

Standards BoosterPak™ for Environment of Care

(EC.04.01.01, EC.04.01.03, EC.04.01.05)



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A. Description of Standard and Implementation Expectations

Section A1: Standard Rationale, Elements of Performance (EPs), Scoring Categories, Implementation Suggestions

Program: Hospital

Chapter: Environment of Care

Standard Number: EC.04.01.01

Standard Text: The hospital collects information to monitor conditions in the environment.

Rationale: The goal of standard EC.04.01.01 is to collect data that can assist in providing and maintaining a safe, functional and supportive physical environment within a hospital so that quality in care and safety are preserved. These data come from the following:

- The analysis of reports on incidents and problems related to the physical environment of the hospital
- Regularly scheduled tours that monitor conditions in both patient care areas and non-patient care areas within the hospital
- Annual evaluation of the management plans for the environment of care

General Information

Risks related to the “Environment of Care” (EC) chapter are specific and should not be confused with patient care-related issues *that are monitored by Patient Safety Committee*. The EC elements of performance (EPs) cover the following:

- A. Injury to patients or others
- B. Occupational illnesses and staff injuries
- C. Incidents of property damage
- D. Safety and security incidents
- E. Hazardous materials and waste spills and exposures
- F. Fire Safety management issues
- G. Medical or laboratory equipment management issues
- H. Utilities systems management issues

Organizations that have the most successful Joint Commission surveys, document every EP that requires a Measure of Success. EPs that require a Measure of Success are identified by a black circle with a white M in the middle (Ⓜ). This can be found at the end of each applicable EP. However, this does not imply that everything has to be in a written format. Other options that are acceptable include the following:

- Graphs and charts on the computer
- Graphs and charts on the wall
- Wall poster with colored sticky dots

The most important thing when developing a Measure of Success is to create “At-a-Glance” quick and intuitive references for the benefit of the responsible person(s) within the organization. These measurement tools, while they are helpful to a surveyor when on site, are even more helpful to the organization on a day-to-day basis for the purpose of being prepared at all times.

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Element of Performance:

1. The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:

- Injuries to patients or others within the hospital's facilities
- Occupational illnesses and staff injuries
- Incidents of damage to its property or the property of others.
- Security incidents involving patients, staff, or others within its facilities
- Hazardous materials and waste spills and exposures
- Fire safety management problems, deficiencies, and failures
- Medical or laboratory equipment management problems, failures, and use errors
- Utility systems management problems, failures, or use errors

Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.

Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality.

Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process.

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

You may want to consider creating a visual process for monitoring, reporting, and investigating incidents and issues related to the categories listed above. Designate a person to coordinate safety management activities, and implement a multidisciplinary safety committee to oversee the process and be involved in associated monitoring and investigations.

Tips:

Tools that can help with monitoring, reporting and investigating each standard and EP include the following:

- Using a risk analysis to establish a baseline so you know whether changes are effective. If you can't demonstrate your level of compliance at the start point, you won't be able to demonstrate improvements or the effectiveness or success of changes.
- Try developing tools to help measure the success of each standard and its EPs (particularly when the EP requires a Measure of Success.
 - o Use graphs, posters with color coded dots, computer-generated spreadsheets, or any other format that works for you and your organization. The main objective is for these measurement tools to be easy to understand.
 - o Use data from these tools to create the necessary reports that are submitted to the safety committee.
- The reports should outline the scope and objective of each EP. The reports should evaluate and document performance measures, identify opportunities for improvement (OFI), and clearly state the effectiveness of the plan. OFIs may be addressed immediately or may become goals for the next reporting period.

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- These tools are important because they provide information at-a-glance that will help the organization quickly identify when corrective action is required and to be continually prepared for an unannounced survey.

Creating scorecards and dashboards can help with this process. The suggested process should be as follows: If there is an incident under any of the plans, a risk analysis should be created and followed. The risk analysis may address at least the following:

- Time, date, location, etc., where the incident occurred
- Name of person completing the report
- Description of the incident
- Cause of the incident
- How was the incident resolved?
- What was the duration of the incident?
- What measures could be implemented to prevent the incident from occurring again
- Distribution list of those within the organization who were notified of the incident

Creating an annual calendar of agenda items for each safety committee meeting assures the organization that all required topics will be reviewed on time and nothing will be missed. Incidents that require repeated and potentially lengthy review (such as *incidents requiring that a legal process be followed* or *incidents that require months of evaluation and/or study*) should appear on the agenda until resolution has been reached (sample safety committee calendar and scorecard are shown on the following pages).

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(SAMPLE)

[Year and Org Name here]—Environmental Safety Committees, Information Collection and Evaluation System

January	February	March	April	May	June
Committees	Committees	Committees	Committees	Committees	Committees
Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety	Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety	Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety	Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety	Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety	Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety
Fire Drills	Fire Drills	Fire Drills	Fire Drills	Fire Drills	Fire Drills
ICU Location, 1st Shift Emergency Department, 1st Shift	Patient Care Floor __, 2nd Shift Off-site Business Location	Patient Care Floor __, 3rd Shift	Security Office Location, 1st Shift Support Service, 1st Shift Location, 1st Shift	Patient Care Floor, 2nd Shift Laboratory, 2nd Shift	Patient Care Location, 3rd Shift Different Off-site Business Location
Monthly Environmental Tour Survey	Monthly Environmental Tour Survey	Monthly Environmental Tour Survey	Monthly Environmental Tour Survey	Monthly Environmental Tour Survey	Monthly Environmental Tour Survey
Radiology/MRI Laboratory Central Processing Recovery Emergency	Sleep Lab AFLAC Patient Care Floor ICU	Patient Care Floor Day Surgery Surgery	Central Sterile Patient Care Floor Pharmacy	Medical Records Administration Gift Shop Food Services Off-site Location(s)	Residents' Qtrs.* Engineering Security* Employee Health* Env. Services* Cath Lab Distribution* (* = Complete together)
Monthly Fire Extinguisher Inspections (Note: Annual Fire Extinguisher Maintenance conducted in January)	Monthly Fire Extinguisher Inspections				
Continual Incident/Injury Report/Review	Continual Incident/Injury Report/Review	Continual Incident/Injury Report/Review	Continual Incident/Injury Report/Review	Continual Incident/Injury Report/Review	Continual Incident/Injury Report/Review
New Employee Orientation/ Departmental Training	New Employee Orientation/ Departmental Training	New Employee Orientation/ Departmental Training	New Employee Orientation/ Departmental Training	New Employee Orientation/ Departmental Training	New Employee Orientation/ Departmental Training
July	August	September	October	November	December
Committees	Committees	Committees	Committees	Committees	Committees
Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety	Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety	Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety	Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety	Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety	Emergency Operations EOC Committee Construction Meeting (if applicable) Radiation Safety
Fire Drills	Fire Drills	Fire Drills	Fire Drills	Fire Drills	Fire Drills
Patient Care Location __, 1st Shift Surgery, Day Surgery, Recovery, 1st Shift	Radiology/MRI/CT 2nd Shift	ICU Location, 3rd Shift Emergency Department, 3rd Shift	Patient Care Location, 1st Shift	Kitchen, 2nd Shift	Patient Care Location, 3rd Shift Environmental Services, 3rd Shift
Monthly Environmental Tour Survey	Monthly Environmental Tour Survey	Monthly Environmental Tour Survey	Monthly Environmental Tour Survey	Monthly Environmental Tour Survey	Monthly Environmental Tour Survey
Radiology/MRI Laboratory Central Processing Recovery Emergency	Sleep Lab AFLAC Patient Care Floor ICU	Patient Care Floor Day Surgery Surgery	Central Sterile Patient Care Floor Pharmacy	Follow up on areas not toured or need follow-up	Follow up on areas not toured or need follow-up
Monthly Fire Extinguisher Inspections	Monthly Fire Extinguisher Inspections	Monthly Fire Extinguisher Inspections	Monthly Fire Extinguisher Inspections	Monthly Fire Extinguisher Inspections	Monthly Fire Extinguisher Inspections
Continual Incident/Injury Report/Review	Continual Incident/Injury Report/Review	Continual Incident/Injury Report/Review	Continual Incident/Injury Report/Review	Continual Incident/Injury Report/Review	Continual Incident/Injury Report/Review
New Employee Orientation/ Departmental Training	New Employee Orientation/ Departmental Training	New Employee Orientation/ Departmental Training	New Employee Orientation/ Departmental Training	New Employee Orientation/ Departmental Training	New Employee Orientation/ Departmental Training

- NOTE: Incident Report Summaries and fire drill deficiencies will be reported to the Environment of Care Committee
- Construction area fire drills will be conducted in accordance to interim life safety measure guidelines. All contractors are required to follow Interim Life Safety Policy and Fire Prevention Management Plans.
- Environment of Care policies will be updated as required and as needed according to process changes.
- In addition to monthly EOC tours, ongoing weekly facility rounds are conducted by the facility team members: Environmental Services, Engineering, Clinical Engineering, Security, and Safety.

