organization has 60 days to complete any Requirements for Improvement (RFI). The Joint Commission requires an organization to implement its interim life safety measures (ILSM) policy to protect patients, staff, and visitors until it corrects any deficiencies. The internal documentation process—such as using the SOC PFI process as a management program—is up to the discretion of the organization. However, if the corrective action will take more than 60 days to complete, the organization must complete a Survey-Related Plan for Improvement (SPFI) to request a time-limited waiver within the first 30 days following the end of survey. (This process has been updated since it was first described in the August 2016 issues of The Joint Commission Perspectives and EC News.)

Following a Joint Commission survey, Life Safety Code deficiencies are occasionally identified as RFIs for a condition that may be eligible for an equivalency. When this occurs, the organization that has an SPFI can request a time-limited waiver for additional time to develop, submit, and approve the equivalency request.

**Addressing EP 5.** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains documentation of any inspections and approvals made by state or local fire control agencies.

Building history documentation is important for understanding which life safety features are designed and installed to protect occupants. Various authorities having jurisdiction (AHJ) review the inspection, testing, and maintenance of these features. These documents must be readily available, and any action by an AHJ must be documented, providing building continuity and identifying conditions considered to support their action.

**Addressing EP 6.** The hospital does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, can be either maintained or removed. (For full text, refer to NFPA 101-2012: 4.6.12.2; 4.6.12.3)

The Life Safety Code has chapters pertaining to both new and existing health care occupancies (NFPA 101-2012, 18/19). Chapter 19, “Existing Health Care Occupancies,” is designed for use with facilities built to comply with earlier editions of the *Life Safety Code*. For example, Chapter 19 allows corridor width to be 48 inches for existing health care facilities (19.2.3.4). In the early 1900s, hospitals were built to accommodate passive ventilation. Large double-hung windows were aligned with the patient door, which was directly across the narrow corridor from the adjacent patient room (with that room window also aligned). This allowed air to enter one side of the building and move through and out the other side of the building. These corridors ranged from 6 to 8 feet in width. The Chapter 19 code requirement of at least 4 feet in width allows the existing facility to continue operation although it does not meet current standards for new facilities.

The *Life Safety Code* does not allow an existing condition to be removed or reduced when such feature is a requirement for new construction. For example, although Chapter 19 accommodates corridor width less than 8 feet in existing construction, it requires 8 feet in width in new construction. The *Life Safety Code* and EP 6 prohibit reducing an existing condition below what is stipulated by new requirements, so if the corridor was built to 8 feet, the corridor cannot be reduced. When performing building rehabilitation work, it is important to review the requirements of NFPA 101-2012 Chapter 43.

In a similar manner, existing life safety features that are obvious to the public, if not required by the *Life Safety Code*, must be either maintained or removed. This EP does not prohibit installing systems that exceed the minimum requirements. However, it does protect patients, staff, and visitors from a perception that a higher level of safety is provided when it may not be. Whenever a system, method, or device exceeds the requirements of the code, it must be either maintained or removed.

For example, suppose a contractor installed a rated door assembly with latching hardware in a smoke barrier. Smoke barrier doors are not required to latch. However, because the latching hardware is in place, it needs to operate, regardless of whether the door protects a fire barrier.

Forthcoming columns will address further standards updates related to the adoption of the 2012 *Life Safety Code*.  

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**UPDATE: Comprehensive Stroke Center Eligibility Criteria**

The Joint Commission’s *Comprehensive Certification Manual for Disease-Specific Care* includes certification requirements and eligibility criteria for **comprehensive stroke centers** (CSCs) and other advanced disease-specific care programs. The CSC eligibility criteria in the certification manual require a CSC to demonstrate, at the time of application, that it meets all the volume-related requirements:

- Care is provided to 20 or more patients per year with a diagnosis of subarachnoid hemorrhage caused by an aneurysm.
- The CSC is capable of treating aneurysms by performing 15 or more endovascular coiling or microsurgical clipping procedures per year.

Continued on page 11
Intravenous tissue plasminogen activator (tPA) is administered 50 or more times over a two-year period for eligible patients. Because it recognizes that there may be fluctuations in the number of patients seen in CSCs on an annual basis, The Joint Commission will begin looking at care provided over a two-year period to determine compliance with volume requirements.

Effective December 1, 2016, the volume-related requirements assessed at the time of application for CSC certification will be that the CSC demonstrates all of the following:

- Care is provided to 40 or more patients over a two-year period with the diagnosis of subarachnoid hemorrhage caused by aneurysm.
- The CSC is capable of treating aneurysms by performing 30 or more endovascular coiling or microsurgical clipping procedures over a two-year period.
- Intravenous tPA is administered 50 or more times over a two-year period for eligible patients.

This change will be reflected in the spring 2017 E-dition update of the Comprehensive Certification Manual for Disease-Specific Care. For additional information on Comprehensive Stroke Center certification eligibility, please contact Business Development at DSCinfo@jointcommission.org.

Posting: Fall E-dition for Accreditation and Certification Manuals (continued)

Deletion of 51 additional EPs from the hospital program as Phase II of the EP Review Project, effective January 1, 2017 (see November 2016 Perspectives, pages 1 and 3–6)


Revisions to requirements for Inpatient Diabetes Care Certification (an advanced disease-specific care program), effective July 1, 2017 (see November 2016 Perspectives, pages 8–10)

New Comprehensive Cardiac Center Certification program for hospitals, effective January 1, 2017 (see article on page 1 of this issue)

Changes to the clarification process for all accredited organizations and certified programs, effective January 1, 2017 (see article on page 8 of this issue)

Expansion of applicability of Leadership (LD) Standard LD.01.03.01, EP 12, from deemed-status home health agencies and hospices to deemed-status hospitals, critical access hospitals, and ambulatory surgical centers, effective January 9, 2017 (see article on page 4 of this issue)

Managing Your Manuals

If there are challenges with accessing updated standards (in the E-dition releases from early November and January 9) from your Joint Commission Connect™ site, please contact Customer Technical Support at support@jcrinc.com. If you are missing a purchased hard copy accreditation or certification manual product, please e-mail jcrcustomerservice@pbd.com (or call 877-223-6866) with your order number and organization name. Print and online manuals, as well as other accreditation resources, are also available for purchase at http://www.jcrinc.com/software/landing and http://www.jcrinc.com/store/publications/manuals and http://www.jcrinc.com/software/landing/.

2017 Accreditation and Certification Manual Print Products

- 2016 Update 2 to the Comprehensive Accreditation Manual for Ambulatory Care
- 2016 Update 2 to the Comprehensive Accreditation Manual for Behavioral Health Care
- 2016 Update 2 to the Comprehensive Accreditation Manual for Home Care
- 2016 Update 2 to the Comprehensive Accreditation Manual for Hospitals
- 2017 Comprehensive Accreditation Manual for Ambulatory Care
- 2017 Comprehensive Accreditation Manual for Behavioral Health Care
- 2017 Comprehensive Accreditation Manual for Home Care
- 2017 Comprehensive Accreditation Manual for Hospital Care
- 2017 Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing
- 2017 Comprehensive Accreditation Manual for Nursing Care Centers
- 2017 Hospital Accreditation Standards
- 2017 Standards for Ambulatory Care
- 2017 Standards for Behavioral Health Care
- 2017 Comprehensive Certification Manual for Disease-Specific Care Including Advanced Programs for Disease-Specific Care
- 2017 Standards for Disease-Specific Care Certification