

EC News

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From the Physical Environment Department

Evidence of Standards Compliance— What You Need to Know

Be sure to complete any periodic tasks you were cited for not doing, in addition to establishing policies and processes to ensure long-term compliance

When surveyors cite an organization for one or more physical environment deficiencies (as with other types of findings), an Evidence of Standards Compliance (ESC) report must be submitted to The Joint Commission within 60 calendar days of the posting of the Summary of Survey Findings Report (which occurs within 10 days of your survey). The form for the ESC report, which is on your Joint Commission Connect™ extranet site, is to be filled out and submitted online. The ESC report must be complete when it is submitted; you can't go back and fill in blank fields later. All deficiencies cited during your organization's survey (both physical environment and clinical) are to be addressed in one ESC report.

In the environment of care, common observations relate to improperly performing inspection, testing, and maintenance (ITM) activities and/or inadequately documenting that these tasks have been completed.

Let's consider biomedical equipment. If you fail to perform the appropriate ITM on your electrocardiogram (EKG) machines, ultrasound equipment, and/or defibrillators, for example, you will see Requirements for Improvement (RFIs) plotted on the *Survey Analysis for Evaluating Risk® (SAFER®)* Matrix that is part of your Summary of Survey Findings Report.

One thing I've seen when I evaluate ESC reports is that an organization might focus on revamping its processes but not on fixing the issue at hand. Using the EKG equipment example, a health care organization (HCO) may state that the reason it didn't maintain its EKG machines appropriately is that it didn't have a policy and procedures addressing this. Or, more often, an organization may state that it had a staffing issue. It is not uncommon then for that HCO to indicate on the ESC report that it has now implemented such a policy or has addressed the staffing issue, which will ensure future compliance. That's great, but you also need to state that you've actually done the preventive maintenance on the EKG equipment.



by Herman A. McKenzie,
MBA, CHSP, Director,
Physical Environment
Department

If you are cited for not completing a periodic task, please show that the task has been completed. You should also say that you've put in a process to sustain compliance; that's where your new policy would come in.

Here are additional examples:

- ▶ If your organization is cited for not conducting a periodic task such as medical gas system evaluation or damper inspection, these missed tasks should be completed prior to ESC submission. Be sure to document these tasks appropriately and explain the processes you've enacted to prevent this finding from occurring again. This applies to any ITM activity for which you've missed the required interval.
- ▶ If your organization is a hospital and was cited for not conducting a worksite analysis as part of its workplace violence prevention program, you need to do the worksite analysis before submitting the ESC, within the 60-day window. (See the article on page 12 for more on The Joint Commission's workplace violence prevention requirements.)

In short, when you are responding to a finding, your ESC report must do the following:

- ▶ **Indicate the issue** that is being corrected in accordance with the finding. Include the number of the standard and element of performance (EP) under which the observation was scored and the particulars of the cited deficiency.
- ▶ Indicate that this issue has been **corrected**.
- ▶ Demonstrate **how compliance will be maintained**.
- ▶ If the finding was about a **periodic task** that has not been completed, show that the task has been completed.

ESC report specifics

For further clarification, let's go over the ESC form section by section (see what a blank form looks like on pages 5–6):

- ▶ **Assigning Accountability.** You need to designate one individual by title (facilities manager, clinical engineering manager, or emergency management coordinator, for example) who is responsible for all corrective actions and ongoing compliance with the cited element of performance (EP). If your organization is cited with a higher-risk RFI (plotted on the red or orange sections of the *SAFER* Matrix), the person accountable should be a member of the leadership team (at the director or officer level).
- ▶ **Corrective Actions.** You must concisely describe the actions taken to correct each finding. This is where you would mention specific tasks completed to resolve the finding, any new policies and procedures developed to address the issue, and staff training and communication initiatives related to the observation.

► **Ensuring Sustained Compliance.** This section is divided into several subsections:

- What procedures or activities have been identified to monitor your compliance with this EP?
- What is the frequency of the monitoring activities?
- What data will be collected from these activities?
- To whom and how often will this data be reported?

Higher-risk findings also require a **preventive analysis**, which needs to be described in the ESC report. For example, if your organization is cited for having stained ceiling tiles, you need to determine the cause of the problem above the ceiling. If your facility has a serious issue such as a leaky roof or sprinkler pipe, that of course needs to be fixed; you can't just replace the ceiling tiles. The preventive analysis would inform the "Corrective Actions" and "Ensuring Sustained Compliance" sections of the report.

The trick is to be both thorough and concise in ESC reports. Mention that you've developed a new policy, procedure, or checklist, but don't copy and paste sections of such documents into your ESC form. And again, while process changes and major underlying problems must be described, don't forget to note that you've corrected the deficiencies that caught the surveyor's eye in the first place. 