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(SAMPLE)
Environmental Safety Committee Performance Report
Annual Report, FY [current year here]

Quality	Warning Value	Caution Value	Standard or Target	Reporting Period	Performance, Most Recent	Performance, YTD
1. Environment of Care Section Requirements						
a. Safety Management Plan Review	95%	97%	99%	Annual	N/A	N/A
b. Security Management Program Review	99%	N/A	100%	Semiannual	100%	
c. Hazardous Materials and Waste Program Review	98%	99%	100%	Semiannual	100%	
d. Fire Safety Management	93%	94%	95%	Semiannual	99.15%	
e. Medical Equipment Management Program Review	98%	99%	100%	Annual	100%	
f. Utility Management Program Review	97%	98%	99%	Semiannual	99.40%	
2. Life Safety Program Review	97%	98%	99%	Semiannual	99.20%	
3. Emergency Management Program Review	99%	N/A	100%	Annual	100%	
4. Vehicle Safety Program (Managed by Security)	98%	99%	100%	Annual	100%	
Service						
1. Completed Number of Departmental Hazard Inspections	83	85	87	Semiannual	87	
2. Fire Drill Review	4	5	6	Semiannual	6	
3. Emergency Preparedness Drill Conducted and Reviewed Annually	1		2	Semiannual	1	
4. Security Equipment Management Reliability Rate (Target = 100%)	97%	98%	99%	Annual	98.5%	98.5%
5. Departmental Safety Policy Review	39	40	41	Annual	41	
6. Product Recall Proper/Timely Follow-up (Running 12-Month)	98%	99%	100%	Annual	100%	100%
7. Product Recall Monthly Departmental Report (Running 12-Month)	83.33%	88.89%	94.44%	Annual	100%	98.25%
8. Environmental Safety QI Program Review	0		1	Annual	1	
9. Annual Bureau of Fire Safety Inspections	93%	94%	95%	Annual	99%	
10. Hazard Vulnerability Analysis	98%	99%	100%	Annual	100%	
11. MDCH-HFES Baseline Survey	93%	94%	95%	Every 6 years	99%	
12. SMDA Review (When applicable to EC— See Risk Management Report)				As Necessary		
People						
1. Employee Knowledge (97% Complete Training Annually)	95%	96%	97%	Annual	97%	
2. Employee Knowledge (95% Score 85% or Higher on Questions)	93%	94%	95%	Annual	100%	

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Element of Performance:

3. Based on its process(es), the hospital reports and investigates the following: Injuries to patients or others in the hospital's facilities. (*See also* EC.04.01.03, EP 1)

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

Incidents reported under this EP can be related to, or caused by, environmental, life safety, or building feature issues. The discovery of these types of incidents may be documented on the hospital patient incident report or on system/utility failure reports. Injuries to patients or others reported under this EP should not be confused with risks associated with Patient Safety Committee responsibilities that include provision of care, treatment, and services.

Tips:

You may want to establish a way to monitor the facility and grounds for potentially unsafe conditions and correct them immediately. Inclement weather can cause trip and fall incidents. Accidents can occur when building features are not maintained. So consider intervening before accidents occur.

- Monitor for inclement weather and take preventive action accordingly.
- Watch for loose handrails.
- Have staff watch for wet floors and clean them up immediately.
- Post appropriate warning signs in areas that could expose people to danger.
- Monitor and maintain security locks.

Because security department staffing tends to be low, and officers may not be able to cover the entire facility at the same time, implement training that makes all employees responsible for being aware of, and reporting, security incidents. When incidents do occur, you may want to evaluate ways to prevent a recurrence and document the process.

Element of Performance:

4. Based on its process(es), the hospital reports and investigates the following: Occupational illnesses and staff injuries. (*See also* EC.04.01.03, EP 1)

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

Incidents reported under this EP can be related to, or caused by, environmental issues even though the discovery of these types of incidents may generally be documented on the hospital patient incident report. Injuries to staff are typically documented on OSHA's Log 300.

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Tips:

Consider having the safety management coordinator work closely with the facilities manager, the employee health department, and the infection control coordinator to monitor and manage occupational illnesses and staff injuries. Findings should be documented and reported to the safety committee periodically, based on a schedule established by the organization. You might find the following helpful:

- Watch for unsafe conditions on the grounds and inside the buildings.
- Monitor occupational illnesses closely in order to minimize additional exposures

Pay special attention to indoor air quality. Although all air handlers should be on a preventive maintenance schedule, some are more important than others. For example, the air handlers for operating rooms, central sterile processing and other sensitive areas are considered life-support utilities or systems. These units should receive special attention in order to control the potential for infections and unnecessary exposures.

If the bird screens become obstructed with debris, or if the condensate drain becomes plugged, situations can be created in which there is not enough airflow from a critical air handler, or moisture can accumulate within the unit and create an environment in which mold can grow. You may want to also pay special attention to room air pressure in areas supplied by one of these critical air handlers. If the volume of airflow changes due to one of the conditions mentioned above, the air pressure of the critical room(s) may also change and create potential infection control issues.

(See the utilities management section EC.04.01.01, EP 11, for more detail.)

Element of Performance:

5. Based on its process(es), the hospital reports and investigates the following: Incidents of damage to its property or the property of others. (See also EC.04.01.03, EP 1)

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

Property damage can be the result of a variety of issues. Personal carelessness, vandalism, and improperly maintained systems are a few examples. Other examples include the following:

- Careless use of wheelchairs and other wheeled equipment
- Mischievous neighborhood children using rocks, paint, etc.
- Careless operation of motor vehicles
- Poorly maintained building features and/or equipment

Tips:

You may want to conduct risk assessments that will identify potential causes and implement preventive actions based on the risk assessments. Consider getting staff involved in monitoring and reporting activities that may cause damage to hospital property or the property of others.

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Element of Performance:

6. Based on its process(es), the hospital reports and investigates the following: Security incidents involving patients, staff, or others within its facilities. (*See also* EC.04.01.03, EP 1)

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

Security risks affect all individuals in the organization—patients, visitors, and those who work in the hospital. A security risk assessment can help prevent some security incidents. (*See* suggestions in the “Tips” section below.) A strong written security management program is essential to managing risk. It should include methods for identifying, minimizing, and/or eliminating security risks in the physical environment (including appropriate maintenance of the grounds and equipment). The written plan should address ways the organization intends to control access to and from security-sensitive areas. When an incident occurs, the plan should outline the organization-approved security procedures that are to be followed. Consider working with community partners to understand each other’s roles during a large scale community event. It may be impossible for the local first responders to help secure the hospital and provide traffic control. Those human resources may very likely have to come from someplace else.

Tips:

You may want to start managing security risks by conducting an initial security analysis. There are expert firms that can be hired to do this for a fee. A low-cost/no-cost option is to collaborate with a local college or university that offers a Criminal Justice (CJ) degree. The students and professors in the CJ program would perform the same service as the hired firm. They will examine the entire health care campus and provide a report that outlines the organization’s strong security practices and will identify weaknesses that can become opportunities for improvement (OFI) that the safety committee may want to address. When the OFIs are identified, the organization can develop its plans for corrective action. Also consider CJ students for emergency deployment in case of a large-scale community event that would stress the human resources of the health care organization and its community partners (first responders).

Hospitals are required to conduct environmental tours, or semiannual safety surveys, in clinical departments and annual surveys in nonclinical departments. During these surveys, you may want to include security reviews that ensure that all locks are functional, and the areas are secure in accordance with the security plan. If your security management plan requires all staff to be aware of and report security incidents, you may want to formulate security-related questions that you can ask staff during the departmental safety survey process.

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Element of Performance:

8. Based on its process(es), the hospital reports and investigates the following: Hazardous materials and waste spills and exposures. (*See also* EC.04.01.03, EP 1)

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

The written Hazardous Materials and Waste Management Plan should address procedures for precautions, use of personal protective equipment (PPE), and the response to a spill or exposure. If there is a spill or exposure, the plan should outline the proper response. Consider addressing all areas where exposures may occur. Isolation rooms and roof exhausts for chemotherapy drugs, formaldehyde, or other hazardous fumes should be marked as hazardous locations. Consider installing eyewash stations in locations where exposure to the chemical(s) being used indicates that flushing with copious amounts of water for 15 to 20 minutes is required. A Safety Data Sheet (SDS) inventory should be available to staff at all times. The SDS can be available in hard copy on site, or can be computer generated. It is a good idea for the SDS inventory to be reconciled annually to assure that the SDS for each product is current and accurate. Hazardous materials or waste must be disposed of properly, and manifests of proper disposal must be filed on site.

