Labeling the Hazard

OSHA to institute “global harmonization” of hazard communications

Hazardous chemical labels will soon have a new look—and workers will need to be trained to recognize it.

Beginning shortly, OSHA will require that hazardous chemical containers be labeled with a whole new set of standardized pictograms (see Figure 1, p. 3). The easily identified symbols will be the same around the world. Having the symbols “globally harmonized” will help workers in countries around the planet recognize exactly what type of hazardous material is in a container, regardless of what country it was shipped from and what language it’s in.


The revised OSHA standard requires that information about chemical hazards be conveyed on labels using quick visual notations to alert the user and provide immediate recognition of the hazards. The label provides information to the workers on the specific hazardous chemical. Labels must also provide instructions on how to handle the chemical so that chemical users are informed about how to protect themselves. Specifically, labels must contain the following information: product identifier; signal word; hazard statement(s); precautionary statement(s); pictogram(s); and the name, address, and telephone number of the manufacturer.

Under OSHA’s recent revision of the Hazard Communications Standard (29 CFR 1910.1200), the symbols and frames presented above will no longer be acceptable as of June 1, 2015. Harmonized pictograms (shown in Figure 1) will replace such symbols on hazardous chemical labels.

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The Questions

Time to get sharp on The Joint Commission EC standards and essential information. Use this feature to beef up your knowledge, as a quick reminder of what you already know, or to help educate your staff on a variety of EC, EM, and LS standards and information. You’ll find the answers (if you don’t already know them) on page 11. Okay, ready?

1. How frequently must a laboratory monitor hazardous gas and vapor levels?
   a. Daily
   b. Monthly
   c. Yearly
   d. At a frequency determined by law and regulation

2. Egress doors in all hospitals must swing in the direction of egress.
   True or False?

3. After granting disaster privileges to a volunteer licensed independent practitioner, within what time frame must a hospital determine whether the practitioner’s disaster privileges should continue?
   a. 24 hours
   b. 48 hours
   c. 72 hours
   d. A week

4. Only hospitals and critical access hospitals must map their utility systems.
   True or False?

5. How frequently must an ambulatory care organization test any visual and audible fire alarms present in the facility (including speakers)?
   a. Once a month
   b. Once a quarter
   c. Every 6 months
   d. Every 12 months

How did you do? Check the answer key on page 11.
chemical manufacturer, importer, or other responsible party (see the box above and Figure 2, below).

Safety data sheets
In addition, safety data sheets (SDS—formerly referred to as “material safety data sheets,” or MSDS) will also have a new standardized look that will help workers anywhere quickly find and understand the information they need. The revised standard requires the use of a 16-section SDS format, which provides detailed information regarding the chemical. As with MSDS, OSHA requires that

What to Look for on a Label

- Name, address, and telephone number
- Product identifier
- Signal word
- Hazard statement(s)
- Precautionary statement(s)
- Pictogram(s)

OSHA will enforce the use of eight of these pictograms on hazardous chemicals. The environmental pictogram is not mandatory but may be used to provide additional information.

Figure 1. Labels and Pictograms

Figure 2. Hazard Communication Standard Labels

This label contains all the elements the new OSHA regulations require. You can use this Quick Card™ to train employees about the new labels.
Labeling the Hazard  
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SDS be kept in work areas where chemicals are used and stored. Labels provide important information for anyone who handles, uses, stores, and transports hazardous chemicals, but, of course, they are limited by design in the amount of information they can provide. SDS are a more complete resource for details regarding hazardous chemicals.

Training

Although the deadline for updating the labels is June 1, 2015,* the deadline for training workers is much sooner: December 1, 2013. Organizations will want to get their training programs up and running quickly, and OSHA has provided training tools including briefs and “Quick Card™” visuals to help do that. You can find them at http://www.osha.gov/dsg/hazcom. A sample Quick Card™ is shown in Figure 2. The box at right contains the minimum required topics for the training that must be completed by December 1, 2013.

Joint Commission requirements

The Joint Commission’s standard EC.02.01.01 and related elements of performance (EPs) require that accredited organizations manage “risks related to hazardous materials and waste.” Specifically, EC.02.01.01, EP 11, requires organizations to have the “safety data sheets required by law,” and EC.02.01.01, EP 12, requires organizations to label “hazardous materials and waste. The labels identify the contents and hazard warnings.”