Blank Evidence of Standards Compliance (ESC) Form

Assigning Accountability Correcting the Non-Compliance Ensuring Sustained Compliance All Sections

Assigning Accountability

Instructions

Please indicate, by title, one individual responsible for all corrective actions and ongoing compliance associated with this element of performance. (Note: Even though multiple individuals will likely have a role in the corrective actions, you are asked to identify the one person who has ultimate accountability for the completion of all actions and ongoing compliance.)

Examples



The is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

To keep this Element of Performance on the "To Do" tab, mark this response as In Progress by selecting the check box below. This selection will need to be removed prior to submitting the ESC or POC.

In Progress

Correcting Non - Compliance

Instructions

Concisely describe the actions completed to correct each finding. This should include policies/procedures developed, revised, and approved. All corrective actions should also include staff training, communications, and/or spreading awareness. This description must illustrate the finding was fully corrected. (Notes: Do not copy and paste entire policies, bylaws, or other documents in this field. Even though the corrective actions may encompass multiple dates, please identify the final date that all corrective actions, including education and approvals were completed. The final date entered must be prior to your ESC submission due date and cannot be a future date.)

Examples



All corrective actions identified below must be completed prior to submission

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All corrective actions described above were completed by



To keep this Element of Performance on the "To Do" tab, mark this response as In Progress by selecting the check box below. This selection will need to be removed prior to submitting the ESC or POC.

In Progress

Ensuring Sustained Compliance

Instructions

While correcting the noncompliant issue is important, the organization should also have a plan for ensuring and sustaining compliance with the element of performance across the organization. To support sustainment, a strong strategy to monitor compliance must be developed and implemented. Please use the area below to describe your plan for monitoring future compliance.

Examples



What procedures or activities have been identified to monitor your compliance with this element of performance?

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What is the frequency of the monitoring activities?

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What data will be collected from these activities?

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To who, and how often, will this data be reported?

Format | Font | Size | **B** *I* U | [List] | [Align] | [Quote] | [Link] | [Unlink] | [Undo] | [Redo]

To keep this Element of Performance on the "To Do" tab, mark this response as In Progress by selecting the check box below. This selection will need to be removed prior to submitting the ESC or POC.

In Progress

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APPLICABLE PROGRAMS: ALL

Designing Health Care Settings for People with Diverse Abilities

The environment of care can play a tremendous role in reducing health care disparities

Approximately 61 million (or 1 in 4) adults in the United States live with a disability, according to the Centers for Disease Control and Prevention (CDC). With age, states the CDC, disability becomes more common, affecting about 2 in 5 adults aged 65 and older.

Reducing health care disparities among marginalized populations, including people with disabilities, is a top strategic priority for The Joint Commission. The health care physical environment heavily influences whether patients facing mobility, vision, hearing, cognitive, or behavioral health challenges can safely and comfortably access care in various settings.

“Achieving health equity is a civil rights struggle. Disability is a human rights issue,” emphasized Andrés J. Gallegos, Esq., the chair of the National Council on Disability, who gave a presentation to The Joint Commission during National Disability in Employment Awareness Month. Paralyzed in an automobile accident in the mid-1990s, Gallegos knows firsthand the health care access hurdles faced by people with disabilities, which have become more pronounced during the COVID-19 pandemic.

Gallegos pointed out that even today, more than 32 years after the enactment of the Americans with Disabilities Act (ADA), many medical facilities lack height-adjustable examination tables, height-adjustable diagnostic equipment, and patient-lifting equipment to transfer a patient from a wheelchair to an examination table. “Before the [COVID-19] virus, people like me struggled and still do to find providers who will transfer us onto diagnostic equipment, examination tables, and examination and treatment chairs when clinically appropriate in the absence of lift and transfer equipment and in the absence of height-adjustable examination tables,” he said. “We struggle to find providers who can weigh us in the absence of wheelchair-accessible weigh scales. Weigh scales that are not wheelchair accessible leave the health care provider guessing at our weight or asking us to guess our own weight.”

As Gallegos noted, people who are deaf or hard of hearing have difficulty communicating with health care professionals. They struggle to explain their symptoms, understand their treatment plans and options, and participate in their care. Since the onset of the pandemic, masking policies in health care settings have made it harder for people with mild hearing loss, including elderly patients, to understand their health care providers.

“Those who are blind or visually impaired struggle to obtain written information from health care providers in an accessible format,” Gallegos continued. “They struggle to read prescription labels on medications. And if they’re fortunate, they may have someone to read to them the often-multiple pages of federally mandated safety disclosures.”