Tips:

During the semiannual and annual hazard surveys, or safety and security assessments that are conducted in each department, consider evaluating the potential for hazardous exposures and implement corrective action immediately. If an eyewash station is required, it must be supplied with tepid water (between 60° and 100° F [15.6° and 37.8° C]), a flow test must be conducted and documented weekly, and the eyewash station must be accessible. It is suggested that a well-trained spill team is more manageable than making all staff responsible for hazardous spill mitigation. It is difficult to expect all staff to know the proper response to a hazardous spill. So the hazardous waste management plan should include a spill policy that addresses the following:

- Immediately moving everyone in danger of exposure to safety
- Ventilate the area to reduce fumes.
- Contain the spill and keep it from spreading.
- The spill team may clean up a small-quantity spill if the chemical is not too dangerous, as determined by referring to the SDS.
- If the spill team responds to large-quantity hazardous spills, the organization will need to implement a respirator program. Most hospitals choose not to do this. Instead, they have the local fire department respond to larger spills because the firefighters are trained and equipped to work in these types of hazardous situations.
- If registered/proper disposal is required, be sure to get a manifest from the disposal company and keep it on file.

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Element of Performance:

9. Based on its process(es), the hospital reports and investigates the following: Fire safety management problems, deficiencies, and failures. (*See also* EC.04.01.03, EP 1)

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

The focus of the written Fire Safety Management Plan is to minimize the potential for harm from fire, smoke, and other products of combustion. There should be a written smoking policy and a written fire response plan that describes the specific roles of staff *at* the point of fire-origin, and *away* from the point of fire origin.

Tips:

It is imperative that the fire alarm system, internal fire suppression system, and other critical systems are functional at all times. If any of these systems is nonfunctional, immediate corrective action is critical. If any of these systems is going to be out of service for four or more hours, a fire watch must be implemented and the local fire department must be notified. Consideration must also be given to implementing interim life safety measures. If the failure of a system is known to compromise infection control, then an Infection Control Risk Analysis (ICRA) should be implemented. All actions mentioned in this paragraph must be documented and kept on file for a period long enough for The Joint Commission and other regulatory agencies to review at least one year in arrears. That means you should probably keep two (2) years of these records available for review at all times.

Conduct fire drills one per shift per quarter. If the organization is staffing three (3) shifts, then 12 drills per year will be required. If there is an active construction project, an additional drill per shift per quarter is required during the construction project. You should consider conducting at least some of the extra drills required by a construction project in the construction site. Rationale: We provide pre-construction training to contractors and subcontractors related to fire safety and ask them to respond to a fire in their location the same way we expect our own staff to respond. This initial training generally covers RACE (Rescue + Alarm + Contain + Evacuate), PASS (P: Pull the pin; A: Aim at the base of the fire; S: Squeeze the trigger; S: Sweep the nozzle from side to side), ICRA and other safety issues the construction people are expected to follow. If we don't test that training once in a while, the construction workers forget the initial training and may have difficulty with an appropriate, timely response.

Thoroughly document all fire drills. Critique each drill with everyone who was involved. If a response deficiency is observed, cover the correct response in the initial critique. Then be sure to test that department again in the near future to ensure that the training was effective. Be sure to document these activities.

If the fire alarm system is equipped with an automatic dialer system that provides notice to a 24 hour off-site dispatch company, you may want to test that part of the system during drills to be sure that the dispatch company calls the local fire department in a timely manner. The organization should establish the expected amount of time it takes from activation of the fire alarm system until the call to the fire department occurs. Generally 90 seconds to 2 minutes is acceptable. Five to 10 minutes is unacceptable because flashover can occur within 2 to 4 minutes.

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It is suggested that you build redundancies into the process. It can be helpful to establish an internal emergency phone number that staff can call during any fire or fire drill. Remember, the fire alarm is a mechanical and electrical system that could fail. If the horns and strobes don't activate, and if there is no enunciated message at the fire alarm panel, then the redundant telephone call is the only method of internal notification for deploying internal first response staff to the fire location. Similarly, have an emergency phone number that in-house staff can use to contact the local fire department. If the automatic dialer system fails, this redundant phone call will be the only notice the fire department receives.

Consider establishing realistic expectations regarding the number of areas observed during drills. Some hospitals expect all department managers to provide written or computer-generated documentation regarding their response during each drill. That is a tall order, and it may set the organization up to fail. What happens if one or more department managers are on vacation during the drill and no one in the departments remembers to complete the fire drill response forms? It may be better to have safety committee members who are thoroughly trained observe a small number of areas and complete the appropriate documentation. The trained safety committee members are also well qualified to conduct the postdrill critique and training session.

Element of Performance:

10. Based on its process(es), the hospital reports and investigates the following: Medical/laboratory equipment management problems, failures, and use errors. (*See also* EC.04.01.03, EP 1)

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

Documentation is critical to demonstrating evidence of substantial compliance. Written procedures for inspecting, testing, and maintaining medical equipment are required. Failure response plans for medical equipment in the inventory are required. Also, if medical equipment fails, a system failure report should be documented and distributed according to the organization's written policy. If the equipment failure pertains to life-support equipment, reporting procedures should be in place for reporting to the safety committee. Have a Safe Medical Devices Act policy in place and know the organization's established process for sequestering equipment, proper notification, and proper reporting processes.

It is recommended that the policy itself, as well as the annual review, address the scope, objectives, performance and effectiveness of the program. This should include the clinical interventions and backup equipment necessary in the event of medical equipment failure. If opportunities for improvement are identified but not immediately corrected, you may want to establish those as goals to be accomplished during the next year.

Tips:

Measure the completion rates for preventive maintenance to ensure compliance with the scoring model of The Joint Commission. For example, divide the number of completed preventive maintenance work orders issued by the number of issued preventive maintenance work orders for a percentage complete. Life-support systems must be completed at a rate of 100% and non-life-support systems at 90% to be fully compliant.

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Performance Standards

- Equipment in the medical management program functions properly, with the exception of unforeseen occurrences. Interruptions are reported and addressed immediately. Variances are reported to the safety committee.
- Performance testing of sterilizers, and testing of equipment and water used for hemodialysis
- General staff: Training and review of the Joint Commission management plans is documented during monthly program/departmental meetings.
- Preventive maintenance: Preventive maintenance is completed on all medical equipment in accordance with regulatory standards and manufacturer specifications, including nuclear medicine and computerized tomography (CT) equipment, as required.

Element of Performance:

11. Based on its process(es), the hospital reports and investigates the following: Utility systems management problems, failures, or user errors. (*See also* EC.04.01.03, EP 1)

Scoring Categories:

Criticality level: Indirect

Documentation required: No

Scoring category (A or C): C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

Similar to medical equipment, documentation for this EP is critical to demonstrating evidence of substantial compliance. Written procedures for inspecting, testing, and maintaining utilities are required. Failure response plans for all utilities are required. Also, if a utility system or component fails, a system failure report should be documented and distributed according the organization's policy. In addition, the utility system failure reports should be reported to the safety committee periodically.

It is recommended that the policy itself, as well as the annual review address the scope, objectives, performance, and effectiveness of the program. If opportunities for improvement are identified but not immediately corrected, you may want to establish them as goals to be accomplished during the next year.

Tips:

Measure the completion rates for preventive maintenance to ensure compliance with the scoring model of The Joint Commission. For example, divide the number of completed preventive maintenance work orders issued by the number of issued preventive maintenance work orders for a percentage complete. Life-support systems must be completed at a rate of 100% and non-life-support systems at 90% to be fully compliant.

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Performance Standards

- Utilities and components in the utilities management program function properly, with the exception of unforeseen occurrences. Interruptions are reported and addressed immediately. Variances are reported to the safety committee.
- General staff: Staff response to the following question in the “Hospital Annual Training Program” (“If the electricity, water, oxygen, or other utility system failed, I would ___”) indicates that 90% of staff know and understand their role in the utilities management program.
- Facilities management staff: Training and review of Joint Commission management plans is documented during monthly program/departmental meetings.
- Preventive maintenance: Preventive maintenance is completed on all utilities systems/equipment in accordance with regulatory standards and manufacturer specifications.