* Distributors may continue to ship containers labeled by manufacturers or importers (but not by the distributors themselves) in compliance with HazCom 1994 until December 1, 2015.

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Hazard Communications Training Topics

This list contains the minimum required topics for the training that must be completed by December 1, 2013, according to OSHA.

Training on label elements must include information on the following:

• The type of information the employee would expect to see on the new labels, including the following:
  ✓ Product identifier: how the hazardous chemical is identified. This can be (but is not limited to) the chemical name, code number, or batch number.
  ✓ Signal word: used to indicate the relative level of severity of hazard and alert the reader to a potential hazard on the label. There are only two signal words, “Danger” and “Warning.” Within a specific hazard class, “Danger” is used for more severe hazards, and “Warning” is used for less severe hazards.
  ✓ Pictogram: OSHA has designated eight pictograms under this standard for application to a hazard category.
  ✓ Hazard statement: describes the nature of the hazard(s) of a chemical, including, where appropriate, the degree of hazard. For example: “Causes damage to kidneys through prolonged or repeated exposure when absorbed through the skin.”
  ✓ Precautionary statement: means a phrase that describes recommended measures that should be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical or improper storage or handling.
  ✓ Name, address, and phone number of the chemical manufacturer, distributor, or importer

• How an employee might use the labels in the workplace, including the following examples:
  ✓ Explain how information on the label can be used to ensure proper storage of hazardous chemicals.
  ✓ Explain how the information on the label might be used to quickly locate information on first aid when needed by employees or emergency personnel.

• General understanding of how the elements work together on a label, including the following examples:
  ✓ Explain that where a chemical has multiple hazards, different pictograms are used to identify the various hazards. The employee should expect to see the appropriate pictogram for the corresponding hazard class.
  ✓ Explain that when there are similar precautionary statements, the one that provides the most protective information will be included on the label

Training on the format of the safety data sheets (SDS) must include information on the following:

• Standardized 16-section format, including the type of information found in the various sections
• How the information on the label is related to the SDS

This article was developed through the cooperative efforts of the OSHA/Joint Commission Resources Alliance.
Ensuring Full Compliance with the Life Safety Code®

Tips on meeting recurring compliance issues

The Joint Commission has identified the need to increase the field’s awareness and understanding of the Life Safety Code®* as well as other key environment of care concepts. To address this need, Environment of Care® News publishes the column Clarifications and Expectations, authored by George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission. This column clarifies standards expectations and provides strategies for challenging compliance issues, primarily in life safety and the environment of care but also in the vital area of emergency management. You may wish to share the ideas and strategies in this column with your organization’s leadership.

Since 1968, The Joint Commission has required accredited organizations to comply with the National Fire Protection Association’s Life Safety Code®. To help organizations with compliance efforts, The Joint Commission created the “Life Safety” (LS) chapter of the Comprehensive Accreditation Manual. This chapter supports an organization’s efforts to be fully compliant with the code.

Because of the size and scope of the Life Safety Code, the LS chapter does not fully delineate every NFPA requirement. However, it has always been the Joint Commission’s intention that health care organizations comply with the complete set of NFPA requirements in The Life Safety Code.

To clearly communicate this intent, The Joint Commission includes several standards in the LS chapter that relate to the topic of full compliance. For example, in Standard LS.02.01.20, which deals with means of egress requirements, element of performance (EP) 32 states that “the organization meets all other Life Safety Code means of egress requirements related to NFPA 101-2000, 18/19.2.” So, if during survey, an organization is found to be noncompliant with one of the means of egress requirements not specifically addressed in EPs 1–31, a surveyor would score that noncompliance at EP 32.

Recently, The Joint Commission has noticed some recurring compliance issues that are scored at EP 32 and similar “full compliance” EPs in the LS chapter. These EPs include, but are not limited to, LS.02.01.20, EP 32; LS.02.01.30, EP 25; and LS.02.01.34, EP 4.

This article looks at some of those issues, so that organizations can be aware that these topics may be addressed during survey.