The website of the ADA National Network provides a [fact sheet on accessible health care](#) with physical environment recommendations for health care settings, including disability-specific suggestions. For example, patients who are blind should have access to an audio recording of patient instructions and information or materials in Braille if they can read that format. For patients with cognitive impairment, a qualified reader could be used (with the patient’s permission) to help explain complex information in simpler terms. Diagrams and illustrations should also be available in examination rooms to help clinicians communicate with individuals who have developmental disabilities.

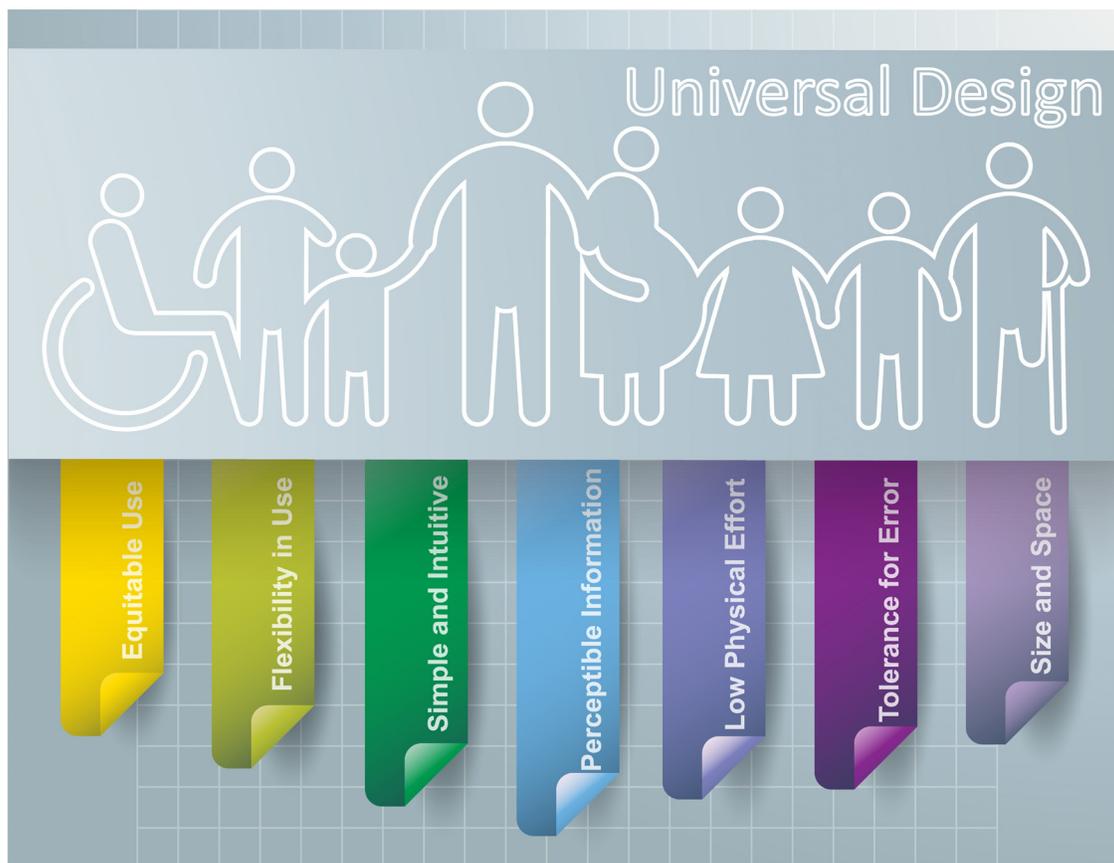
People with hearing challenges should be given an electronic tablet or comparable tool (such as a notebook) to facilitate written communication with clinicians, or speech-to-text and text-to-speech applications can be used to enable two-way communication. A sign language interpreter (or telehealth access to such services) should be available for deaf patients who are fluent in American Sign Language (ASL) but not in written English.

A website of the US Department of Justice Civil Rights Division, [ADA.gov](#), provides ample information on [access to medical care for individuals with mobility disabilities](#), including a detailed section on accessible medical equipment and patient lifts. The Joint Commission requires all accredited organizations to comply with laws and regulations, including the ADA, per Leadership (LD) Standard LD.04.01.01.

The [commonly asked questions section](#) of the site clarifies federal requirements versus recommendations. For example, one frequently asked question is whether every examination room requires an adjustable examination table. “Probably not” is the answer. “The medical care provider must be able to provide its services in an accessible manner to individuals with disabilities. In order to do so, accessible equipment is usually necessary. However, the number of accessible exam tables needed by the medical care provider depends on the size of the practice, the patient population, and other factors. One accessible exam table may be sufficient in a small doctor’s practice, while more will likely be necessary in a large clinic.”