Element of Performance:

12. The hospital conducts environmental tours every six months in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks.
(See also EC.04.01.03, EP 1)

Scoring Categories:

Criticality Level: Indirect

Documentation Required: No

Scoring Category: A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

There should be an individual responsible for ensuring that environmental tours are conducted (Typically the safety officer or facility manager, but this can vary widely based on the organization’s structure). Although not defined in the EP, a best-practice program for conducting these tours is a team of individuals that have responsibility for various disciplines—such as the Safety representative, Environmental Services, Biomed/Clinical Engineering, Engineering/Plant Operations, and Security. Although not required, it is helpful to have an Infection Control representative, Occupational Health representative, and the clinical leader(s) of the area attend the tour to assist with discussing items of concern. Some organizations may choose to incorporate these tours as part of ongoing regularly scheduled Facility Department tours at which all department representatives are present. Having a schedule of these environmental tours to ensure completion every six months in all clinical locations (patient care) is a good practice. In addition, there should be a checklist of items that are reviewed when these locations are toured (a sample checklist can be found on pages 17–18).

To assist in the validation of any previously implemented activities or changes in process due to uncovering issues during these tours, the checklist for the location(s) toured the previous six months should be reviewed while touring the same areas in order to verify that an item does not continue to exist. If there is an item that continues to exist, be sure to verify that the previous implemented changes were completed thoroughly.

Sample the knowledge and any competencies of staff on minimizing risks and responding to incidents related to the physical environment. Pay special attention to areas where change in care processes or space reconfiguration has occurred. Also, performance improvement/quality monitoring initiatives for the Environment of

Standards BoosterPak™ for Environment of Care (EC.04.01.01, EC.04.01.03, EC.04.01.05)

Care Management Plans could be assessed during these tours. For example, if the Infection Control representative is present during the tours, he or she might be assessing hand-washing compliance numbers. The person responsible for safety management might want to assess staff knowledge on the reporting of injuries to patients or others within the facility, occupational illnesses and staff injuries, and incidents of damage to hospital property or the property of others.

The representative responsible for hazardous materials and waste might want to retrieve various chemicals in a department to assess the accessibility of Safety Data Sheets (SDS), or if staff know how/where to access a SDS. The individual responsible for fire safety might want to ask staff fire/smoke response questions to assess knowledge. The individual responsible for medical equipment could ask staff what the protocol is for reporting medical equipment problems/failures. The person responsible for utilities management might want to assess staff knowledge on reporting maintenance needs, or what frontline staff would implement for an electrical or water outage.

Again, these are merely examples of performance improvement monitors given as a reference of what can be assessed during environmental tours. Performance improvement monitoring should be written in the management plans to assess what the organization feels are risks specific to them. This can be based on geographic location, populations served, department or service line function, etc. Keep in mind that performance improvement initiatives are intended to decrease risks (after monitoring results have been compiled) to the organization after any needed changes have taken place. The key concepts are to continually monitor the environment, implement any needed changes or training initiatives, and reevaluate to validate that the implementation of changes or training needs has been successful.

Tips/Resources:

- A sample Environmental Tours Checklist is on pages 17–18.
- A sample Project/Report Schedule is on page 19.

Standards BoosterPak™ for Environment of Care
(EC.04.01.01, EC.04.01.03, EC.04.01.05)

Element of Performance:

13. The hospital conducts annual environmental tours in nonpatient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate risks in the environment. (*See also* EC.04.01.03, EP 1)

Scoring Categories:

Criticality Level: Indirect

Documentation Required: No

Scoring Category: C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

Conduct environmental tours annually in all nonpatient care locations. Examples of these nonpatient locations include medical records, materials management, sterile processing/central processing, support services areas, and various other business offices occupied by the organization that do not have inpatient or outpatient activities. This also includes off-site locations occupied by the organization for nonpatient care activities.

There should be an individual who is responsible for ensuring that the environmental tours occur (typically the safety representative or facility manager, but this can vary widely based on the organization's structure). A best-practice program for conducting these rounds is a team of individuals that have responsibility for various disciplines—such as the Safety representative, Environmental Services, Biomed/Clinical Engineering, Engineering/Plant Operations, and Security). Some organizations may choose to incorporate these tours as part of ongoing regularly scheduled Facility Department tours at which all department representatives are present. A schedule of these environmental tours should be in place in order to verify that all nonpatient care locations are toured at least annually (a sample schedule appears on page 19).

In addition, there should be a checklist of items that are reviewed when these locations are toured (a sample checklist appears on pages 17–18). To assist in the validation of previously implemented items, the checklist for the location(s) toured should be reviewed prior to and while touring the same areas in order to verify that an item does not continue to exist. If an item does continue to exist, be sure to verify that the previously implemented changes were completed thoroughly. Examples could be any related staff training, change in processes, space reconfiguration, etc.

Tips/Resources:

- Sample Environmental Tours Checklist is provided on pages 17–18.
- Sample Project/Report Schedule is provided on page 19.
- Sample Environmental Safety Committee Information Collection and Evaluation System is provided on page 5.

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(EC.04.01.01, EC.04.01.03, EC.04.01.05)

(SAMPLE)
[Organization Name]
Environmental Tours Checklist

Score: N/A (Not Applicable) 1 – not in compliance 2 – minor deficiency 3 – meets compliance
--

Location:	Completed By:	Date:	
Item	Score	Identified Issues	Completion Date (See Corrective Action Log)
1. Firefighting equipment unobstructed			
2. Fire extinguishers inspected monthly			
3. Fire doors functional and unobstructed			
4. Exits and entrances clear and marked			
5. Hallways and corridors clear			
6. Stairs and stairways clear			
7. Storage (e.g., clean and uncluttered, 18" clear in sprinkled areas, clean storage houses clean items only)			
8. Storage of flammables			
9. Storage of gas cylinders (chained to wall or secured in carrier), not in violation of storage requirements			
10. Rolling items clean and in good repair (e.g., carts, IV poles, wheel)			
11. Medical records area lockable (if applicable)			
12. Work surfaces clean			
13. Smoking regulations enforced			
14. Safety Manual/Environment of Care Manual in place with required policies and Safety Data Sheets (SDS)			
15. Emergency cart/drug box/defibrillator checks			
16. Refrigerator/freezer temperature checks current			
17. Expiration dates checked (meds, food, supplies)			
18. Personal protective equipment available (all rooms)			
19. Emergency ventilation device accessible and conveniently located close to patient care areas			

(continued on next page)

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(EC.04.01.01, EC.04.01.03, EC.04.01.05)

(SAMPLE)
[Organization Name]
Environmental Tours Checklist
(continued)

Location:	Completed By:	Date:	
Item	Score	Identified Issues	Completion Date (See Corrective Action Log)
20. Syringes/needles in secured areas			
21. Eyewash station available and unobstructed.			
22. Ceiling tile not stained or dirty			
23. Specimens stored in area free from patient contact, separate from clean areas, and labeled biohazardous			
24. Specimen refrigerator is labeled biohazardous			
25. Hand-washing facilities readily accessible (i.e., easy access, soap dispenser present and functional, paper towels present)			
26. Sharps containers are located as close as possible to where sharps are used			
27. Sharps containers are not overfilled and replaced routinely			
28. Sharps containers contain appropriate materials (i.e., no gloves, gauze, tubing)			
29. All chemicals are properly labeled with name and hazard identified			
30. Patient care items not stored under sinks			
31. Able to overhear any patient information in public areas(e.g., elevators, cafeteria, nonclinical areas)			
32. Able to observe patient information on an unattended computer screen			
33. Able to see unattended patient-identifiable information while in area (e.g., copies of medical record)			
34. Find patient-identifiable information in trash cans			
35. Test clinical alarms in area, if applicable. (This can be accomplished by either pulling one of the patient bathroom call buttons, sounding the emergency call device from the bathroom, pulling the regular patient bed nurse call, code blue, etc. Test at least one of these methods and observe staff response.)			

