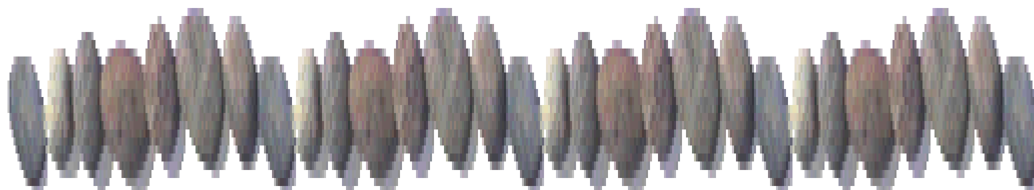
CENTER OF EXCELLENCE IN ENVIRONMENTAL HEALTH & SAFETY

Policies
Standards
Survey Process

Effective January 2018



INTRODUCTION

The CIHQ "Center of Excellence in Environmental Health & Safety" (CEEHS) program recognizes hospitals and other healthcare entities that create a safe environment for staff, patients, and visitors based on industry best practices and measurable outcomes.

The standards contained herein are based on the following:

- Recommendations from the National Institute of Occupational Safety & Health (NIOSH)
- Industry guidance from the Occupational Safety & Health Administration (OSHA)
- Standards and Recommendations from the British Standards Institution (BSI)
- Recommendations from the American National Standards Institute (ANSI)
- Recommendations from the Center for Disease Control (CDC)
- Recommendations from the American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE)
- Recommendations from the Environmental Protection Agency (EPA)
- Recommendations from the American College of Radiology (ARC)

CENTER OF EXCELLENCE IN ENVIRONMENTAL HEALTH & SAFETY POLICIES

ELIGIBILITY REQUIREMENTS

In order to obtain/maintain CEEHS designation, an organization must:

- Be licensed as a healthcare entity in the State or locality in which the organization operates
- Be in full compliance with CIHQ CEEHS policies
- Be in full compliance with CIHQ CEEHS standards or have developed and implemented an acceptable plan of correction to come into compliance in areas of deficient practice.
- Pay CEEHS fees in a timely manner
- Permit the CEEHS survey to occur
- For initial designation the organization must demonstrate compliance to CEEHS policies and standards for at least three months prior to the survey.

CIHQ reserves the right to withdraw/deny CEEHS status to an organization that does not meet/maintain eligibility requirements.

APPLICATION FOR CEEHS DESIGNATION

An organization must submit a formal application to CIHQ requesting CEEHS designation. The application must be complete and accepted by CIHQ before a designation survey can occur. Once designated, the organization is responsible for assuring that information contained in the application is current. Organizations must notify CIHQ of any substantive changes to information contained in their application in a timely manner. At a minimum, the organization must inform CIHQ within 30 days of any of the following:

- A change in ownership
- A change in contact information
- Addition or closure of a physical location under the organization's auspices

BUSINESS ASSOCIATE AGREEMENT

If an organization requires CIHQ to sign a business associate agreement for HIPAA compliance, the agreement must be provided to CIHQ at the time the application is filed.

PERMISSION TO SURVEY

Any organization wishing to obtain or maintain CEEHS designation must agree to allow CIHQ surveyors complete and unfettered access to their facility(s), documents, staff, patients, and other sources of information necessary to determine the organization's compliance. CIHQ reserves the right to immediately deny or withdraw an organization's designation for failure to do so.

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DURATION OF CEEHS DESIGNATION

CEEHS designation is awarded to an organization for a maximum of 36 months. Prior to the 36 month, the organization must undergo another approval process to maintain its status. For initial approval, the date of designation will be the date that a submitted plan of correction has been accepted by CIHQ to address any identified deficiencies.

USE OF CIHQ SURVEYORS AS CONSULTANTS

CIHQ surveyors are not permitted to independently serve as consultants. Organizations may not employ, retain, contract with, or otherwise utilize CIHQ surveyors for any of the following:

- Provide consulting services or standards interpretation to prepare the organization for a survey. This does not apply to accessing CIHQ central office staff for official standards interpretation.
- Providing tools or documents to assist in designation compliance. This does not apply to organizations that utilize CIHQ officially approved documents obtained directly from CIHQ.
- Provide education programs on CIHQ standards. This does not apply to attendance at CIHQ officially sponsored education programs and activities
- Assist with developing and/or reviewing appeals or corrective action plans for deficiencies identified during a CIHQ survey.
- Conduct mock surveys

RELATIONSHIP BETWEEN CIHQ STAFF & APPLICANT ORGANIZATIONS

Surveyors/staff may not survey, or be involved in, an organization with which the surveyor has a professional or financial interest. A surveyor/staff is considered to have a professional or financial interest in an organization under any of the following conditions:

- The surveyor / staff person is currently employed or has been employed within the past five years by the organization
- The surveyor / staff person has an ownership interest in, or receives monies or other compensation from the organization
- The surveyor / staff person serves on the Board of the organization or in another professional capacity.

Surveyors are required to disclose to CIHQ any professional or financial interest they have in an applicant organization that they may be scheduled to survey so that reassignment can occur.

FALSIFICATION & MISREPRESENTATION

Honesty and the provision of truthful and accurate information is at the heart of the CEEHS designation process. Organizations are expected to engage in all activities in an honest and truthful manner. Information presented to CIHQ in any manner, for any reason, at any time must be accurate.

If an organization's leadership or staff intentionally misrepresents their compliance to CEEHS standards and/or policies, lies, falsifies documents or is otherwise dishonest or untruthful, CIHQ reserves the right to immediately withdraw/deny designation.