Means of egress (LS.02.01.20, EP 32)

A deficiency scored at EP 32 of LS.02.01.20 may address door width in means of egress doors and doors from sleeping rooms and diagnostic and treatment areas, such as x-ray, surgery, physical therapy, and nursery rooms. A means of egress is a continuous and unobstructed way of exit travel from any point in a building or structure to a public way. For existing buildings, the Life Safety Code requires that these doors not measure less than 32 inches clear width (see NFPA 101-2000, ‡ 19.2.3.5). Doors located in these areas in new health care buildings must have a minimum clear width of 41.5 inches (see 18.2.3.5). Clear width—that is, the unobstructed width of the door opening without projections into such width—is measured by subtracting the door stops built into the door frame plus the thickness of the door itself at the hinge edge from the total door opening. For example, subtracting the door stop and hinge stile edge from a 44-inch door leaf would be 41.5 inches clear width. (Note that prior to 1994, the Life Safety Code specified door measurements for the door leaf width rather than the current clear width.)

Smoke barrier doors (LS.02.01.30, EP 25)

Several issues regarding smoke barrier doors have been cited at LS. 02.01.30, EP 25. One deals with the fire rating of smoke barrier doors. The Life Safety Code requires that doors found in a smoke barrier be either of substantial construc-

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(continued from page 5)

tion (for example, 1.75 inches thick, solid-bonded wood core) or of construction that resists fire for not less than 20 minutes. Any door that is either not substantial or fails to resist fire for at least 20 minutes is not compliant (see 18/19.3.7.5 and 18/19.3.7.7).

Another code requirement scored at EP 25 relates to the swing direction of smoke barrier doors. Under the code, in existing construction doors are not required to swing in the direction of egress. Pairs of doors in existing construction often swing in the same direction, which is acceptable under the code. However, in new construction, swinging doors must be hung so the doors swing in opposite directions (see 18.3.7.5).

Smoke barrier door width is also addressed at EP 25. Similar to means of egress doors, smoke barrier doors in existing health care occupancies must measure 32 inches clear width; they must measure 41.5 inches clear width in new construction (see 18.3.7.5 and 19.3.7.7). New construction also requires door edge treatments, such as rabbets, bevels, or astragals, at the meeting edges of smoke barrier doors (see 18.3.7.8). Door edge treatments are not required in existing construction.

Fire alarms (LS.02.01.34, EP 4)
To comply with the Life Safety Code under Standard LS.02.01.34, EP 4, a fire alarm system must be activated in one of the following ways:

• Manual fire alarm initiation (that is, someone pulls the alarm)
• Automatic detection
• Extinguishing system operation

To ensure that the manual fire alarm pull box is easy to get to, the Life Safety Code requires that the box be always accessible, unobstructed, and visible. Accessibility includes travel distance, with travel distance to the manual fire alarm pull box not exceeding 200 feet. The pull station must be located in a natural exit access path near each exit from an area, unless located at the nurse’s station (or other continuously attended staff location).

Although this requirement may seem straightforward, an organization may inadvertently place itself out of compliance. For example, suppose an organization has located the manual fire alarm pull box in the nursing station rather than at the unit exit. During a remodeling project, the organization moves the nursing station but leaves the manual fire alarm pull box in place, about 100 feet from an exit. The pull box is no longer correctly positioned because it is not at the nursing station and is too far from an exit. This situation results in noncompliance for the organization (see 18/19.3.4.2 and 9.6.2.1–9.6.2.6).

Automatic sprinkler systems (LS.02.01.35, EP 14)
If an organization is required to have an automatic sprinkler system, then it must have an adequate and reliable water supply to feed the system. Systems that have fire pumps must be tested to ensure that there is adequate flow to support the pumps. Standard EC.02.03.05, EP 11, addresses this issue, requiring systems with fire pumps to be tested annually.

Some fire extinguishing systems are fed directly by a city supply (or other means that are out of an organization’s control). These systems might face challenges. If the organization experiences a reduction in water supply, this becomes a Life Safety Code issue because Section 18/19.3.5.1 requires compliance with the Standard for the Installation of Sprinkler Systems (NFPA 13-1999), which requires that there be an adequate water supply.