OTHER COMMENTS:

Possible Total Score: _____

Score: _____

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(EC.04.01.01, EC.04.01.03, EC.04.01.05)

(SAMPLE)
[Organization Name]
Environmental Safety Committee
[current year] Project/Report Schedule*

* All Meetings Scheduled @ 1:00–2:30 P.M. in the Board Room unless otherwise noted or rescheduled.	Jan 13	Mar 10	May 12	Jul 14	Sep 8	Nov 10
Semiannual Environmental Tour Report			V			V
Annual Review of Hazard Vulnerability Analysis			D			
Occurrence Reports related to Environmental Safety	K by ref	K by ref	K by ref	K by ref	K by ref	K by ref
Semiannual Hazardous Materials and Waste Report						B
Annual Review of Hazardous Materials and Waste Program			B			
Semiannual Security Report			S			S
Semiannual Utility Report						D
Annual Review of Utility System Program			D			
Semiannual Fire Drill Report		S			S	
Semiannual Life Safety Report		D				
Annual Review of Life Safety Program					D	
Annual IT Disaster Recovery Report					J	
Annual Product Recall Report					V	
Annual OSHA Log Review		M				
Semiannual Review of SMDA		K			K	
Annual Review of Safety Management Plan		M/D				
Annual Review of Environmental Safety QI Plan				D/K		
Annual Review of Vehicle Safety Plan	S					
Environmental Safety Related to Infection Control	R by ref	R by ref	R by ref	R by ref	R by ref	R by ref
Annual Review of Medical Equipment Management Program				D		
Annual Review of Emergency Management Program				D		
Emergency Preparedness Drill Semiannual Report			D			D
Departmental Safety Policy Report				V		

B = Bob
D = David
J = John
K = Kathryn
M = Mary
R = Roger
S = Sara
V = Valerie

The safety committee issues for review are shown in the right column, while the alphabetical letters in the other columns designate the person responsible for presenting the report on time. The calendar is distributed to each Environmental Safety Committee Member at the beginning of each year. So each member is aware of the schedule and has ample time to prepare his or her report.

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(EC.04.01.01, EC.04.01.03, EC.04.01.05)

Element of Performance:

14. The hospital uses its tours to identify environmental deficiencies, hazards, and unsafe practices. (*See also* EC.02.01.01, EP 1; EC.04.01.03, EP 1)

Scoring Categories:

Criticality Level: Indirect

Documentation Required: No

Scoring Category: A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

Examples should be made available during the survey of how the organization's environmental tours have identified unsafe practices or hazards, along with the efforts the organization has implemented or changed to assist with minimizing hazards or unsafe work practices (examples could be a policy change, staff training initiative, or environmental change). This has also been referred to in the past as the cradle-to-grave process, which is identifying an issue and showing resolution of that issue. Also, if applicable, it is helpful to show references to various agency regulations or guidelines that might have helped support a change. Examples include, The Joint Commission, OSHA, ANSI, NIOSH, ADA, and/or FGI. At times these agency regulations, standards, or guidelines might not specifically address a particular item. However, when applicable, the organization should use these as references to assist in changing a process or a making change in the physical environment if needed.

Tips/Resources:

- A comprehensive checklist should be utilized when conducting environmental tours. This will assist in validating the thoroughness of the tours (a sample checklist appears on pages 17–18).
- Summarize any findings on a spreadsheet to assist in tracking deficiencies and trending any potential issues.

Element of Performance:

15. Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. (*See also* EC.01.01.01, EPs 3–8; EC.04.01.03, EP 1).

Scoring Categories:

Criticality Level: Direct

Documentation Required: No

Scoring Category: A

Measure of Success: No

Identified risk area: Yes

Implementation Suggestions:

You may want to consider establishing a performance monitor for each EC risk area “that is useful to the organization.” For example, if an organization is tracking employees wearing appropriate identification badges, and has been tracking this for three years with 100% compliance, the surveyor might question why this has continued to be monitored and are the data useful. Collecting data to simply report numbers is not being productive or helping to reduce risk in the environment.

Standards BoosterPak™ for Environment of Care (EC.04.01.01, EC.04.01.03, EC.04.01.05)

The EC risk areas include:

- Safety/Security
- Hazardous Materials and Waste
- Fire Safety
- Utilities
- Medical Equipment

Note: Each plan, every 12 months, should be evaluated to include the following:

Scope

The scope of the management plan annual evaluation should cover all locations and spaces that are outlined in the respective management plan and share a Joint Commission certificate (that is, where the organization's patients, staff, volunteers, physicians, and family members are located). Each location can have a separate management plan based on clients served, geographic location, and occupancy type. However, if each location has a separate management plan, a separate annual evaluation is required. Also, remember to consider any new locations/buildings that might have been added during the previous year.

Objectives

There are multiple ways to determine if the management plan met outlined objectives, such as performance indicator monitoring data and trending of injuries or events. An example could be scoring of fire drill performance for the Fire Safety Management Plan. A large organization may choose to continue monitoring this due to staff turnover ratios (ongoing new employees coming into the organization), or may choose to continue monitoring this item due to poor performance indicator monitoring scores. But, be careful if poor performance continues to occur. If scores continue to be unfavorable with regard to fire safety response knowledge, it could trigger the need for additional staff training programs to specifically address this issue. Below are some additional basic examples of performance improvement monitoring:

- **Safety Management:**
 - Fit testing of staff for N95 masks (having a goal of 100% for fit testing)—conducted during environment tours in patient and nonpatient locations
- **Security Management:**
 1. Staff knowledge of the hospital emergency phone number—assessed during the scheduled environmental tours (Goal of 100%)
 2. Staff knowledge of emergency phone number (Goal of 100%)—currently assessed during environmental tours
 3. Staff knowledge of security sensitive locations and the controls implemented to continually secure them (Goal of 100%)
 4. Wearing of identification badges for staff, volunteers, physicians, patients, and visitors (according to hospital policy) (Goal of 100%)
- **Hazardous Materials and Waste**
 1. Monitoring of hazardous waste streams monthly (hazardous, medical/biohazard, recyclables)
 2. SDS available for chemicals (recorded during environmental tours) (Goal of 100%)
 3. Chemicals labeled (Goal of 100%)
 4. Availability of PPE (Goal of 100%)

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- **Fire Safety**

1. Tracking staff knowledge of fire response procedures according to policy (Goal of 90%)
2. Staff knowledge of who is able to close piped medical gas valves in a fire/evacuation emergency (Goal of 90%)

- **Medical Equipment**

1. Preventive maintenance goal for all life-support equipment on inventory (Goal of 100%). If the goal was not achieved, the organization should explain why the goal was not met.
2. Preventive maintenance goal for all non-life-support equipment on inventory (Goal of 95%). If the goal was not achieved, the organization should explain why the goal was not met.
3. Staff knowledge of reporting equipment problems or failures (Goal of 95%)

- **Utilities Management**

1. Preventive maintenance goal for all life support equipment on inventory (Goal of 100%). If the goal was not achieved, the organization should explain why the goal was not met.
2. Tracking of utility interruptions (expected and unexpected) for review of trending issues/opportunities for improvement
3. Testing or drills of utility failure plan monthly—test to fluctuate depending on utility (water, gas, electricity, steam, HVAC, medical gasses, etc.)

Performance

Although there are many ways to document performance for each management plan, the information the organization has been tracking/trending should be made available to the surveyors to show that the management plans were either successful or not successful for the previous year.

An example of performance improvement data for Fire Safety Management could be (as referenced above):

Fire Safety Performance Indicator: During fire drills, staff knowledge of proper procedures to follow in the event of a fire/smoke emergency is evaluated using a fire drill performance form with scoring matrix (Target Goal = 90%). (See sample fire drill performance form and scoring matrix on pages 24–25.)

The total of previous year staff knowledge of fire response procedures @ 92%

Previous year total of staff knowledge related to fire response procedures was found to be successful due to exceeding goal of 90% (actual outcome reflects 92%).

Effectiveness

For each management plan above, describe how effective each plan was for the previous year. As with the performance section above, the effectiveness can be measured using the performance improvement data from that year, environmental tour outcomes, etc. The organization's EC team should analyze all data and events related to each of the EC areas and make decisions going forward to determine the goals for the upcoming year. The EC team should also make a determination if performance improvement monitoring in each area should change or remain the same. If your quality/performance improvement data will remain the same, be sure to justify why this decision was made.

Tips/Resources:

- See sample Fire Drill Matrix on pages 24–25 and sample Utilities Management Plan Annual Evaluation on page 26.

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(EC.04.01.01, EC.04.01.03, EC.04.01.05)

Fire Drill Matrix

To effectively conduct a fire drill, several things must occur:

1. The local fire response must be prewarned about the activity (to prevent false alarm expenses).
2. The observers must be stationed and ready to observe staff action.
3. The smoke compartment of fire origin is chosen, and the fire simulation begins.
4. During the fire drill, observers begin to complete the Fire Drill Evaluation form.
5. Immediately after the drill, the observer asks the post-drill questions.
6. Observer discusses the observation results. Following the fire drill, the observer sends the completed form to the safety officer.
7. The safety officer reviews the comments and scoring for opportunities to enhance staff training.
8. A summary is presented to the Safety Committee.
 - a. An annual summary is presented to the Environment of Care Committee.

The first page, Observer Worksheet for Use During a Fire Drill, is used in the field by the observer (*see* page 24). The second page, Fire Drill Evaluation, is the formal summary the observer will submit to the safety officer after the drill (*see* page 25).