NOTIFYING ORGANIZATIONS OF CHANGES TO CEEHS STANDARDS, REQUIREMENTS, & POLICIES

All changes to CEEHS standards, requirements, and policies will be communicated to organizations in writing. The notification will include the effective date of implementation. In addition, all notifications will be posted on the CIHQ website and permanently archived for review.

CIHQ may from time to time issue official interpretation of existing CEEHS standards, requirements, and policies. These interpretations will be posted on the CIHQ website and are accessible to organizations. It is the organization's responsibility to access this information.

Organizations may request official interpretation of an existing CEEHS standard, requirement, or policy. Requests must be made in writing. Information on submitting a written request is available on the CIHQ website. CIHQ will provide a written response to each request within 5 business days of submittal.

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CEEHS SURVEYS

The survey is one or two days in length – depending on the size of the organization. The survey is conducted by a single surveyor. The survey is announced and scheduled in coordination with the organization

<u>Sample One Day Survey Agenda</u>
0830 – 0845 – Welcome & Opening Conference
0845 – 1030 – Review of Requested Documents – See Attachment A
1000 – 1200 – Tour of Work & Care Areas
1200 – 1300 – Lunch
1300 – 1500 – Tour of Work & Care Areas
1500 – 1600 – Staff Training & Education Review
1600 – 1630 – Surveyor Preparation Time
1630 – Exit Conference

ISSUANCE OF A SURVEY REPORT

Following the conclusion of the survey, a preliminary report is produced. The preliminary report will then be reviewed by senior staff at CIHQ. The purpose of the review is to assure the following:

- There is sufficient information in a finding to assign a deficiency
- The deficiency has been assigned to the appropriate standard

The survey report will be modified as necessary as a result of the review process. Following this review the report will be considered final.

CITATION OF DEFICIENCIES

Non-compliance to CEEHS standard requirements results in a cited deficiency. Non-compliance is cited on a per occurrence basis – meaning there are no percentages or thresholds of compliance.

DETERMINATION OF A CEEHS DESIGNATION DECISION

Based on the number of deficient standard requirements contained in the final report, a designation decision will be rendered. In order for an organization to achieve CEEHS designation, it must be in compliance with at least 85% of standard requirements at the time of the survey. There are a total of 100 requirements embedded within 19 standards. Hence an organization would have to meet at least 85 of the 100 requirements. In addition, an acceptable plan of correction for any deficiencies is required.

NOTIFICATION TO THE ORGANIZATION

Upon completion of the review, the final report and designation decision will be communicated in writing in electronic form to the contact person listed on the organization's application. Unless there are extenuating circumstances, the final report and designation decision will be provided within 10 business days following completion of the survey.

REQUIREMENTS FOR A CORRECTIVE ACTION PLAN

The organization is required to submit an acceptable corrective action plan (CAP) to CIHQ within 20 business days following receipt of their CEEHS survey report for any deficiencies identified.
A CAP must be developed and submitted for each deficiency identified. In order for the CAP to be accepted, it must address at least the following:

- The specific steps that the organization has taken (or will take) to correct the deficiency. The plan must address both the specific finding and the processes that led to the deficiency.
- A description of how the CAP was (or will be) implemented
- The monitoring process that has been (or will be) put in place to assure ongoing implementation of the CAP. Documentation must include the frequency and duration of monitoring, sample size, and target thresholds.
- The title of the person responsible for implementing the CAP; and
- The date the CAP was (or will be) implemented.

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The CAP should be implemented as quickly as possible. The expectation is that – whenever possible – corrective action has already occurred by the time the CAP is submitted. Due dates for completion of corrective actions should not exceed 90 days. If specific actions require a longer timeframe, please notify CIHQ for assistance and direction.

REVIEW / ACCEPTANCE OF CORRECTIVE ACTION PLANS

Upon submission, the CAP will be reviewed by senior staff at CIHQ. If a determination is made that the corrective action plan is acceptable, the organization will be notified in writing and no further action on the part of the organization will be required.

- If a determination is made that the CAP is unacceptable, the organization will be notified in writing of the reason(s) for declination, and the specific modifications necessary for the plan to be accepted. The organization will then be required to submit a second CAP within 10 business days.
- If the second corrective action plan is unacceptable, the organization will be notified in writing of the reasons for declination and the specific modifications necessary for the plan to be accepted. The organization will then be required to submit a third and final CAP within 5 business days.
- If the third corrective action plan is unacceptable, then the organization's CEEHS designation will be denied / withdrawn.

Request for Extension of the Corrective Action Plan

If an organization is unable to implement a corrective action(s) within the time frame submitted/accepted, it must request a one-time extension from CIHQ prior to the action(s) due date. The request must include the reason why the original date of completion cannot be met, as well as any supporting evidence justifying the request. Granting of an extension is at the sole discretion of CIHQ.

Failure to Implement a Corrective Action Plan

Failure to implement a corrective action plan within the time frame submitted/accepted, may result in withdrawal / denial of a CEEHS designation

Validation of the Corrective Action Plan

CIHQ may, at its sole discretion, require an organization to submit evidence that the accepted CAP has actually been implemented. If requested, the organization is required to submit the evidence within the requested time frame. Failure to submit evidence that a CAP has been implemented will result in a withdrawal / denial of CEEHS designation.