If the organization is unable to meet the minimum requirements of the Life Safety Code regarding this issue, its sprinkler system will be considered to be compromised, and the organization will need to take additional action. For example, one hospital experienced a lack of water pressure following several construction projects. If the organization had left this situation unaddressed, it could have been cited for noncompliance at Standard LS.02.01.35, EP 14. Fortunately, repiping the supply and replacing several 90° turns with 45° turns reduced piping restrictions and allowed the system to meet minimum building requirements.

“No Smoking” signage and ashtrays (LS.02.01.70, EP 4)
One of the topics that falls within LS.02.01.70, EP 4, relates to No-smoking signage. The Life Safety Code requires that no smoking signs be prominently displayed at all major entrances and supported by policy. (See EC.02.01.03 for prohibition of smoking except in specific circumstances.) If the signs are not prominently displayed at major entrances, then no-smoking signage must be used in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored, and in any other hazardous location (see 18/19.7.4). A risk of noncompliance occurs when no smoking signs are removed from major entrances and oxygen use areas do not have appropriate signage. (Note that the international symbol for NO SMOKING, right, may be used as alternative signage.)

Another issue scored at EP 4 deals with ashtrays. The Life Safety Code requires that all areas where smoking is allowed must have noncombustible ashtrays and must also have metal containers (continued on page 9)
Note: This is Part 2 of a two-part series that explores the significance of mutual patient and worker safety and ways both groups can be better protected.

A confused elderly patient attempts to leave her hospital bed in the middle of the night to use the bathroom. A nursing assistant rushes to help her return to bed, but the patient slips from her grip and strikes the floor and the bed frame. The patient sustains bruising, and her stay is lengthened, while the nursing assistant experiences back pain and misses three days of work.

Scenes like this hypothetical one play out in health care settings with alarming frequency. Consider that one out of three hospital patients experiences adverse events during hospitalization.1 And more workers in the health care and social assistance industry sector are injured (5.2 out of 100 workers in 2010, on average) than in any other private industry (an average of 3.5 out of 100 workers).2

The example also demonstrates that the safety of employees and patients in health care organizations (HCOs) is inseparably linked. The Joint Commission’s recent monograph, Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation, is devoted to this concept.3 Understanding this synergy, the value of mutual safety, and how to better protect both groups (issues that are explored in Part 1 of this series, published last month) is vital. Equally important, however, are learning how to increase your organization’s reliability, stressing incident reporting and feedback, and creating an effective safety climate.

High-reliability organizations

Working to improve both worker and patient safety is essential to becoming a high-reliability organization (HRO). HROs have been described as “systems operating in hazardous conditions that have fewer than their fair share of adverse events.”4

“[HROs] understand that humans fail. Everybody makes mistakes; it’s part of human nature. And it will happen when you least want it to,” says Rosemary Sokas, MD, MOH, professor and chair, Department of Human Science, Georgetown University School of Nursing and Health Studies, Washington, DC. “So you plan for that and create backup systems to catch failures before they can cause a bad outcome. In an [HRO], there’s an obsession ahead of time with what can go wrong and how you can prevent it.”

To help with prevention of adverse events, HROs should respect the experience of workers and train them appropriately. “That way, when things do go wrong, you have a trained workforce that knows how to adapt,” says Sokas. “You should also promote teamwork and communication across hierarchies, and include frontline workers as safety monitors who can really tell you if you’re ‘walking the walk.’”

The Joint Commission strongly supports health care organizations working toward becoming HROs. In fact, The Joint Commission’s High Reliability Resource Center webpage is devoted to tools, tips, and articles to help organizations in this quest. See the website at jointcommission.org/highreliability.aspx.

Essential changes

HCOs must make the following three interdependent, essential changes to become highly reliable:

1. Leadership must commit to the goal of high reliability.
2. An organizational culture that supports high reliability must be fully implemented.
3. The tools of robust process improvement must be adopted.5

For example, per Joint Commission Environment of Care (EC) standards, an HCO aiming to become an HRO should carefully evaluate new types of medical equipment before initial use and maintain a written inventory of all medical equipment. (See EC.02.04.01 and EC.02.04.03.) An HCO should ensure that it has a reliable emergency electrical power source for alarm systems, exit routes, emergency communication systems, essential medical equipment, and clinical care areas. (See EC.02.05.03.)