Standards BoosterPak™ for Environment of Care
(EC.04.01.01, EC.04.01.03, EC.04.01.05)

SAMPLE
[Organization Name]
Observer Worksheet for Use During a Fire Drill

Clinical Areas/Nursing Units Location: _____

Issue	Yes	No	Comments
1 Were ALL patients accounted for?			
2 Were the patient room doors closed?			
3 Were ALL the patients removed from the corridor during the drill?			
4 Were patients and visitors informed of the drill, and advised what to do?			
5 Did one staff member stay near a phone for communication purposes?			
6 Did the fire/smoke doors close?			
7 Does the staff know what RACE represents?			
8 Does the staff know the pull station locations?			
9 Does the staff understand the policy regarding medical gas shutoff?			
10 Is the staff aware of evacuation procedures, including where to meet during a building evacuation?			
11 Is the Fire Plan accessible?			
12 Does the staff understand what PASS represents?			

Clinical Areas/Nursing Units Location: _____

Issue	Yes	No	Comments
1 Does the staff know what RACE represents?			
2 Does the staff know the pull station locations?			
3 Did the fire doors close?			
4 Did the smoke doors close?			
5 Did one staff member stay near a phone for communication purposes?			
6 Is the Fire Plan accessible?			
7 Is the staff aware of the paging code for a "Fire" situation?			
8 Does the staff know the elevator use policy during a "Fire" situation?			
9 Does the staff know exit locations?			
10 Is the staff aware of evacuation procedures, including where to meet during a building evacuation?			
11 Does the staff understand what PASS represents?			
12 Does the staff know their responsibilities in a fire situation?			

Observer: _____ Date: _____ Time: _____

Standards BoosterPak™ for Environment of Care
(EC.04.01.01, EC.04.01.03, EC.04.01.05)

SAMPLE
[Organization Name] Fire Drill Evaluation

Issue	Yes	No	Response Value
1 Was RACE fire procedure explained by first staff member contacted?			25
2 Was the fire alarm pull station utilized?			10
3 Was the emergency contact (i.e., operator) notified on extension _____ and informed of fire situation?			5
4 Was the chime code heard and correct?			5
5 Did the fire alarm strobe devices function?			5
6 Was the overhead page heard?			5
7 Did the fire/smoke doors close properly? If not, provide location of door:			10
8 Did the first response team respond within ____ minutes, and were they properly equipped?			5
9 Did the nursing staff know the proper procedure regarding medical gases shutoffs?			5
10 Asking one staff member, did he or she know the meeting location in the event of department/unit evacuation?			5
11 Asking another staff member, did he or she know the meeting location in the event of department/unit evacuation?			5
12 Asking another staff member, did he or she know the meeting location in the event of department/unit evacuation?			5
13 Were patients and visitors informed what to do during the fire situation?			5
14 Was the "code clear" properly announced over the paging system?			5
Total			

A total score of 80 or more is required to pass the fire drill.

Unit: _____ Date: _____ TIME: _____ Shift (Circle): 1 2 3

OBSERVERS: _____ SCORE: _____

If comments on BACK check here: _____ Date routed to safety officer: _____

Standards BoosterPak™ for Environment of Care
(EC.04.01.01, EC.04.01.03, EC.04.01.05)

SAMPLE
[Organization Name] Utilities Management Plan
[current year] Annual Evaluation

Goals:

The goals of the Utilities Management Plan are to:

1. Ensure operational reliability of utility systems.
2. Reduce the potential for organization-acquired illness to be transmitted through utility systems.
3. Assess the reliability of, and minimize potential risks of, utility system failures.

The goals have been reviewed and remained appropriate throughout this evaluation period.

Scope

The scope of this program includes all activities related to utilities management at [Facility Name]. The scope of the Utilities Management Plan remains appropriate to the services provided by the organization.

Applicability

The Utilities Management Plan is applicable to staff, physicians, and volunteers. There has been no change to this aspect of the program during the evaluation period.

Performance Metrics (Objectives) for [previous year]

The table below outlines the objectives (performance metrics) established for the Utilities Management Plan in [previous year], and the organization's performance in each of these areas:

Performance Metrics	Performance
Number of adverse patient outcomes resulting from utility failures	The number of adverse patient outcomes resulting from utility failures was zero, providing a safe environment.
Percentage of scheduled utility preventive maintenance completed	Goal 95%, Achieved 100%
Percentage of compliance with monthly generator testing done for 30 minutes	Goal 100%, Achieved 100%

Evaluation of Effectiveness

Based on the performance metrics noted above, the Utilities Management Plan is assessed to be effective in meeting its stated goal(s).

Performance Metrics (Objectives) for [current year]

Based on a review of data, performance measures, the annual hazard vulnerability assessment and regulatory/accreditation standards, the following performance activities will be undertaken in [current year]:

Performance Metrics	How Effectiveness Will Be Measured
Maintain a minimum of 95% preventive maintenance (PM) completion of all tier 1 assets.	Monthly report to the EOC committee using ISIS maintenance management program
Monitor the reliability of the substation power system as it relates to adverse patient outcomes.	Monthly report to the EOC committee of the number of adverse patient outcomes resulting from utility failures

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Program: Hospital

Chapter: Environment of Care

Standard Number: EC.04.01.03

Standard Text: The hospital analyzes identified environment of care issues.

Element of Performance:

1. Representatives from clinical, administrative, and support services participate in the analysis of environment of care data. (*See also* EC.04.01.01, EPs 3–6 and 8–15; EC.04.01.05, EP 3)

Scoring Categories:

Criticality Level: Indirect

Documentation Required: No

Scoring Category: A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

In most cases, organizations choose to present environment of care data to the multidisciplinary EOC, Safety, or Quality Committees. The Joint Commission does not specify the frequency of how often the organization's Safety, EOC, or Quality Committee should meet. The frequency of this information being reviewed is based on hospital policy but should be considered to be reviewed at least quarterly. The timely review of this information is important as it can assist in preventing or reducing injuries, show the need for more frequent preventative maintenance activities, or highlight the need for staff training. For example, the Occupational Health Department might be seeing increased reports from sharps injuries and not be able to explain why. But, when presented to the group, the clinical representative states that the sharps containers are located too far away from the bedside/exam table, therefore staff are unable to easily dispose of the sharps, and place them in the bed or on the exam table causing "uncapped" sharps to be present. All of these environment of care data should be presented to the surveyors, along with a crosswalk to what changes have been implemented as a result of unfavorable data.

Tips/Resources:

- Review this information at the organization's multidisciplinary Safety/EOC Committee.
- Summarize events and performance improvement data results to the organization's senior leadership or Board Committee.

Element of Performance:

2. The hospital uses the results of data analysis to identify opportunities to resolve environmental safety issues. (*See also* EC.04.01.05, EP 1)

Scoring Categories:

Criticality Level: Indirect

Documentation Required: No

Scoring Category: C

Measure of Success: Yes

Identified risk area: No

Standards BoosterPak™ for Environment of Care (EC.04.01.01, EC.04.01.03, EC.04.01.05)

Implementation Suggestions:

Data analysis that has been presented and reviewed by the representatives from clinical, administrative, and support services should be made available to the surveyors. The data reviewed under this EP can vary widely, but usually includes the following:

- Performance improvement monitoring data results for each environment of care management plan
- Environmental tour findings
- Medical equipment events
- Utility-related events
- Injuries to patients, staff, and visitors

Tips/Resources:

If the data analysis reflects the need for a change in process, the information should be presented to the surveyors. As stated previously, this change could be a policy-driven change, staff training need, or a physical environment change. In addition, be sure to present any ongoing data analysis that supports decisions made by representatives from clinical, administrative, and support services. This can be data tracked that are related to items that have been both successful and not successful.

Element of Performance:

3. Annually, representatives from clinical, administrative, and support services recommend one or more priorities for improving the environment of care.

Scoring Categories:

Criticality Level: Indirect

Documentation Required: No

Scoring Category: A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

The multidisciplinary team that reviews the Environment of Care data as referenced in EC.04.01.01, EP 1, should recommend one or more initiatives to improve the environment of care (Safety, Security, Hazardous Materials and Waste, Fire Safety, Medical Equipment, and Utilities). Examples could include improving fire safety response knowledge, providing a more secure environment in a specific clinical location, improving Safety Data Sheet (SDS) availability for hazardous chemicals, medical equipment replacement needs, and utility failure plan testing or replacement of roofing due to tracking of leaks. This typically is driven from the monitoring of data analysis as described throughout this BoosterPak™.

Tips/Resources:

- A good forum for recommending one or more of the environment of care priorities is the organization's summation of environment of care activities to the leadership team or board of directors.