APPEAL PROCESS

CIHQ has established an appeals process for organizations wishing to contest a deficiency and/or designation decision.
If an organization wishes to appeal a deficiency, it must notify CIHQ in writing within 10 calendar days following receipt of the report. The appeal is to be submitted on-line. Senior staff will review the appeal, contact the organization for any questions, discussion, further information, etc. and issue a determination in writing of the organization's compliance to the standard/requirement in question. The decision by CIHQ senior staff is final

If an organization wishes to appeal a CEEHS designation decision, it must notify CIHQ in writing within 10 business days following issuance of the decision. There is no specific format for the appeal. The content must specifically address the following:

- The basis for appealing the designation decision
- Why the organization believes that the designation decision was incorrectly rendered
- The specific relief being requested

The written request must be submitted to:
Center for Improvement in Healthcare Quality
ATTN: Chief Executive Officer
P.O. Box 3620
McKinney, TX 75070
rcurtis@cihq.org

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Senior staff at CIHQ will make the decision with respect to any appeal submitted. In making this decision, the following will be carefully considered:

- Information that led to the decision
- The position and any information provided by the organization as part of the appeal
- Input and feedback from the surveyor

The decision by CIHQ senior staff is final.

AFFECT OF THE APPEAL PROCESS ON SUBMISSION OF A CORRECTIVE ACTION PLAN

Initiating the appeal process does not obviate the organization from submitting an acceptable plan of correction within required time frames. The organization should submit due dates for completion on deficiencies they wish to appeal with enough lead time to allow the appeal process to occur and still implement corrective actions in a timely manner should the appeal be denied. The organization should contact CIHQ for assistance in this regard.

INFORMATION THAT IS PUBLICLY SHARED BY CIHQ

CIHQ will make the following information available to the public:

- Verification that the organization is CEEHS designated or is seeking designation
- The organization's current CEEHS status
- The dates of the organization's initial or last CEEHS survey
- The expiration date of the organization's current CEEHS designation

CEEHS FEES

Fees are billed on an annual or quarterly basis as preferred by the organization. Fees include surveys and surveyor travel expenses.

- The CEEHS designation fee for a CIHQ member organization is $2,500 annually.
- The CEEHS designation fee for a non-member CIHQ organization is $4,500 annually

INDEMNIFICATION

By submitting an application, organizations agree that CEEHS designation does not constitute a warranty of compliance to standards, and further that designation is not a substitute for self-monitoring and assessment of environmental safety by the organization.

The organization agrees to indemnify and hold harmless the CIHQ, its commissioners, officers, agents, employees, and member organizations from any and all professional liability claims of other parties against CIHQ, its commissioners, officers, agents, employees, or member organizations arising from its CEEHS designation program, process, policies, and survey activities, including all judgments, settlements, costs, expenses, and reasonable attorneys' fees, unless and until any such judgments, settlements, costs, expenses and attorneys' fees are found by a final judgment of a court of competent jurisdiction to have resulted solely from negligence or wrongdoing on the part of the CIHQ.

This indemnification and hold harmless provision shall apply only to professional liability claims, i.e., claims based on the CIHQ' performance of its professional services, and not to general liability claims for bodily injury or property damage arising out of the CIHQ' negligence or intentional misconduct.

The organization agrees that in the event of any error or omission in connection with or as a result of CIHQ' performance of CEES designation services including, but not limited to, the scheduling and conduct of any survey, the processing of the results of any survey, and the disclosure of any survey results, the CIHQ' liability to the organization for any loss or damage arising therefrom, shall be limited to the total fees paid or payable for any CEEHS services provided.

This limitation of liability shall apply to the fullest extent permitted by law regardless of whether the organization's claim for loss or damage is based upon contract, tort, strict liability, or otherwise, and shall constitute CIHQ' sole liability to the organization and the organization's exclusive remedy against the CIHQ in the event of any such error or omission.

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CENTER OF EXCELLENCE IN ENVIRONMENTAL SAFETY STANDARDS

ORGANIZATIONAL STANDARDS

Standard: EHS-1

The governing body and the senior leadership of the organization assure the development and implementation of policies, procedures, and the infrastructure necessary to support an organization-wide environmental health and safety program

A. There is an individual within the senior leadership structure that is appointed to provide administrative support and guidance to the organization's environmental health and safety program. This is demonstrated by either a formal letter of appointment by the organization's Chief Executive Officer or by notation on the job description of the individual's job title.
B. Sufficient resources are allocated in the form of capital / operating budgets as well as allocation of labor resources to support an environmental health and safety program.
C. The governing body and senior leadership receive regular reports on the status of the environmental safety program as outlined in Standard EHS-4. The governing body and senior leadership assure that any issues or untoward performance are addressed in a timely manner.
D. Leadership can articulate the goals and objectives of the organization-wide environmental health and safety program.

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Standard: EHS-2

The organization develops and implements a formal written environmental health and safety program

A. There is an organization-wide written environmental health and safety program. This may be evidenced by a single document or by a collection of multiple documents such as policies, plans, and procedures. The program must address at least the following:
   - The scope and goals of the program
   - The specific objectives that the organization intends to accomplish on an annual basis to meet the goals of the program
   - At a minimum, the components of the program must address:
     - Engagement of staff in workplace environmental health and safety in accordance with Standard EHS- 5
     - Training of staff on environmental health and safety issues in accordance with Standard EHS-5
     - Identification and mitigation of environmental and safety hazards and risks in accordance with Standard EHS-6
     - Inspections of worker and patient care areas in accordance with Standard EHS-7
     - Job hazard evaluations in accordance with Standard EHS-8
     - Reporting of employee and patient injuries related to environmental health and safety in accordance with Standard EHS-5
     - Workplace violence in accordance with EHS-10
     - Prevention of staff musculoskeletal injuries in accordance with Standard EHS-9
     - Sharps injury prevention in accordance with Standard EHS-11
     - Safe patient handling and mobility in accordance with Standard EHS-12
     - Management of slips, trips, and falls in accordance with Standard EHS-13
     - Ionizing radiation safety in accordance with Standard EHS-14
     - Management of hazardous materials and waste in accordance with Standard EHS-15
     - Management of legionella and other water-borne pathogens in accordance with Standard EHS-16
     - Management of air quality in accordance with Standard EHS-17
     - Management of medical and utilities equipment in accordance with Standard EHS-18