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**Effective reporting systems**

A safe culture and workplace is also highly dependent on a proactive surveillance system to identify hazards and risks, evaluate them, prevent future occurrences, and mitigate the effects of breakthrough occurrences. Managers should encourage employees and other stakeholders to report hazards. Hazard identification will be more effective with an easy-to-use reporting system that rewards those who choose to file reports.

Essentially, workers want to do a good job, “but they need to have the tools, information, and training to do so. They also want to be appreciated for what they do,” says Sokas. “Encouraging incident reporting and providing healthy feedback lets them know they’re appreciated and builds trust.”

“Systems for (incident) reporting and investigation of individual events as well as near misses or close calls can generate useful information to identify opportunities for improvement in local systems and processes,” says Barbara Braun, PhD, project director, Department of Health Services Research, Division of Healthcare Quality Evaluation for The Joint Commission.

Without an effective feedback system in place, workers either can’t report a problem or don’t bother because they don’t expect anything to be done about it, Sokas says.

**Safety culture club**

One of the most significant ways to become an HRO and, thus, better protect both patients and workers is to promote an effective culture of safety. According to the Joint Commission monograph, a safety culture is a subset of an organization’s overall climate that does the following:

- Focusees on people’s perceptions about the degree to which the organization values safety for workers, patients, and/or the environment
- Commits resources to safety-related initiatives and equipment
- Promotes safe behaviors

A safety culture can serve as a leading indicator of safety performance, as opposed to error and injury rates, which are lagging indicators of performance.

“A culture of safety has to start from the top and be consistent day after day. There has to be enough trust and the idea that this is a culture where workers can be respected, where they can be free to admit mistakes without being afraid they’ll get in trouble,” Sokas says. “It’s hard to establish that level of respect and trust, and it’s easy to break it if people wind up being punished when they made a mistake but intended to do well.”

An inadequate safety culture and poor working conditions are linked to unfavorable outcomes for workers, which are associated with poorer patient outcomes, per the Joint Commission monograph.

Thus, HROs should emphasize both worker and patient safety, which are inseparably integrated, and identify their safety culture strengths and weaknesses (see “Safety Culture Characteristics,” above).

HCOs can improve their safety culture in many ways. For example, they can train frontline and security staff in assault and violence prevention and management. This training can benefit patients by leading to fewer injuries and less use of restraint. Such training can help workers by reducing anxiety and promoting teamwork. HCOs can install effective locks, lights, and video surveillance equipment in and around the facility, which can allay patient and staff fears of violence. HCOs can also enforce better infection prevention programs by

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**Safety Culture Characteristics**

According to findings of a recent survey by the Agency for Healthcare Research and Quality (AHRQ), most health care organizations (HCOs) that could be considered to have a culture of safety display four areas of strength.

**Areas of strength**

1. Teamwork within units—staff support each other, treat each other with respect, and work together as a team.
2. Supervisors/managers consider staff suggestions for improving patient safety, praise staff for following patient safety procedures, and do not overlook patient safety problems.
3. Organizational learning—mistakes have led to positive changes, and changes are evaluated for effectiveness.
4. Hospital management provides a work climate that promotes patient safety and shows that patient safety is a top priority.

However, for many HCOs, flaws still remain, specifically in three areas for improvement.

**Areas for improvement**

1. Workers should feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file.
2. Important patient care information should be transferred across hospital units and during shift changes.
3. There should be enough staff to handle the workload, and work hours should be appropriate to provide the best care for patients.
having workers receive regular immunizations, follow recommended hygiene practices, and wear personal protective equipment (PPE)—resulting in decreased transmission of pathogens from workers to patients and patients to patients.

Setting a good example
Although it’s important to train workers properly and expect them to follow established procedures designed to stress safety, effective modeling from the top down is necessary.

“As with any other business improvement initiative, a proactive approach to safety and health starts with management leadership and visibility,” says Patricia Bray, MD, MPH, medical officer for the Office of Occupational Medicine, Occupational Safety and Health Administration (OSHA). “It is essential for management to lead by example and to provide necessary resources to maintain a safe environment and to encourage safe behaviors.”