Having sufficient adjustable or assistive equipment to meet patients’ needs is what’s important. Another vital factor: Staff must be trained on how to use that equipment correctly.

“Staff must also know which examination and procedure rooms are accessible and where portable accessible medical equipment is stored,” states [ADA.gov](#). “Whenever new equipment to provide accessible care is received, staff should be immediately trained on its proper use and maintenance.”



The Joint Commission specifically prohibits discrimination against patients with physical or mental disabilities in Rights and Responsibilities of the Individual (RI) Standard RI.01.01.01, EP 29. Disability is also a characteristic that should be taken into account when complying with The Joint Commission’s new health care equity standard, which takes effect January 1, 2023:

LD.04.03.08: Reducing health care disparities for the [organization’s] patients is a quality and safety priority.

This standard will be elevated to a National Patient Safety Goal (NPSG)—NPSG.16.01.01—effective July 1, 2023. The content of the standard will remain the same.

Universal design

Rather than make piecemeal or additive modifications to a space, it’s best to incorporate universal design *from the onset*, emphasizes Erin Lawler, MS, Human Factors Engineer for The Joint Commission’s Office of Quality and Patient Safety. Universal design principles apply to building and interior design as well as to the selection of equipment, furnishings, and commonly used devices and tools. Universal design is not a requirement of The Joint Commission but a recommended consideration.

A term coined by architect Ron Mace in 1985, *universal design* is defined as “the design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design,” [according to the American Institute of Architects](#).

Universal design is a more inclusive approach to the design of health care environments, and it helps prevent stigmatization of people with disabilities in such settings, noted Lawler in a presentation to her Joint Commission colleagues during National Disability in Employment Awareness Month.

“Universal design is the concept that all products in the built environment should be usable by everyone, regardless of age, regardless of ability, regardless of status in life, by considering the diverse needs and abilities of all throughout the design process,” Lawler explained.

Developed at the North Carolina State University Center for Universal Design, [the seven principles of universal design are as follows:](#)

- ▶ **Equitable use:** Create environments that are equally useful to people with diverse abilities.
- ▶ **Flexibility in use:** Incorporate elements that can be adjusted based on preference and ability.
- ▶ **Simple and intuitive use:** Select items that are easy to understand, regardless of experience, knowledge, language skills, or current concentration level.
- ▶ **Perceptible information:** Ensure that necessary information is easily discernable, regardless of ambient conditions or the user’s sensory abilities.
- ▶ **Tolerance for error:** Minimize hazards and adverse consequences of accidental or unintended actions.
- ▶ **Low physical effort:** Create environments that can be used efficiently and comfortably with minimum effort and risk of fatigue.
- ▶ **Size and space for approach and use:** Consider how elements can be reached, manipulated, and used, regardless of body size, posture, or mobility.

Universal design requires tremendous empathy and imagination on the part of the interdisciplinary teams that design health care environments. For example, architects need to consider how having a separate entrance or a separate door for people in wheelchairs aggravates the sense of otherness felt by individuals with mobility issues. Such segregation is contrary to the philosophy of universal design. Instead, suggested Lawler, why not have automatic doors for everyone at building entrances (as in supermarkets)? Many people would appreciate this, including people with children in strollers, people with limited strength, individuals with cognitive impairment, and people carrying items into a facility.

As Lawler pointed out, other features that can be integrated into health care environments from the beginning include remote-control light switches, motion-activated faucets, interior doors that open with a lever rather than a doorknob, and cabinets with pull-out shelving that eliminate the need to bend and stretch to reach stored items.

When purchasing everyday devices for a facility, such as kitchen utensils or office supplies, select options that can be used by everyone (patients, staff, and so on). For instance, choose storage containers that can be opened easily by individuals

with limited dexterity and grip strength, can openers and jar openers that are simple to use, and scissors that can be used equally easily by right- and left-handed individuals.

For signage in health care facilities, use high-contrast colors and large fonts. Make spaces easy to navigate with visual, audio, and tactile landmarks to promote wayfinding. In the design of examination rooms, include storage nooks for the resources and tools clinicians need to communicate with the widest range of patients.

“When design is universal, it is no longer design for the average user but instead design for the broadest user and most diverse range of abilities and situations,” Lawler said. “It is inclusive not by request after the fact but because it was there at the beginning. Universal design increases participation through design rather than inducing separateness.” 