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(EC.04.01.01, EC.04.01.03, EC.04.01.05)

Program: Hospital

Chapter: Environment of Care

Standard Number: EC.04.01.05

Standard Text: The hospital improves the environment of care.

Element of Performance:

1. The hospital takes action on the identified opportunities to resolve environmental safety issues. (*See also* EC.04.01.03, EP 2)

Scoring Categories:

Criticality Level: Indirect

Documentation Required: No

Scoring Category: C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

Documentation should be made available to the survey team that reflects any identified opportunities, along with how the organization actually resolved them. This is usually shown in the form of a committee's minutes or a summary of environmental tour findings and the action taken to resolve the findings. Also, be sure to show documentation if any funding was requested and approved to make the improvement or change. This assists in showing the link between leadership and the EOC/Safety Team.

Tip:

- When problems or issues are found through the environmental tour process, the organization should resolve the problems or issues as soon as possible. The actions should be documented as stated above.

Element of Performance:

2. The hospital evaluates changes to determine if they resolved environmental safety issues.

Scoring Categories:

Criticality Level: Indirect

Documentation Required: No

Scoring Category: C

Measure of Success: Yes

Identified risk area: No

Implementation Suggestions:

If the organization corrects an environmental issue, it should be evaluated to determine if the correct action was taken. This can be accomplished through environmental tours or data analysis related to performance improvement monitoring or injury report reviews.

Examples could include the following:

- **Change in the process for transporting medical waste within the facility.**
Change made—larger carts purchased that are equipped with straps to secure containers during internal transport. Ongoing monitoring will be conducted during environmental tours for 12 months to validate that carts are adequate and staff are using the tie-down straps to secure containers

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- **Change in the main lobby flooring—issue related to slips/falls when raining outside**

Change made—installed carpet strip flooring at main lobby vestibule to dry shoes before entering main lobby. Ongoing monitoring will be conducted during environmental tours, or when raining outside, to monitor floor condition. In addition, staff at the main lobby will monitor slips/falls and report through the incident reporting system.

Tips:

- It is good practice to use a tracking and trending methodology to help resolve any environment of care priorities. The data collected can be used to make changes to the plan if current resolution activities are not working effectively. The trending identifies activities that do not reach the desired goals. The frequency of data collection depends on the activity's level of risk and on the recommendations of the Safety Committee. Also, the frequency of some data collection activities may be mandated by law and regulation.

Element of Performance:

3. The hospital reports performance improvement results to those responsible for analyzing environment of care issues. (*See also* EC.04.01.03, EP 1; EM.03.01.03, EP 15)

Scoring Categories:

Criticality Level: Indirect

Documentation Required: No

Scoring Category: A

Measure of Success: No

Identified risk area: No

Implementation Suggestions:

Results from performance improvement data should be presented to the multidisciplinary group that reviews all other environment of care items. The frequency of this information being reviewed is based on hospital policy. However, timely review is important as it can assist in preventing or reducing injuries as well as show the need for more frequent preventive maintenance activities or highlight the need for staff training. Most organizations choose to present performance improvement results to the EOC Committee or Safety Committee. The results should be closely reviewed by the committee in order to highlight opportunities for improvement.

Tip:

- A good forum for forwarding reports of the environment of care performance improvement initiatives is the organization's summation of the activities to the leadership team or board of directors.

B. Frequently Asked Questions, Definitions, and Additional Information

Section B1: Frequently Asked Questions (FAQs)

Standard EC.04.01.01

Q: What do standards focus on?

A: The Joint Commission's state-of-the-art standards focus on patient safety and quality of care. The Joint Commission standards are updated regularly to reflect the rapid advances in health care and medicine. The hospital accreditation standards number more than 250, and address everything from patient rights and education, infection control, medication management, and preventing medical errors, to how the hospital verifies that its physicians, nurses, and other staff are qualified and competent, how it prepares for emergencies, and how it collects data on its performance and uses those data to improve itself.

Q: Is a written plan required for monitoring the conditions of the environment?

A: Yes. Each of the five (5) plans under this Standard EC.01.01.01 should be written to include the scope, objectives, performance, and effectiveness of the plans. Annual review summaries of each plan should also include activities and responses outlining the scope, objective, performance, and effectiveness of each plan.

Q: If a health care organization has several types of care (for example, hospital, nursing care center, and behavioral health care) does each EC management plan have to specifically address each of these areas?

A: Yes. Either one plan covers all five functional areas, or a unique plan must be written for each specific area. Either approach is acceptable. There will be specific and unique issues that must be addressed regardless of method. Remoteness will complicate attempts to write a common plan. Separate facilities might be better served with independent plans.

Q: How is the Measure of Success performed to ensure that improvement has occurred?

A: There are multiple ways to measure success or quality improvement for these standards and elements of performance. For the sake of clarity and consistency the assumption is that the various components of the standards and elements of performance will be written. The most important thing when developing performance measures should be to create "at-a-glance" quick and intuitive references for the benefit of the responsible person(s) within the organization. These measurement tools, while they are helpful to a surveyor when on site, are even more helpful to the organization on a day-to-day basis for the purpose of being prepared at all times.

Q: What tools can be used to ensure all elements of the standard are met?

A: Creating an annual calendar of agenda items for each Safety Committee meeting assures the organization that all required topics will be reviewed on time and nothing will be missed. Also, a calendar ensures that incidents that require repeated and potentially lengthy reviews appear on the agenda until resolution has been reached.

Q: What would be monitored when incidents involving injuries to patients occur?

A: While investigating injuries to patients, you may establish tools that identify patient injuries by category. This would be helpful when applying a team to analyze the injuries in order to identify any trends. When the data are analyzed, the team can implement measures for improvement. You may also monitor the facility and grounds for potentially unsafe conditions and correct them immediately. Many injuries occur due to unsafe conditions in the environment that are not process related.

Additional information can be found in the “Leadership” chapter related to patient safety (*see* LD.03.01.01–LD.03.06.01).

Q: When injuries occur to employees, how are these monitored and what records are required?

A: You may establish tools that record all employee injuries and occupational illnesses of hospital employees. Some illnesses and injuries require a physician’s release to return to work. An infection control practitioner and/or an employee health practitioner are helpful to monitor illnesses and injuries. Second, when incidents do occur, you may want to evaluate ways to prevent a recurrence and document the process. The revised 29 CFR Part 1904, titled “Recording and Reporting Occupational Injuries and Illnesses,” is in effect for OSHA–reportable injuries and illnesses. The following logs are required:

- OSHA Form 300, Log of Work-Related Injuries and Illnesses
- OSHA Form 300A, Summary of Work-Related Injuries and Illnesses
(The 300 and 300A forms will replace the former OSHA Form 200, Log and Summary of Occupational Injuries and Illnesses)
- OSHA Form 301, Injury and Illness Incident Report
(The 301 form will replace the former OSHA Form 101, Supplementary Record of Occupational Injuries and Illnesses.)

Q: Do hypodermic needles and syringes need to be stored under lock and key?

A: The Joint Commission standards do not specify locking needles and syringes. This is usually addressed through a risk assessment as identified in EC.02.01.01, EPs 1 and 3. Apply the organization risk assessment process, and, if the method of storage is deemed inappropriate, mitigate the risk.

Q: Are food and drinks for staff members allowed in patient care areas?

A: The Joint Commission standards do not specifically address this issue. However, several other points apply:

- Standard LD.04.01.01 requires compliance with applicable law and regulation. The OSHA Bloodborne Pathogen Standard prohibits food and drink in areas where contamination is likely. For example, if lab specimens are handled in a work area, the OSHA standard would prohibit food and drinks if contamination might occur.
- Under the same LD.04.01.01 standard, many states prohibit food and drink in clinical areas, requiring that they be consumed in break areas.
- Many organizations have policies that prohibit this for infection control, risk management, or even public appearance purposes. These policies are often established after conducting a risk assessment, as required in standard IC.01.03.01. Organizations must be in compliance with their own policies.
- An Environment of Care risk assessment should be performed to address potential patient safety issues, per EC.02.01.01.

Q: How often do eyewashes need to be inspected or flushed?

A: Based on the requirements of the ANSI Z358.1-2009 Standard, The Joint Commission would expect organizations to formulate their own rationale for frequency, write it in policy, and follow the policy. If the organization has defined a frequency substantially less than is generally observed, then documentation should be available to support the rationale. Organizations typically select frequencies of weekly.

