, Georgia; his master's degrees in business administration and healthcare administration from Texas Woman's University in Dallas, Texas; his doctorate in nursing practice from Texas Tech University Health Science Center in Lubbock, Texas. Dr. Blanchard is a U.S. Air Force veteran.
George Mills, MBA, FASHE, CEM, CHFM, CHSP
Director, Department of Engineering
The Joint Commission

George Mills is the Director for the Department of Engineering at The Joint Commission. In this role, Mr. Mills provides standards interpretation and education to The Joint Commission's surveyors and accredited organizations, is active in advocacy issues, conducts surveys, and is a nationally recognized speaker.

Mr. Mills has over 25 years of experience in the healthcare setting, and previous experience in the construction industry and structural steel fabrication. Prior to joining The Joint Commission, he served as a Director of Facilities; held national positions related to Codes and Standards, including serving as Director of Codes & Compliance for ASHE; and consulted.

Mr. Mills is a Fellow with the American Society for Healthcare Engineering (FASHE), a Certified Healthcare Facility Manager (CHFM), a Certified Energy Manager (CEM), a Certified Healthcare Safety Professional (CHSP), and also was a past President of HESNI – an ASHE local state chapter.

Mr. Mills earned an MBA from California Coast University in Santa Ana, California.
Appendix C: Continuing Education (CE) Accrediting Bodies

To be eligible for CE credit from any of the following accrediting bodies, you MUST view the video presentation and read the Resource Guide first. Then, complete the post test at http://twnlms.com/ by the due date listed online. See Appendix E.

The Joint Commission is accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Live activity ACPE #0573-0000-16-045-L05-P; Enduring ACPE #0573-0000-16-045-H05-P

The Joint Commission is provider approved by the California Board of Registered Nursing, provider number CEP 6381, for 1 contact hour.

The Joint Commission is authorized to award 1.0 contact hour of pre-approved ACHE Qualified Education credit for this program toward advancement or recertification in the American College of Healthcare Executives. Participants in this program wishing to have the continuing education hours applied toward ACHE Qualified Education credit should indicate their attendance when submitting application to the American College of Healthcare Executives for advancement or recertification.

This activity has been approved by the National Association for Healthcare Quality (NAHQ) for 1.0 Certified Professional Healthcare Quality (CPHQ) credit.

The Joint Commission Enterprise has been accredited as an Authorized Provider by the International Association for Continuing Education and Training (IACET).

This education offering qualifies for 1.0 Certified Joint Commission Professional (CJCP) credit hours towards CJCP recertification. In order to obtain CJCP credit hours, an individual must first be certified before they start acquiring CJCP credit hours. CJCP credit hours will not be retroactive.

Full attendance at every session is a prerequisite for receiving full continuing education credits. If a participant needs to leave early, his or her continuing education credits will be reduced.

Successful completion of this CE activity includes the following:
- View the presentation and read the accompanying Resource Guide.
- Complete the online Evaluation Form and Post Test.
- A CE certificate/statement of credit can be printed online following successful completion of the Post Test and the Evaluation Form

NOTE: This information applies to The Joint Commission Resources Quality & Safety Network program titled, *Complying with the Most Challenging Joint Commission Standards*, originally presented on Thursday, October 27, 2016 from 2:00 – 3:00 p.m. ET. There is no individual participant fee for this educational activity.
## Appendix D: Discipline Codes Instructions

Some of our programs are accredited for more than one discipline. To ensure that we issue each participant a certificate by the appropriate accrediting body, we ask that you supply us with the following information: 1) two-digit discipline code. 2) followed by the position code (example: for a medical doctor, use 10 MD).