Bray says managers can promote an effective safety culture in several ways—by wearing PPE, asking workers during walk-abouts if they have any safety concerns, responding promptly when issues are raised, and investigating any incidents or near misses involving patients, workers, or visitors.

Bray also encourages health care organizations to enroll in OSHA’s Voluntary Protection Program (VPP; see http://osh.gov/dcep/vpp for details). VPP facilities have demonstrated a high degree of effectiveness in reducing injuries and illnesses, and VPP participation can also lead to lower employee turnover, increased productivity, and cost savings.

References

Ensuring Full Compliance with the Life Safety Code®
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with self-closing cover devices into which ashtrays can be emptied. Surveyors have noticed that in some instances, metal containers used for emptying ashtrays fail to have self-closing cover devices. They are therefore cited as being noncompliant (see 18/19.7.4).

Bedding, curtains, and other furnishings (LS.02.01.70, EP 4)

Cubicle curtains are included in this section and are also discussed in 18/19.3.5.5, with a reference to NFPA 13-1999, Standard for the Installation of Sprinkler Systems. NFPA 13 requires that hanging cubical curtains not compromise the 18-inch clear space below the sprinkler. Noncompliance with this requirement is scored at LS.02.01.35, EP 6.

Note that organizations often address this requirement by designing a cubical curtain to have a mesh top (¼-inch diagonal or a 70% open weave) that extends 18 inches below the sprinkler deflector. This solution is compliant with LS.02.01.35, EP 6.

Further concerns
This column offers a brief discussion of some compliance issues that surveyors are seeing, but it does not represent an exhaustive list. Organizations must keep in mind that The Joint Commission requires full and complete compliance with the NFPA’s Life Safety Code. Taking time to review that document along with the LS Chapter may be beneficial in furthering your organization’s compliance efforts.
Revisions to Applicability of EC Requirements for Freestanding Ambulatory Infusion and Rehabilitation Technology Settings in the Home Care Program

The Joint Commission is committed to an ongoing process of gathering customer and stakeholder feedback on current standards. It uses this feedback to assess standards and clarify, restructure, or delete requirements based on their value and applicability to accredited organizations.

Recently The Joint Commission received comments and questions from customers concerning several Environment of Care (EC) standards and elements of performance (EPs) as they relate to two home care settings: freestanding ambulatory infusion (FSAI) and rehabilitation technology (RT). FSAI organizations provide the dispensing and administration of drug therapy by infusion or inhalation (and other related services) to ambulatory patients under the supervision of a licensed health care professional (for example, a nurse). These services are provided in a room or an office that is neither an extension of a physician office or hospital nor part of a larger ambulatory home care organization. RT is a component of home medical equipment (HME) services that enhances the lifestyle of physically challenged individuals through the sale and rental of custom medical equipment (such as mobility systems and adaptive equipment) and ongoing evaluation by trained rehabilitation technologists. RT services may be provided in the patient’s home, rehabilitation clinics, or the home care organization’s facility/office.

Most FSAI and RT services are provided in office settings that are classified as business occupancies according to National Fire Protection Association (NFPA) guidelines. Business occupancy health care settings include facilities in which no one stays overnight and, given the nature of their treatment, three or fewer individuals are rendered incapable of self-preservation at any time. Because most FSAI and RT services are provided in business occupancy settings, they are not required to follow the same set of NFPA fire safety guidelines required for other inpatient and outpatient health care settings.

In response to customer feedback requesting a review of the applicability of EC standards to these two settings, The Joint Commission convened an internal group of home care representatives (staff and surveyors) and Life Safety Code® engineers in the fall of 2012. Specific issues raised by customers focused on standards that require these organizations to maintain the following:

- Fire safety building features (EC.02.03.05)
- Utility systems (EC.02.05.01)
- Emergency communication systems (EC.02.05.03)
- Testing of utility systems before initial use (EC.02.05.05)
- Testing of emergency power systems (EC.02.05.07)

(continued on page 11)
In addition to the internal group’s review of Joint Commission standards and related NFPA fire safety guidelines for business occupancy settings, the research included a review of internal data collected from various customers. The information gathered was then presented to The Joint Commission’s Home Care Advisory Group for its review and recommendations.