B. The environmental health and safety program is evaluated on at least an annual basis. The evaluation must address at least the following:
   - Whether the scope of the program remains appropriate to the current complexity and scope of the organization's services. If changes to the scope of the program are necessary, the evaluation notes what changes are required
   - The extent to which the goals of the program remain appropriate. If changes to the goals of the program are necessary, the evaluation notes what changes are required
   - The extent to which the specific performance objectives were met during the evaluation period. If objectives were not met, the evaluation identified why, and what actions were – and will be – taken to address the issue(s)
   - The overall extent to which the organization determined the effectiveness of the program
   - As a result of the evaluation, the specific objectives that will be accomplished during the next annual period

C. The results of the annual evaluation of the environmental health and safety program are submitted to the program's oversight committee and to the governing body.

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Standard EHS-3

The organization provides appropriate oversight of the environmental health and safety program

A. There is a multidisciplinary committee(s) that is assigned to oversee implementation of the environmental health and safety program. This can be accomplished by a single committee, or the activities of the program can be assigned to multiple committees. If the latter, the organization has a written document(s) that clearly identifies what aspects of the program are overseen by specific committees.

B. Membership on the committee(s) shall include at least those individuals identified by job function as having direct operational control of aspects of the program to which the committee oversees.

C. Membership on the committee(s) shall include staff who work in areas affected by aspects of the program to which the committee(s) oversees.

D. The committee(s) shall receive and act on reports regarding the status of components of the environmental health and safety program as outlined in Standard EHS-2 and Standard EHS-4.
   - The committee(s) shall analyze data presented to identify opportunities to reduce risk and/or improve the program
   - The committee(s) shall either undertake appropriate action to address opportunities identified, or recommend such actions to senior leadership.

E. The committee(s) shall meet at least quarterly or more frequently if necessary

Standard EHS-4

The organization collects, aggregates, and analyzes performance data on the environmental health and safety program

A. The organization collects, aggregates, and analyzes data on at least the following performance metrics related to environmental health and safety:
   - Staff / patient injuries broken out as follows:
     - General injuries
     - Musculoskeletal injuries related to handling of materials and equipment
     - Injuries related to the use or disposal of sharps
     - Injuries related to slips, trips, and falls
     - Injuries related to patient handling and mobility
   - Incidences of workplace violence or reported concerns
   - Results of inspections of work and patient care areas including implementation of corrective actions to address issues identified
   - Incidences of ionizing radiation safety risks such as:
     - Staff dosimetry badge readings outside of permissible limits
     - Excessive radiation exposure to patients as a result of diagnostic studies
     - Radiopharmaceuticals or other radioactive materials being inappropriately stored and/or disposed of before decaying to background levels
   - Incidences of hazardous chemicals, medications, and material safety risks such as:
     - Lack of available and/or proper use of personal protective equipment
     - Lack of and/or improper labeling of hazardous chemicals, medications, and materials
     - Improper preparation, storage, use, and/or disposal of hazardous chemicals, medications, and materials
   - Incidences of medical and/or utilities equipment risks such as:
     - Inappropriate use of equipment
     - Injuries or illness related to the use of equipment
     - Equipment failures that result in injury / illness (or near misses)
   - Presence of legionella and/or other waterborne pathogens
   - Incidences of air quality issues

B. The results of data collection, aggregation, and analysis are reported to the committee(s) having oversight of the environmental health and safety program at least quarterly or more frequently if necessary.

C. For each performance metric noted in this standard, the organization identifies opportunities for improvement based on the analysis of data, undertakes necessary corrective action, and evaluates whether said actions were effective.

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Standard EHS-5
The organization establishes and implements processes to engage staff in creating a successful environmental health and safety program

A. The organization communicates to staff that environmental health and safety is a priority. At a minimum, staff must be informed of the following:
   - The scope, goals, and objectives of the organization's environmental health and safety program
   - Staff role in the environmental health and safety program
   - How to report environmental health and safety risks or near misses
   - That the organization supports reporting of risks without fear of retaliation or discrimination

B. The information noted in Requirement A is communicated to staff as part of new-hire orientation and on an annual basis thereafter

C. Staff are provided training and education on specific risks in their work environment, and the policies and procedures to be followed to address those risks. This training is provided on-hire and on an annual basis thereafter. Education and training must be provided in a manner that allows the organization to confirm that information was understood by staff. In addition, there must be a mechanism for staff to ask questions or seek clarification on information provided.

D. Staff are assigned to specific roles in supporting environmental health and safety activities in their department / work area. Leadership provides the time and resources to enable staff to engage in these activities

E. The organization seeks input from staff on a regular basis on suggestions for reducing risk and improving the environmental health and safety program. At a minimum, staff input is sought on an annual basis.

F. The organization communicates the status of its environmental health and safety program, as well as attendant performance metrics and identified risks, to staff on at least a quarterly basis. This includes injuries and near-misses that have occurred that could also occur in other work areas.

