Standards Connection

**LS.02.01.30, EP 15**
Corridors serving adjoining areas are not used for a portion of an air supply, air return, or exhaust air plenum.

**Note:** *Incidental air movement between rooms and corridors (such as isolation rooms) because of the need for pressure differentials in hospitals is permitted. In such cases, the direction of airflow is not the focus for this element of performance. For the purpose of fire protection, air transfer should be limited to the amount necessary to maintain positive or negative pressure differentials.* (For full text, refer to NFPA 101-2012: 19.5.2.1; NFPA 90A-2012: 4.3.12.1; 4.3.12.1.3.2)

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**Capnography Monitoring Required in NY Office-Based Surgery Practices**

The New York State Department of Health (NYS DOH) Office of Quality and Patient Safety has adopted a new regulation that requires monitoring for adequate ventilation during procedures performed with moderate sedation, deep sedation, and general anesthesia in office-based surgery settings. As an accrediting agency approved by the NYS DOH for accreditation of office-based surgery practices, The Joint Commission will begin assessing compliance with this regulation **January 31, 2018**, by assessing compliance with requirements such as those shown in the sidebar at right.

Office-based surgery practices located in New York State will be required to provide continual* end tidal carbon dioxide (CO₂) monitoring using capnography for patients receiving moderate sedation, deep sedation, and general anesthesia.† Capnography monitoring measures CO₂ levels in exhaled gas from the lungs and provides a continual evaluation of ventilation. The addition of capnography to the monitoring of patients receiving moderate, deep, and general sedation has been found to decrease the number of adverse events, including apnea and hypoxia.

In order to be compliant, New York office-based practices will need to provide monitoring of adequate ventilation during moderate or deep sedation and general anesthesia through continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide using capnography, unless made impossible or restricted by the nature of the patient, procedure, or equipment. When capnography is used, the end tidal CO₂ alarm should be audible to the clinical staff responsible for monitoring the patient. Capnography will be documented at frequent intervals in the physiologic monitoring record.

Questions may be directed to Jennifer Hoppe, MPH, senior associate director, State and External Relations, The Joint Commission, at jhoppe@jointcommission.org.

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**APPLICABLE JOINT COMMISSION REQUIREMENTS**

**LD.04.01.01, EP 2**
The practice provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations.

**PC.03.01.01, EP 6**
For operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia: The practice has equipment available to monitor the patient’s physiological status.

**PC.03.01.05, EP 1**
During operative or other high risk procedures, including those that require the administration of moderate or deep sedation or anesthesia, the patient’s oxygenation, ventilation, and circulation are monitored continuously. (See also RC.02.01.03, EP 8)

**Note:** Monitoring includes pulse oximetry, blood pressure monitoring, electrocardiograms as needed, and respiratory frequency and adequacy.

* *For the purpose of this standard, continual is defined as “repeated regularly and frequently in steady rapid succession” (whereas continuous is defined as “prolonged without any interruption at any time”).
† End-tidal carbon dioxide monitoring refers to the noninvasive measurement of exhaled carbon dioxide.