- Several differing frequencies for flushing eyewash stations have been published in some noted resources. Under OSHA's Chemical Hygiene Plan, Appendix A of CFR 1910.1450, section (D)(4)(c), there is a nonmandatory recommendation to perform eyewash checks at least every three months.
- In a Hazard Information Bulletin published by the Department of Energy (DOE) on December 23, 1986, and titled "Potentially Hazardous Amoebae Found in Eyewash Stations," there is a recommendation to flush eyewash stations for at least three minutes on a weekly basis. Organizations should consider resources such as these when developing their policy.
- View OSHA's 29 CFR 1910.1450 Appendix A:
http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10107
- View OSHA's response to the DOE Hazardous Information Bulletin:
http://www.osha.gov/dts/hib/hib_data/hib19861223.html

Q: Do physician offices that are owned and managed by the hospital have to follow the hospital accreditation regulations for fire drills?

A: Under the hospital program, outpatient areas classified as business occupancies perform one fire drill per shift per year, whereas the hospital does one per shift per quarter.

Q: Who conducts environmental tours and how often?

A: The hospital should appoint an individual responsible for ensuring that environmental tours are conducted. Typically the hospital safety officer conducts environmental tours at least once every six months in patient care areas and at least once a year in nonpatient care areas (EC.04.01.01, EPs 12 and 13). Although not required by the element of performance, best practice involves others in the hospital with specific knowledge and various disciplines to help with the tours (infection control, facilities managers, environmental services, security, biomedical engineering). A schedule of inspections is maintained in the hospital, as well as a database of areas surveyed and findings. Inspection reports are sent to the department managers, with copies to appropriate administrators. Written responses from each area surveyed are required as evidence of correction of deficiencies noted. Inspection reports and responses are maintained in binders arranged by the individual appointed the responsibility of the tours.

Q: When a new standard is implemented midyear and there is an action required on an annual basis, when is the action expected to be completed?

A: When a new standard with an annual reporting or measurement requirement is implemented midyear, The Joint Commission will specify compliance options. Typically, the new requirement is published with enough lead time to allow for the organization to adjust to the new requirements.

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Standard EC.04.01.03

Q: What is the requirement for the meeting intervals or schedule for the Environment of Care/Safety Committee?

A: The standards do not address the interval between Safety Committee/EOC Committee meetings. The Safety/EOC Committee is a mechanism to comply with the Environment of Care standards. EC.04.01.01–EC.04.01.05 require the hospital to monitor conditions in the environment, collect information, and analyze identified EC issues and then improve its environment of care.

Standard EC.04.01.05

Q: The Environment of Care standards state, “The hospital reports performance improvement results to those responsible for analyzing environment of care issues” (EC.04.01.05, EP 3). How is this process completed?

A: Documentation should be made available to the survey team that reflects any identified opportunities, along with how the organization actually resolved them. This is usually shown in the form of a committee’s minutes or a summary of environmental tour findings and the action taken to resolve the findings. Also, be sure to show documentation if funding was requested and approved to make the improvement or change. This assists in showing the link between leadership and the EOC/Safety Team.

Section B2: Definitions of Key Terms

Environmental tours: Activities routinely used by the organization to determine the presence of unsafe conditions and whether the organization's current processes for the environment of care itself or managing environmental safety risks are practiced correctly and are effective.

Fire safety management: Activities selected and implemented by the organization to control the risks of fire, smoke, and other byproducts of combustion that could occur during the organization's provision of care, treatment, or services.

Hazardous materials and waste: Materials whose handling, use, and storage are guided or defined by local, state, or federal regulation, such as the Occupational Safety and Health Administration's Regulations for Bloodborne Pathogens regarding the disposal of blood and blood-soaked items and the Nuclear Regulatory Commission's regulations for the handling and disposal of radioactive waste. This also includes hazardous vapors (for example, gluteraldehyde, ethylene oxide, nitrous oxide) and hazardous energy sources (for example, ionizing or nonionizing radiation, lasers, microwave, ultrasound). Although The Joint Commission considers infectious waste as falling into this category of materials, federal regulations do not define infectious or medical waste as hazardous waste.

Medical equipment: A medical device is an instrument, apparatus, implant, in vitro reagent, or other similar or related article, which is intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, or intended to affect the structure or any function of the body and which does not achieve any of its primary intended purposes through chemical action within or on the body.

Risk assessment, proactive: An assessment that examines a process in detail, including sequencing of events, actual and potential risks, and failure or points of vulnerability and that prioritizes, through a logical process, areas for improvement based on the actual or potential impact (that is, criticality) of care, treatment, or services provided.

Safety Data Sheet (SDS): A Safety Data Sheet is a document that contains information on the potential health effects of exposure to chemicals, or other potentially dangerous substances, and on safe working procedures users should adhere to when handling chemical products.

Utility systems: Building systems that provide support to the environment of care, including electrical distribution and emergency power; vertical and horizontal port; heating, ventilating, and air-conditioning (HVAC); plumbing, boiler, and steam; piped gases; vacuum systems; and communication systems, including data exchange systems.

Section B3: Additional Information

See Environmental Tours Checklist (pages 17–18), Fire Drill Matrix (page 24), Fire Drill Evaluation (page 25), and Utilities Management Plan (page 26).

C: Supporting Documentation, Evidence, Values, Historical Information, and Additional References

Section C1: CMS Tags, Evidence Base, and Consensus Process

CMS Conditions of Participation and Interpretive Guidelines, June 5, 2009: http://www.cms.hhs.gov/manuals/Downloads/som107ap_a_hospitals.pdf.

§482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

§482.13(c)(2) The patient has the right to receive care in a safe setting.

§482.26(b)(2) Periodic inspection of equipment must be made and hazards identified must be properly corrected.

EC.04.01.01	COP	TAG
EP 1	§482.41(a) §482.13(c)(2) §482.26(b)(2)	A-0701 A-0144 A-0537
EP 3	§482.41(a) §482.13(c)(2) §482.26(b)(2)	A-0701 A-0144 A-0537
EP 4	§482.41(a) §482.13(c)(2) §482.26(b)(2)	A-0701 A-0144 A-0537
EP 5	§482.41(a)	A-0701
EP 6	§482.41(a)	A-0701
EP 8	§482.41(a) §482.26(b)(2)	A-0701 A-0537
EP 9	§482.41(a) §482.26(b)(2)	A-0701 A-0537
EP 10	§482.41(a) §482.26(b)(2)	A-0701 A-0537
EP 11	§482.41(a) §482.13(c)(2) §482.26(b)(2)	A-0701 A-0144 A-0537
EP 12	§482.41(a) §482.13(c)(2) §482.26(b)(2)	A-0701 A-0144 A-0537
EP 13	§482.41(a) §482.13(c)(2)	A-0701 A-0144
EP 14	§482.41(a) §482.13(c)(2)	A-0701 A-0144
EP 15	§482.26(b)(2) §482.41(a)	A-0537 A-0701

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EC.04.01.03	COP	TAG
EP 1	§482.41(a) §482.13(c)(2) §482.26(b)(2)	A-0701 A-0144 A-0537
EP 2	§482.41(a) §482.26(b)(2)	A-0701 A-0537
EP 3	§482.41(a)	A-0701

EC.04.01.05	COP	TAG
EP 1	§482.41(a) §482.26(b)(2)	A-0701 A-0537
EP 2	§482.41(a)	A-0701
EP 3	§482.41(a)	A-0701

Evidence Base and Consensus Process During Development:

Consensus was based on review and collaboration for tables and charts used.

No evidence-based process available at the time of development.

Section C2: Field Testing, Values, Relationship to Measures, and Other Initiatives

Value to Field (Projected or Actual)

Projected: The EC standards are organized around the concepts of planning, implementing, and evaluating, and evaluation of results. The chapters discussed provide oversight on how the hospital collects information to monitor the conditions in the environment, analyzes the data from identified environment of care issues, and improves the environment of care. The hospital can address specific risks and the unique conditions at each of its sites. The process will help to ensure that the hospital continuously improves the environment.

Section C3: Historical Information and Changes

Changes to the EC chapter were effective January 1, 2012.

For application of the standards discussed in various occupancies, see the Standards Applicability Grid (SAG) on the Joint Commission website.

Section C4: Additional References and Links

Information was summarized from the Joint Commission website as per <http://www.jointcommission.org>.

Medical equipment is summarized from the FDA's definition as per <http://www.fda.gov>.

OSHA reporting is summarized as per <http://www.osha.gov/recordkeeping/entryfaq.html>.

Controlling contaminant is summarized as per <http://www.ashrae.org>.

Controlling contaminant is summarized as per <http://www.cdc.gov>.

Environmental Tours is summarized as per <http://www.healthsafe.uab.edu/pages/hospitalsafety/faq.htm>.

OSHA's safety standards for hazardous materials as per: http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10107.

View OSHA's response to the DOE Hazardous Information Bulletin:

http://www.osha.gov/dts/hib/hib_data/hib19861223.html.

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