Standard EHS-6
The organization develops and implements policies and procedures to identify, track, and respond to environmental health and safety risks

A. Policies and procedures must address at least the following:
   - How risks will be identified, documented, and reported. This includes the role of staff and managers in doing so
   - How the severity of risk will be determined (e.g. quantified with an numerical score)
   - How risks will be logged and tracked. This includes both actual and potential risks
   - How appropriate risk mitigation efforts will be determined. In determining said efforts, the organization is expected to demonstrate an appropriate "hierarchy' of control" methodology. This means a focus on using engineering (environmental) control to mitigate risk versus an overreliance on process (administrative) controls.
   - Assignment of specific responsibility to leadership and/or staff to spearhead and coordinate risk mitigation efforts

B. A database is developed and maintained on both actual and potential risks. At a minimum, the following data elements are contained in the database:
   - The date the risk was identified (time of identification should also be included if pertinent)
   - The location where the risk was identified
   - The name / title of the individual(s) who identified the risk
   - The date the risk was reported (time of reported should also be included if pertinent)
   - The name / title of the individual(s) who received the report
   - The category of risk (actual or potential)
   - A description of the risk
   - The assigned severity of the risk
   - A description of the actions taken to mitigate the risk
   - A determination as to whether any further actions are necessary, and if so, a description of said actions
   - The date the risk was determined to have been mitigated.
   - If the risk was determined to not be mitigated (or only partially mitigated), than an explanation as to why, and what future actions will be taken.

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Standard EHS-7

The organization conducts audits of the environment to identify health and safety risks

A. The organization determines the overall risk level of departments and work areas based on the results of targeted assessments noted in Standards EHS-9 through EHS-18. In addition, risk is determined by:
   - The results of job hazard evaluations
   - Data on incidences of injury and near misses
   - Performance metrics as outlined in Standard EHS-4

B. For those areas that the organization has determined to be at high risk, environmental audits are performed on at least a quarterly basis

C. For those areas that the organization has determined to be at moderate risk, environmental audits are performed at least every six months

D. For those areas that the organization has determined to be at low risk, environmental audits are performed at least annually.

E. The focus of the audit is to identify the following:
   - Presence of risk previously determined to have been mitigated
   - Lapses in compliance to environmental health and safety practices
   - Actual or potential new risks

F. Staff is to be included as part of the audit team

G. The results of the audit are presented to the leadership team having administrative responsibility for the department / work area

H. Issues identified as a result of the audit are corrected

Standard EHS-8

The organization performs a hazards analysis of all job positions

A. The organization analyzes each job position to determine at least the following:
   - A physical demand analysis (walking, standing, bending, sitting, lifting, etc.)
   - Determination of ergonomic risks
   - Determination of risks associated with violence in the workplace
   - Determination of risks associated with the use of equipment
   - Determination of risks associated with the use of hazardous chemicals / materials
   - Determination of risks associated with the use of ionizing radiation
   - Determination of risk for injury associated with the job function such as patient handling, presence of sharps, etc.
   - Other risks as identified by the organization

B. Staff input is included in the development of the job hazard analysis

C. The results of the hazard analysis are reflected in job position description and communicated to staff who perform said job function(s)

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RISK SPECIFIC STANDARDS
EHS-9
The organization develops and implements a program to address musculoskeletal injuries due to manual handling of materials and ergonomic design

A. The organization provides training and education to all staff on musculoskeletal injury risks associated with their job function. This training is provided on hire and at least on an annual basis thereafter. At a minimum, this training must include:
- Use of appropriate body mechanics
- Use of adaptive or assistive equipment as applicable
- Recommendations to reduce the risk of injury specific to their job function

B. The organization conducts an assessment to determine those job positions that are at high risk of musculoskeletal injury due to poor ergonomic design. This risk assessment is performed by a professional ergonomist.
C. Based on the results of the risk assessment, the organization takes action to provide an ergonomically appropriate work environment for those job positions.
D. Procedures are in place for staff in any job function to request an ergonomic evaluation of their work environment by a professional ergonomist
E. Designs and plans for the purchase of new types of equipment / furnishings are reviewed by a professional ergonomist prior to purchase and installation

Standard EHS-10
The organization develops and implements a program to address the risk of violence in the workplace

A. The organization adopts a policy of zero tolerance for workplace violence. This policy is communicated to staff upon hire, and is also communicated to patients upon admission or presentation for care.
B. The organization conducts an assessment to determine those patient care areas that are considered high-risk for workplace violence. Emergency departments and inpatient behavioral health units are automatically considered high-risk.
C. Staff who work in high-risk areas receive training on hire and at least on an annual basis thereafter addressing the following:
- Identification of potentially violent patients
- How to identify and diffuse escalating behaviors that can lead to violence
- Techniques to protect oneself from a violent individual

D. Staff who work in all other areas of the organization receive training on hire and at least annually thereafter on how to summon assistance in the event of a work place violence incident.
E. There is a mechanism to identify patients who are or may be violent. This information is communicated to staff and others who interact with the patient.
F. Staff who work in high-risk areas have a mechanism to summon assistance in the event of an emergency (e.g. panic button, personal alarm device, etc.)
G. The organization has the capability to respond to a workplace violence situation to provide additional assistance to staff in the area in a timely manner.
H. The organization has a defined approach on how it will respond to an active shooter incident. This approach must address at least the following:
- Alerting staff, patients, and visitors
- Evacuation and lock-down procedures
- Shelter in place procedures
- Communication and coordination with law enforcement agencies
- Conducting periodic drills of its response to an active shooter incident

I. The organization investigates any incidence of workplace violence and takes appropriate action based on findings.
J. The organization maintains a database of workplace violence incidents. The database is reviewed on a regular basis to identify any patterns or trends of incidents. This information is then used to determine if changes to an area's risk level and/or risk mitigation strategies are warranted.
K. The organization provides medical and/or psychological support and resources to individuals affected by a workplace violence incident

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Standard EHS-11

The organization develops and implements a program to address the risk of injury due to sharps

A. The organization develops, implements, and enforces policies and procedures that address at least the following:
  - A prohibition on recapping of needles
  - Use of needleless intravenous medication delivery systems
  - Discarding of needles and other sharps only in approved disposal containers
  - Use of "sharp safe" needles when possible
  - Evaluation of products and procedure kits to address sharp safety concerns

B. The organization assures that rigid puncture-resistant sharps disposal containers are readily available in patient care and treatment areas.
  - At a minimum, disposal containers are located in each patient room, treatment bay, operative suite, and procedure room.
  - Disposal containers are secured in a manner that prevents spillage and access by non-authorized personnel
  - Disposal containers that are wall mounted are done so at a height that enables staff to visualize the top of the container when disposing of sharps
  - Disposal containers are replaced when they are three quarters full
  - Disposal containers are transported to a central area and secured for removal from the organization.