Workplace Violence Prevention Requirements—Compliance Challenges

Since the requirements took effect one year ago, hospitals* have been cited for failure to conduct a worksite analysis, lack of a lead to coordinate compliance, and insufficient staff training

Compared to workers in other occupations, health care and social service employees are at five times greater risk of experiencing workplace violence, states a [fact sheet from the US Bureau of Labor Statistics \(BLS\)](#) that was updated in April 2020. In 2018, health care workers accounted for 73% of all nonfatal workplace injuries and illnesses due to violence, according to the BLS.

From January 1, 2018, through November 30, 2022, more than 200 violence-related sentinel events were reported to The Joint Commission’s Office of Quality and Patient Safety. The number of cases is likely much higher, as these events are reported voluntarily. Sexual assault (including rape), physical assault, and homicide count among the reported events, noted Kathryn Petrovic, MSN, RN-BC, The Joint Commission’s Director of the Department of Standards and Survey Methods (DSSM), who gave a presentation on workplace violence prevention at the Joint Commission Resources 2022 Hospital Executive Briefing (currently [available on demand](#)).

Due to the rise in violence in health care settings, The Joint Commission enacted several new workplace violence prevention requirements for hospitals and critical access hospitals on January 1, 2022. The Joint Commission also expanded its definition of *workplace violence* to include verbal threats and intimidation as well as physical and sexual assault and battery. The full definition is as follows:

An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors.

The new and revised standards and elements of performance (EPs) on workplace violence prevention span the “Environment of Care” (EC), “Leadership” (LD), and “Human Resources” (HR) chapters of the *Comprehensive Accreditation Manual for Hospitals*, the *Comprehensive Accreditation Manual for Critical Access Hospitals*, and their E-dition® counterparts. During her presentation, Petrovic discussed the new requirements and some compliance challenges observed in 2022.

Worksite analysis

EC.02.01.01, EP 17: The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate

*In this article, the term *hospitals* includes critical access hospitals.

or resolve the workplace violence safety and security risks based upon findings from the analysis.

Note: *A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations. (See also EC.04.01.01, EP 1)*

Multiple hospitals were cited in 2022 for noncompliance with this new EP, which requires documentation. In some cases, Petrovic noted, the worksite analysis wasn't conducted at all; in some cases, it was incomplete.

The Joint Commission does not dictate the format of this risk assessment and the resulting risk mitigation plan but recommends consulting the following resources:

- ▶ Occupational Safety and Health Administration (OSHA) [Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers](#)
- ▶ National Institute for Occupational Safety and Health (NIOSH) [Additional Resources](#) (checklists for worksite records analysis and environmental risk factors)

For the worksite analysis, “remember [to obtain] multidisciplinary team input,” Petrovic reminded her audience. And don't forget to look at the entire campus, the exterior as well as the interior, she cautioned. The worksite analysis should assess the pathways to different campus parking lots and parking structures, the landscaping near building entrances, and so on.

“Once you do the analysis and you find those risks,” said Petrovic, “have they been mitigated? Is there a correction plan in place? Those are the things that [surveyors] will look at.”

Workplace violence data collection and investigation

EC.04.01.01, EP 1: The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following [only the bullet point related to workplace violence is included here]:

- Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence

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, and services, or to prevent similar incidents, are not lost as a result of following the legal process. (See also EC.02.01.01, EP 17)*

EC.04.01.01, EP 1 was revised to specifically mention workplace violence in the bullet point about monitoring safety and security incidents. In other words,

Petrovic said, hospitals must establish a process for continually monitoring and internally reporting and investigating workplace violence incidents. In 2022, surveyors cited a number of hospitals for noncompliance with these reporting requirements.

EC.04.01.01, EP 6: Based on its process(es), the hospital reports and investigates the following: Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence.

EC.04.01.01, EP 6 was also revised to specifically mention workplace violence. “So, you must have a process in place,” stressed Petrovic. “And then based on that process, you’re going to report and you’re going to investigate [incidents of workplace violence].”

Workplace violence prevention program with a designated leader

LD.03.01.01, EP 9: The hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes the following:

- Policies and procedures to prevent and respond to workplace violence
- A process to report incidents in order to analyze incidents and trends
- A process for follow up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary
- Reporting of workplace violence incidents to the governing body (See also HR.01.05.03, EP 29)

For LD.03.01.01, EP 9, a new requirement, findings have included not having a designated leader and not having a process for reporting incidents to the hospital’s governing body. Hospitals have also been cited for incomplete policies and procedures.

Regarding leadership oversight, The Joint Commission requires a designated person to ensure that the key components of the workplace violence program are in place. “Having that one person is really important,” Petrovic emphasized, noting that gaps in programs initiated by accredited organizations can often be traced to lack of a leader to ensure comprehensive policy and procedure development and implementation. As she explained, “That one person may not be responsible for completing everything but has that overall view. Are the policies and procedures developed? Did we include everyone? What about all the sites?”