<table>
<thead>
<tr>
<th>Discipline (CME)</th>
<th>Discipline Code</th>
<th>Position Code</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>10 MD</td>
<td>20 RT</td>
<td>Respiratory Therapist, Registered</td>
</tr>
<tr>
<td></td>
<td>MDFP MD-Family Practice</td>
<td>RTC Respiratory Therapist, Certified</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MDPS MD-Psychiatrist</td>
<td>RPNC Resp. Practitioner, Non-Critical Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MDPH MD-Public Health Certificate</td>
<td>RPCC Resp. Practitioner, Critical Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MDPF MD-Public Psychiatry Certificate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MDAC MD-Area Clinical Needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MDMF MD-Medical Faculty Certificate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MSP MD-Medical Staff Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MDLL MD-Limited License</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DO Doctor of Osteopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>12 HA Hospital Administrator</td>
<td>25 HQP Healthcare Quality Professional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ADM LTC Administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OA Other Administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>13 PH Pharmacist (PharmD)</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PHN Pharmacist, Nuclear</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PHC Pharmacist, Consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PA Pharmacy Technician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietary</td>
<td>14 RD Registered Dietitian/Nutritionist</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NC Nutrition Counselor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DTR Dietetic Technician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>17 LTG Laboratory Technologist/Professional</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LT Laboratory Technician</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LS Laboratory Supervisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LD Laboratory Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>18 PT Physical Therapist</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PTA Physical Therapy Assistant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>19 OT Occupational Therapist</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OTA Occupational Therapy Assistant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>20 RT Respiratory Therapist, Registered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records</td>
<td>21 RHA Health Information Administrator</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RHT Health Information Technician</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CCS Coding Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CP Coding Specialist, Physician-Based</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>22 RAD Radiologic Technologist</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>Sonography</td>
<td>23 MS Medical Sonographer</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>Athletic Training</td>
<td>24 AT Athletic Trainer</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>HC Quality</td>
<td>25 HQP Healthcare Quality Professional</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>Activity Professional</td>
<td>26 ADP Profession Activity Director</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ADC Activity Director</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AAC Activity Assistant</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ACC Activity Consultant</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>Nurse (CNE)</td>
<td>30 RN Registered Nurse</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ARNP Advanced RN Practitioner</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NP Nurse Practitioner</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LPN Licensed Practical Nurse (or LVN)</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ON Other Nursing Professional</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>Psychology</td>
<td>33 PSY Psychologist (non-MD)</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PSYL Psychologist, Limited License</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>Case Mgmt</td>
<td>35 CCM Certified Case Manager</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>45 CNA Certified Nursing Assistant</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RA Restorative Care Aide</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HSA Health Support Aide</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NA Nurse Aide, Non-certified</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NT Nursing Technician</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Services</td>
<td>46 CFR First Responder</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EMTB EMT, Basic Level/EMT1</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EMTI EMT, Intermediate Level/EMT2/EMT3</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EMTP EMT, Paramedic Level/EMT4</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OTH Other</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>Health Unit Coor</td>
<td>55 CHUC Health Unit Coordinator, Certified</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>27 OTH Other</td>
<td>10 MD Medical Doctor</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E: Post-Test

To be eligible for CE credit, you MUST view the video presentation and read the Resource Guide first. Then complete the post-test at http://twnlms.com/ by the due date listed online.

1. Which Joint Commission Standard requires that hospitals reduce the risk of infections associated with medical equipment, devices, and supplies?
   a. IC.01.01.01
   b. IC.01.01.02
   c. IC.02.01.02
   d. IC.02.02.01

2. For standard RC.01.01.01 - the hospital maintains complete and accurate medical records for each individual patient - challenging Element of Performance 19 requires that all entries are _____.
   a. dated
   b. signed
   c. timed
   d. None of the above.

3. More effective care planning can be enabled by _____.
   a. improving collaboration among the healthcare team
   b. including the patient on the healthcare team
   c. recognizing care planning is a continuous process
   d. All of the above.

4. Which Joint Commission Standard requires that hospitals safely store medications?
   a. PC.03.01.01
   b. PC.03.03.03
   c. MM.03.01.01
   d. MM.03.03.03

5. Effectively providing care for a patient prior to an operative procedure can be compromised by the lack of a pre-anesthesia assessment.
   a. True
   b. False

6. A hospital must provide and maintain building features to protect individuals from the hazards of fire and smoke, as per Joint Commission standard _____.
   a. LS.02.01.30
   b. EC.01.01.01
   c. EC.02.01.30
   d. LS.01.01.01

7. As long as emergency generator tests are conducted every other calendar month, an organization is considered compliant by The Joint Commission.
   a. True
   b. False
8. Joint Commission standard LS.02.01.10 states that ____.
   a. the hospital maintains fire safety equipment and fire safety building features
   b. building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat
   c. during survey, specific documentation is reviewed
   d. dead end corridors may be used for storage

9. A hospital's ventilation system should provide appropriate pressure relationships, air-exchange rates, and filtration efficiencies throughout the facility.
   a. True
   b. False

10. Joint Commission standard EC.02.05.01 states: the hospital ____.
    a. manages fire risks
    b. manages risks related to hazardous materials and waste
    c. plans activities to minimize risks in the environment of care
    d. manages risks associated with its utility systems
Appendix F: JCRQSN Contact Information

General information, customer service issues, or program reception issues
JCRQSN Customer Service Team
support@jcrqsn.com
toll-free 1-888-219-4678

Questions or comments about JCRQSN educational programming
George Riccio
Executive Producer, Video and Audio Programs
Lean Six Sigma Certified Yellow Belt
Publications and Education Department
griccio@jcrinc.com
1-630-792-5428

Questions about continuing education
JCRQSN Continuing Education Support Team
support@jcrqsn.com
1-888-219-4678

Questions about standards
Joint Commission Standards Interpretation Group
1-630-792-5900

Questions about JCR education or other resources
JCR Customer Service Center
1-877-223-6866