C. All clinical staff are trained on sharps safety as part of new hire orientation and on an annual basis thereafter. The content of said training is specific to the staff' job function

D. Physicians and other practitioners granted privileges by the medical staff receive information on sharp safety upon appointment and at the time of reappointment

E. Environmental service staff (and other applicable staff) receive specific training on assessing linen during change-out and trash containers for the presence of sharps. This training is provided on-hire and on an annual basis thereafter

F. Staff who are involved in a sharps related injury due to non-compliance with safety practices are required to undergo a retraining program

G. The organization implements a "neutral zone" in operative and procedure settings whereby sharp instruments are not passed directly from the hands of one practitioner to another.

Standard EHS-12

The organization develops and implements a program to address the risk of injury due to patient handling and mobility

A. The organization develops, implements, and enforces policies and procedures that address at least the following:
  - Requirements for staff to assess a patient's mobility status and develop a plan to safely address identified needs. Reassessment should occur any time there is a change in the patient's condition
  - Communicating a patient's handling and mobility needs to members of the healthcare team
  - Notation in the patient's plan of care of the patient's handling and mobility needs and the specific interventions to address those needs
  - Required use of adaptive and assistive equipment / devices when handling and mobilizing patients

B. The organization shall conduct an assessment of each patient care area to determine the type and amount of adaptive / assistive equipment and devices needed to safely address patient handling and mobilization issues. The organization shall then provide – or have a concrete plan to provide (with a commitment of resources) – said equipment / devices within a reasonable time frame.
  - Staff who will utilize the equipment / devices shall be involved in the assessment, and in the evaluation and selection of equipment / devices

C. Staff responsible for patient handling and mobility will receive training (appropriate to their job function) on-hire, and on an annual basis thereafter, on at least the following:
  - How to assess and determine a patient's handling and mobility needs
  - Methods for safe handling and mobilizing patients (e.g. lifting, turning, positioning, etc.)
  - The requirement to use adaptive and assistive equipment / devices provided for their safety
  - The appropriate use of adaptive and assistive equipment / devices

D. Staff who sustain injury due to non-compliance with safe patient handling and mobility practices are required to undergo a retraining program

E. Adaptive / assistive equipment used for patient handling / mobility is appropriately maintained

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Standard EHS-13

The organization develops, implements, and enforces a program to prevent injuries related to slips, trips, and falls

A. The organization conducts an assessment of all care and work areas, as well as entrances to buildings and the overall campus, to identify environmental hazards that increase the risk of a slip, trip, or fall. For each area, the assessment takes into consideration at least the following:
   - Sources of liquid that could spill, splash, or overflow
   - Adequacy of lighting and visibility
   - Evenness of walking surfaces (e.g. curbs, ramps, and sidewalks)
   - The type and condition of flooring or walking surfaces
   - Presence of non-slip stair treads
   - Presence of equipment or obstructions
   - Location of cords and lines
   - Types of rugs (if any) used in work areas
   - Speed of opening / closing of automatic doors
   - Accumulation of snow and ice on walkways and entrances to buildings

   The organization takes action to address issues identified as a result of the risk assessment.
B. The organization provides appropriate signage, or other warning devices when a slip, trip, or fall hazard is present
C. The organization requires staff to wear non-slip footwear in areas assessed to be at high-risk for slips
D. Staff are trained on slip, trip, and fall hazards in their work areas on hire and on an annual basis thereafter. Training includes actions that staff need to take to mitigate said hazards.
E. The organization must develop and implement a program to reduce the incidence of patient falls that result in injury. At a minimum, the organization must do the following:
   - Conduct a patient-specific fall risk assessment on all patients admitted to inpatient status.
     - The organization determines the scope and content of this assessment.
     - The assessment must be completed within 24 hours of the patient's admission. The frequency of any further assessment is defined by the organization.
     - Note: This assessment is not required for neonatal, infant, and toddler patients. These patients developmental age inherently places them at risk for drop or fall.
   - For outpatient care areas the organization must at least perform an environmental assessment to identify and correct hazards that could contribute to a fall.
     - In addition, there must be a general plan in place to assist patients who inherently or obviously present as a fall risk (e.g. provide protective and/or assistive devices, assist with ambulation, etc.).
   - When a patient is identified as a fall risk, the organization must take steps to protect the patient.
     - The organization determines the interventions that will be employed for the patient. These interventions are then consistently implemented.
     - In addition, for inpatient settings, a proactive rounding program is established to anticipate patient care needs to prevent unassisted ambulation and attempts to get out of bed.
   - Should a patient fall, the organization must assess the patient for any injury and take action as necessary.