Staff education and training

HR.01.05.03, EP 29: As part of its workplace violence prevention program, the hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leadership, staff, and licensed practitioners. The hospital determines what aspects of training are appropriate for individuals based on their roles and

responsibilities. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows:

- What constitutes workplace violence
- Education on the roles and responsibilities of leadership, clinical staff, security personnel, and external law enforcement
- Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents
- The reporting process for workplace violence incidents (*See also* LD.03.01.01, EP 9)

A new requirement, HR.01.05.03, EP 29, focuses on the education and training of staff and leaders. A key aspect of this EP is determining what aspects of training are appropriate for individuals based on their roles and responsibilities in the hospital. “That’s going to take some meaningful thought,” said Petrovic. “Are you going to give a nurse who is working on a psych unit the same training as a doctor working in an OR? What about temporary staff? What about security personnel? What about the personnel in admissions? These are the kinds of things that you need to think about.” 

For more resources on workplace violence prevention that will facilitate compliance with the new requirements, see the [Workplace Violence Prevention Compendium of Resources](#) on jointcommission.org.

APPLICABLE PROGRAM: OME

Home Oxygen Therapy Risks and Safety Precautions

Meeting National Patient Safety Goal (NPSG) NPSG.15.02.01 needs to be a priority for Joint Commission–accredited home health organizations

Oxygen therapy in the form of compressed gas, oxygen concentrators, and pressurized liquid oxygen can be a lifesaver to homebound patients with respiratory or cardiac illnesses such as chronic obstructive pulmonary disease. The problem is that as many as half of all home oxygen users smoke, which significantly increases the possibility of home oxygen–related fires. Alarming, these fires result in more than one patient fatality every four days.¹ In fact, hospital emergency departments document approximately 1,200 injuries due to home oxygen fires annually.²



Home oxygen fires resulting in severe harm or patient death are the number-one Joint Commission sentinel event reported over the past few years by accredited home health care organizations.

Kathy Kaiser, MBA, BSN, RN, CJCP, a Joint Commission Resources home care consultant, notes that National Patient Safety Goal (NPSG) NPSG.15.02.01, Element of Performance (EP) 1, which addresses home oxygen therapy risk assessment, has consistently been among the top seven most commonly cited requirements for accredited home care organizations during each of the past five years. “This continues to be a top-scored Joint Commission standard among surveyors,” she says.

Where there’s smoke, there’s fire

Home health staff—including home health registered nurses, physical therapists, occupational therapists, and speech therapists—are responsible for educating patients and monitoring the use of oxygen concentrators and oxygen cylinders

stored in their homes. The protocols they use are established by their home health leadership and based on related NPSG and Environment of Care (EC) standards and EPs. But root cause analyses conducted by home health organizations often point to missed opportunities for home health staff to identify fire risks and respond effectively to the risks being assessed.

“That’s why home health leadership and their staff need to increase their knowledge and awareness of the issue. They must be more cognizant of the dangers and better able to assess a patient’s environment and potential oxygen safety hazards,” Kaiser explains. “Without proper due diligence, patients could lose their lives, their families, and their homes as a result of an oxygen fire caused by smoking, open flames, or other heat sources in the home. There is also a risk of neighboring buildings catching fire because of an oxygen-related blaze in the patient’s home or apartment.”

The pathway of a potential fire is relatively predictable. Often, the nasal cannula or mask starts to burn first, and the combustion runs down the tubing all the way to the concentrator. As the tubing burns, it creates a torch that can scorch the patient’s face and body and cause their clothes and any covers/linens surrounding them to catch fire. As many patients are bed- or chair-bound and unable to get up without assistance, the event can cause third-degree burns before the fire is extinguished. Or worse, the event can cause a major fire in the home.

Consequently, oxygen cylinders must be stored in a temperature-controlled, well-ventilated area because they are combustible at higher temperatures and oxygen can slowly leak from the cylinders without being detected.

“Surveyors frequently identify the risk of oxygen cylinders stored in a closet when the risk was not recognized by the home health staff,” Kaiser points out. “The cylinders can leak oxygen, causing an oxygen-enriched environment that even the smallest spark can ignite.”

Oxygen cylinders in a patient’s residence must also be secured in an appropriate stand to prevent tipping and physical damage, placed away from heat sources, and located with adequate ventilation. Inappropriate storage locations include open porches or decks, areas near a furnace or water heater, and closets. Even a cylinder stored by a sunny window can heat up and potentially ignite.

Fire isn’t the only major peril associated with home oxygen therapy. Kaiser reminds home health professionals that there’s also the possibility the patient won’t fully comply with the physician’s orders for oxygen use and that the patient or caregiver may trip over the oxygen tubing coming from an oxygen concentrator/cylinder. It’s also important to prioritize and prevent these and other non-fire-related risks.