The Joint Commission used this research as well as feedback from the Home Care Advisory Group to make several editorial revisions and remove applicability for the following EPs determined to be irrelevant to or inappropriate for FSAI and RT settings (though they remain applicable to other home care settings):

- EC.02.03.05, EPs 1–14, and 17–20
- EC.02.05.01, EPs 3–4
- EC.02.05.03, EP 3
- EC.02.05.05, EP 1
- EC.02.05.07, EPs 3–6

The editorial revisions to the EC standards for all home care settings are summarized in the two boxes on page 10. All changes are effective July 1, 2013, and appear in the 2013 Update 1 to the Comprehensive Accreditation Manual for Home Care as well as the spring 2013 Edition® update.

If you have any questions about the home care EC standards revisions or applicability changes, contact Kathy Clark, MSN, RN, associate project director and home care specialist, Department of Standards and Survey Methods, at kclark@jointcommission.org.

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**Test your IQ**

**The Answers**

Here are the answers to the questions on page 2. How did you do?

1. **D. At a frequency determined by law and regulation.** Laboratories, along with ambulatory care organizations, hospitals, critical access hospitals, and office-based surgeries, must monitor levels of hazardous gases and vapors to verify that they are within safe range. Law and regulation should dictate the frequency of this effort as well as acceptable ranges. Organizations may want to consult the websites of the Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH) for guidance in establishing safe ranges.
   
   **STANDARDS REFERENCE:** EC.02.02.01, EP 10

2. **False.** Although it is wise to have doors in the means of egress (the path for safely leaving an area during a fire) open in the direction of egress, this is **required** only for organizations whose occupancy is 50 or more. Having doors swing in the direction of egress ensures that people can exit an area quickly and creates a safe path without restrictions. If this requirement were not in place, egress doors in larger organizations could restrict movement during an emergency. For example, if a press of people is trying to get through a door quickly, it could be problematic if they have to stop and open the door toward them prior to leaving. (For full text and any exceptions to this requirement, refer to NFPA 101-2000: 7.2.1.4.2.)
   
   **STANDARDS REFERENCE:** LS.02.01.20, EP 2

3. **C. 72 hours.** A hospital has 72 hours in which to decide whether to continue a volunteer licensed independent practitioner’s granted disaster privileges. To help with this determination, organizations must conduct primary source verification of licensure as soon as the immediate emergency situation is under control. If such verification cannot be completed within 72 hours due to extraordinary circumstances, the hospital must document all of the following:
   - Reason(s) primary source verification could not be performed within 72 hours of the practitioner’s arrival
   
   **STANDARDS REFERENCE:** EM.02.02.13, EPs 7–9

4. **False.** The need for organizations to map the distribution of their utility systems is not limited to hospitals. Standard EC.02.05.01, EP 7, requires all settings, with the exception of home care organizations, to engage in this activity. A utility map should show the operations of all an organization’s various utility systems, including water; medical gas; heating, cooling, and ventilating; and electrical systems. These drawings should show where the utilities enter the building and how they are distributed throughout the facility. They should also show where the end points of use are and where emergency interventions can be performed, if necessary. It’s important for organizations not only to have such maps but to understand and use them as a reference during partial or complete emergency shutdowns. Note that for office-based surgery, only those practices that use electrical life support equipment, provide patients with assisted mechanical ventilation, or have blood, bone, and tissue storage units are required to have utility distribution maps.
   
   **STANDARDS REFERENCE:** EC.02.05.01, EP 7

5. **D. Every 12 months.** Ambulatory care organizations that have visual and audible fire alarms must test those alarms every 12 months and document test completion. Annual fire alarm testing is also required for all other settings except laboratories, provided that the organization has visual and audible fire alarms in place. To determine the appropriate method for testing, organizations should consult NFPA 72, 1999 edition (Table 7-3.2).
   
   **STANDARDS REFERENCE:** EC.02.03.05, EP 4
The Joint Commission/NFPA® Life Safety Book for Health Care Organizations

By George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission, and James K. Lathrop, FSFPE, vice president, Koffel Associates, Inc.

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