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Standard EHS-14

The organization develops, implements, and enforces a program to prevent injuries due to ionizing radiation

A. The organization must develop and implement policies and procedures related to:
- Adequate shielding for patients, personnel and facilities;
- Labeling of radioactive materials, waste and hazardous areas;
- Transportation of radioactive materials between locations within the hospital;
- Security of radioactive materials, including determining who may have access to radioactive materials and controlling access to radioactive materials;
- Testing of equipment for radiation hazards;
- Maintenance of personal radiation monitoring devices (badges), including testing staff for radiation exposure;
- Review of personal radiation monitoring devices (badges) to identify and address excessive radiation exposure
- Education of staff on the importance of tracking their radiation exposure over various timeframes as well as their cumulative exposure through work. Staff also must be educated about the appropriate storage of the meters and/or badges as well as the procedures to follow if the exposure device exceeds cumulative dosage parameters specified by policy
- Proper storage of radiation monitoring badges when not in use;
- Storage of radio nuclides and radio pharmaceuticals as well as radioactive waste;
- Disposal of radio nuclides, unused radio pharmaceuticals and radioactive waste;
- Methods of identifying pregnant patients and employees;
- Posting of radiation precaution and warning signage in appropriate areas

B. The organization must have policies and procedures in place to ensure that periodic inspections of radiology equipment are conducted and that problems identified are corrected in a timely manner.
- The organization must ensure that radiation producing equipment is inspected in accordance with manufacturer's instructions, Federal and State laws, regulations and guidelines and organization policy.

EHS-15

The organization develops, implements, and enforces a program to prevent injuries when managing hazardous chemicals, medications, and materials

Note: For the purposes of this standard, the term "hazardous" includes biohazard or medical waste.

A. There must be written policies and procedures developed and implemented that address the procurement, storage, use, transport and disposition of hazardous chemicals, medications, and materials.

B. Designated hazardous chemical, medication, and material storage areas must be appropriately identified and secured against access to unauthorized individuals.

C. Hazardous waste must be removed from the organization's premises within a time frame required by law and regulation. Documentation of removal of hazardous waste from the premises must be maintained.

D. Safety data sheets must be readily available to staff for the hazardous chemicals, medications, and materials in their work area.

E. Hazardous chemicals, medications, and materials must be identified by labeling along with necessary precautions and hazard information. This includes transferring to secondary containers.

F. Staff who use, collect, transport and dispose of hazardous chemicals, medications, and materials must use appropriate personal protective equipment. This equipment must be readily available in the work area.

G. There must be written procedures developed and implemented to contain and/or clean up a hazardous chemical, medication, and material waste spill.
- The organization defines those spills that may be managed internally versus those spills that require an outside entity (e.g. external hazmat team) to manage.

H. Staff who procure, store, use, transport and/or dispose of hazardous chemicals, medication, and materials receive training on hire and on an annual basis thereafter on at least the following:
- Identification of the specific hazards associated with the chemicals, medication, and materials in their work environment
- Use of safety data sheets
- Use of personal protective equipment
- Staff responsible for cleaning up a hazardous chemical, medication, and material spill must be provided with the training and protective equipment to do so

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Standard EHS-16

The organization develops and implements a program to reduce the risk of illness due to legionella and other waterborne pathogens

A. The organization shall proactively perform an environmental assessment of its water systems. This assessment involves reviewing building characteristics, hot and cold-water supplies, cooling and air- handling systems, chemical treatment systems, or systems where water may have low or no flow for extended periods of time. The purpose of the assessment is to discover any vulnerabilities that would allow for amplification of *Legionella* and other waterborne pathogens to structure a response in advance of any environmental sampling for *Legionella*.

B. Initial or ongoing assessment should be conducted by a multidisciplinary team composed of key individuals that represent the expertise, knowledge and functions related to the facility operations and service.

C. Based on the results of the environmental assessment, water systems shall be operated and maintained as follows:
- Hot water heating systems (non-potable) and – if applicable – cooling towers shall be maintained according to the manufacturer's recommendations and current industry standards (ASHRAE; CTI, 2008). This includes annual start-up and shut-down procedures.
- If applicable, the operation and maintenance of the cooling tower should be conducted under the guidance of a water treatment expert experienced in cooling tower design and operation. Cooling tower documentation should include written details regarding the proper use of corrosion inhibitors, biocides, and disinfectants, and records on repairs, alterations, operating times, monitoring, routine disinfection, and inspections.

D. If a single case or multiple cases of Legionnaire disease is detected, it shall be immediately reported to local and State public health authorities. The organization, in consultation with public health authorities, should consider disinfection of the implicated water system.

E. Disinfection should be performed if indicated by the results of an environmental assessment or in response to disease. If multiple possible or definite case(s) are identified, it is advisable to consider immediate disinfection. The disinfection and culture sampling should be done in consultation with public health authorities. When possible, a baseline assessment or an updated Environmental Assessment should be completed prior to disinfection. The facility's multidisciplinary team should be involved in all disinfection decision making.

Standard EHS-17

The organization develops and implements a program to reduce the risk of illness due to indoor air quality issues

A. The organization conducts an assessment of all work areas to identify risks associated with illness due to indoor air quality issues.

B. The organization regularly inspects building areas such as roofs, ceilings, walls, basements, crawl spaces, and slab construction for evidence of dampness; and takes prompt steps to identify and correct the causes of any dampness problems found.

C. The organization conducts regularly scheduled inspections of heating, ventilating, and air-conditioning (HVAC) systems and promptly corrects any problems.

D. The organization prevents high indoor humidity through the proper design and operation of HVAC systems.

E. Steps are taken to dry any porous building materials that have become wet from leaks or flooding within 48 hours.

F. The organization cleans and repairs or replaces any building materials that are moisture-damaged or show evidence of visible mold growth.

G. The organization follows remediation guidelines such as those established by the Environmental Protection Agency

H. The organization Informs staff that respiratory effects from exposure in damp buildings can occur and implements a system for response to:
- Building dampness and musty or moldy odors,
- Leaks, and flooding incidents.
- Building-related respiratory symptoms or disease.