Relevant standards and elements of performance (EPs)

Kaiser points to the NPSG requirements related to this topic that health care professionals need to implement into their practices.

NPSG.15.02.01: Identify risks associated with home oxygen therapy such as home fires.

This standard is applicable only to home care organizations, in recognition of reported incidents involving injuries and deaths caused by home fires related to oxygen use.

NPSG.15.02.01, EP 1: Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated.

This requirement includes a minimum of three questions that must be asked in a home health documented safety assessment:

- ▶ Are smoking materials in the home?
- ▶ Does the home have functioning smoke detectors?
- ▶ Does the home have other fire safety risks such as the potential for open flames?

The questions must each be included in the assessment documentation and answered with “yes” or “no.” Charting by exception is not recommended and has frequently resulted in noncompliance citations during survey. Home health staff must conduct the assessment before starting oxygen therapy in the home. If oxygen is already in the home when the patient is admitted to home health, the assessment documentation should be in the initial assessment visit documentation.

“Note that the question about whether there are smoking materials in the home is not the same as the question ‘Does the patient smoke?’” clarifies Kaiser. “Smoking materials may include ashtrays, lighters, cigarettes, cigars, pipes, electronic cigarettes, vaping devices, and any smoking paraphernalia. It does not matter whether or not they are used or smoked by the patient. Answer ‘yes’ to the question if they are present at the home. If the answer is ‘yes,’ the assessment of the risk and related documentation should include the type of smoking materials and who is using them.”

NPSG.15.02.01, EP 2: Reevaluate potential fire risks at intervals established by the organization. Evidence of unsafe practices leading to potential risk is used to establish these intervals. Document the reevaluation of potential fire risks.

Each home health organization is responsible for identifying the minimum interval between documented safety assessments. During risk reevaluation, the documentation should again minimally address the three questions in EP 1 with “yes” or “no” answers.

“A commonly recommended interval is whenever the comprehensive assessment, or OASIS* assessment, is completed,” says Kaiser.

NPSG.15.02.01, EP 3: Inform and educate the patient, family, and/or caregiver about the following:

- The findings of the safety risk assessment
- The causes of fire
- Fire risks for neighboring residences and buildings

* OASIS (Outcome and Assessment Information Set) is a comprehensive assessment designed to collect information on nearly 100 items related to a home care recipient’s demographic information, clinical status, functional status, and service needs.

- Precautions that can prevent fire-related injuries
- Recommendations to address the specific identified risk(s)

The provision of this information and education must be documented. “This education is most commonly in the documents given to all patients at admission to home health,” observes Kaiser. “Home health leadership should review the oxygen safety information provided to patients to ensure that all three topics are covered.”

“In the assessment documentation, organizations should also confirm whether an ‘Oxygen in Use’ sign is posted and visible to neighboring residences and buildings,” Kaiser continues. “Often, home health staff responsible for conducting safety assessments are unaware that an ‘Oxygen in Use’ sign alerts neighboring residents and any first responders to the presence of the oxygen and the potential fire risks. If a sign is not posted, this education should be documented as part of the safety risk assessment. The documentation should include the recommendations to address the specific identified risk.”

When any risks are identified, EP 3 requires documentation of recommendations to address the specific identified risk(s). It is not recommended that any time risks are identified to merely check a box that education was provided; the documentation should include the specifics of that patient’s risk with the particular recommendations given to address that risk.

NPSG.15.02.01, EP 4: Assess the patient’s, family’s, and/or caregiver’s level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment.

Note that there are two separate requirements here: “level of comprehension” and “compliance.” It is recommended that staff document who was instructed, the specific recommendations given, and the patient’s or caregiver’s response to the recommendations, including their compliance. Surveyors often see documentation that just shows checkmarks on a visit note but no specific recommendations the staff discussed, who was instructed, or their comprehension level or compliance information.

NPSG.15.02.01, EP 5: Implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home.

One strategy should be notifying the practitioner who ordered the oxygen. The standard addresses documenting the implementation of strategies to address compliance. These strategies should be specifically documented and not just by checking a box in the patient record.

Another commonly scored Joint Commission standard related to oxygen safety is Environment of Care (EC) Standard **EC.02.01.01, EP 3:** The organization takes action to minimize identified safety and security risks.

“The oxygen safety risk assessment documentation should note whether or not oxygen tanks/cylinders are stored safely,” says Kaiser. “This standard is cited by

surveyors when oxygen cylinders are not stored safely and home health staff have not addressed the risk.”

Best practices

In addition to closely following the aforementioned standards and EPs, Kaiser recommends the following steps to minimize home oxygen therapy hazards and improve safety:

- ▶ **Conduct and complete a thorough risk assessment** at admission or when oxygen is ordered after the start of care if it is not present in the home at admission. The risk assessment should cover all the elements in NPSG.15.02.01, EP 1 and address storage of oxygen tanks/cylinders.
- ▶ **Evaluate and remediate any identified risks** and include follow-up documentation in the record. The documentation should cover at least the specific risks identified, who was educated, what strategies were reviewed or implemented, the patient’s or caregiver’s level of understanding of the risks, and the patient’s or caregiver’s compliance with recommended strategies.
- ▶ **Carefully and properly educate home health staff** during orientation and via ongoing in-services about the risks associated with home oxygen use and how to conduct a thorough home oxygen safety assessment. Some staff, for instance, are not aware that electronic cigarettes or vapes are just as dangerous as traditional cigarettes in a home oxygen therapy setting.
- ▶ **Target home oxygen therapy patients for tracers and/or supervisory visits** to ensure that staff are addressing all oxygen safety risks, and provide individualized follow-up education to staff as needed.
- ▶ **Implement ongoing chart audits** that target patients on home oxygen to make sure oxygen safety assessments are being conducted and followed up on appropriately.
- ▶ **Establish an “oxygen safety assessment contract”** with the patient or caregiver that addresses the patient’s smoking practice and includes the risks identified, recommended solutions, and the patient’s acknowledgment of the potential consequences if the risk is not addressed, including potential discharge.
- ▶ **Conduct a case conference to discuss ongoing oxygen safety risks.** The conference can include the patient or caregiver, the practitioner who ordered the oxygen for the patient, the durable medical equipment (DME) company providing the oxygen, and any home health staff involved in the care.

Prepare for challenges

While compliance with oxygen safety–related standards is not hard for home care surveyors to assess during an accreditation visit, these requirements can be difficult for home health staff to address when a patient insists on smoking or when smoking is suspected.

“The challenge is for the staff to identify if the patient is cognitively able to consistently remove their oxygen before smoking,” notes Kaiser. “If a patient is not cognitively able to remember every time, the home health staff need to assess if there is an available, willing, and able 24-hour caregiver to manage the patient’s smoking.”

Remember, too, that home health staff are responsible for reporting safety risks to the licensed practitioner ordering the oxygen and implementing strategies that address compliance with applicable standards and EPs, including NPSG.15.02.01, EP 5.

“Home health professionals are often the last line of defense between a vulnerable patient and an oxygen-related fire or other associated risk,” Kaiser adds. “By knowing and understanding accepted standards and guidelines and following best practices, they can help prevent catastrophe and ensure a safer overall home therapy environment.” 

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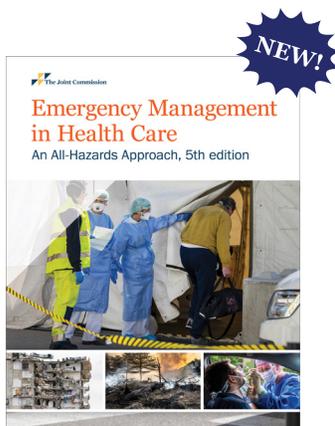
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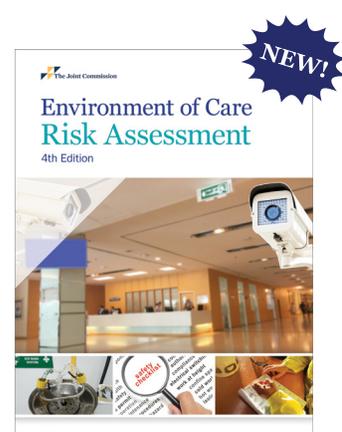
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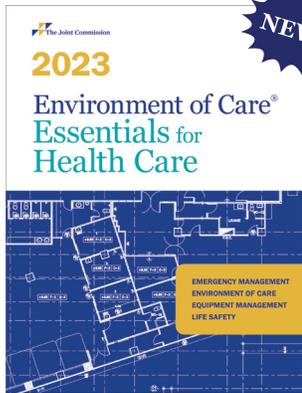
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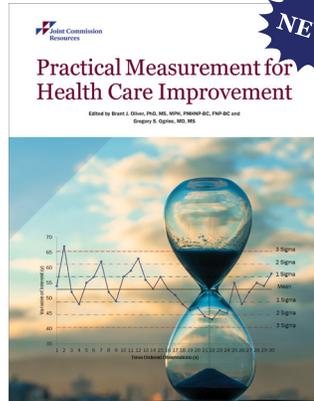
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