I. The organization encourages staff who have developed persistent or worsening respiratory symptoms while working in the building to seek appropriate medical attention. The organization provides assistance to staff in doing so

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Standard EHS-18

The organization develops and implements a program to reduce the risk of injury due to use of medical and utilities equipment

A. The organization assures that individual(s) responsible for overseeing the development, implementation, and management of equipment maintenance programs and activities are qualified by education, training, and/or experience to do so.
   - The organization's leadership assures that all equipment maintenance policies, procedures, programs, specific maintenance inventories, activities, and schedules are under the purview of qualified personnel.

B. Medical and utility equipment must be inspected, calibrated, tested, and maintained by qualified personnel

C. Medical and utility equipment must be tested for performance and safety before initial use and after major repairs or upgrades

D. Medical and utility equipment is to be used for its intended purpose(s).

E. Staff must be trained on the safe operation of medical and utility equipment before they use it.

F. Patients must be determined to be competent before using their personal equipment that is brought into the hospital

G. Medical and utility equipment brought into the organization (e.g. rentals, vendor-owned, physician-owned, and patient-owned) for use on a patient must be inspected to assure it is operating properly before use.

H. Medical equipment must be kept clean and in good working order.

I. A process must be developed and implemented to identify and remove broken, malfunctioning or inoperable equipment from patient care areas.

Standard EHS-19

The organization assures a safe environment for staff, visitors, and patients during periods of construction and renovation

A. The organization assures that construction or renovation is performed in accordance with State or local building code and other appropriate regulation.

B. Prior to commencing construction or renovation, the organization assesses the impact of such activity. This assessment addresses at least the following:
   - Impact on fire and life safety systems
   - Impact on the control and prevention of infections
   - Impact on prevention of legionella and other waterborne pathogens
   - Impact on indoor air quality
   - Identification of hazards that could affect the safety of staff, patients, and visitors

C. Based on the assessed impact, the organization takes appropriate action to assure that the safety of patients, staff, and visitors is maintained. This includes at least the following:
   - Communicating with contractors and vendors on identified risks and specific actions that they must take to address those issues
   - Monitoring of contractors and vendors to assure that risk mitigation activities are consistently performed.
   - Informing staff affected by the construction / renovation on risk issues and actions they must take to address those issues.
   - As necessary, implementation of interim life safety measures to address deficiencies to the NFPA Life Safety Code as a result of construction / renovation activities

--- END ---

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Attachment A

Please have the following documents available for review on the morning of the survey. If the organization is undergoing an initial designation survey, documents are only required for 3 months rather than 12 months where indicated.

Standard	Document Requested
EHS-1	Evidence that a senior leader has been appointed to provide administrative support and guidance to the organization's environmental health and safety program
EHS - 1	Evidence that the governing body and senior leadership receive regular reports on the status of the environmental safety program as outlined in Standard EHS-4 for the past 12 months
EHS-2	Most recent iteration of the organization-wide written environmental health and safety program including statements of goals and objectives
EHS-2	Most recent evaluation of the organization-wide environmental health and safety program with evidence that the evaluation was submitted to the programs oversight committee and to the governing body.
EHS-3	Minutes of the multidisciplinary committee(s) that is assigned to oversee implementation of the environmental health and safety program for the past 12 months
EHS-4	Evidence that the organization collects, aggregates, and analyzes data on performance metrics related to environmental health and safety for the past 12 months as outlined in EHS-4.
EHS-5	Copy of information provided to staff at new hire orientation an on an annual basis as noted under Requirement A
EHS-5	Evidence that the organization seeks input from staff on a regular basis on suggestions for reducing risk and improving the environmental health and safety program.
EHS-6	A copy of the database for the past 12 months on both actual and potential risks as outlined in Requirement B
EHS-7	Evidence for the past 12 months that the organization conducts audits of the environment to identify health and safety risks in accordance with assigned risk levels in the different work areas.
EHS-8	List of all job positions for which a hazard analysis has been performed in accordance with Requirement C
EHS-9	Evidence that the organization has conducted an assessment to determine those job positions that are at high risk of musculoskeletal injury due to poor ergonomic design.
EHS-10	Evidence that an assessment has been conducted to determine those patient care areas that are considered high-risk for workplace violence.
EHS-11	Evidence that the organization developed policies and procedures that address at least the following: • A prohibition on recapping of needles • Use of needleless intravenous medication delivery systems • Discarding of needles and other sharps only in approved disposal containers • Use of "sharp safe" needles when possible • Evaluation of products and procedure kits to address sharp safety concerns • Establishment of a neutral or "no passing" zone for instrument use in operative areas
EHS-11	Evidence that physicians and other practitioners granted privileges by the medical staff receive information on sharp safety upon appointment and at the time of reappointment

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Standard	Document Requested
EHS-12	Evidence that the organization has conducted an assessment of each patient care area to determine the type and amount of adaptive / assistive equipment and devices needed to safely address patient handling and mobilization issues, along with a concrete plan to provide (with a commitment of resources) – said equipment / devices within a reasonable time frame.
EHS-13	Evidence that the organization has performed an environmental assessment to identify and correct hazards that could contribute to a fall in outpatient care areas.
EHS-16	Evidence that the organization has performed an environmental assessment of its water systems discover any vulnerabilities that would allow for amplification of Legionella and other waterborne pathogens
EHS-17	Evidence that the organization has conducted an assessment of all work areas to identify risks associated with illness due to indoor air quality issues.
EHS-19	Evidence that the organization has conducted an assessment for any construction or renovation performed in the past 12 months in accordance with Requirement C

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