## General Requirements:

### 11.00.01 Condition of Participation: Physical Environment.
The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment, and for special hospital services appropriate to the needs of the community.

§482.41

### 11.00.02 Required Plans & Performance Standards.
The hospital shall maintain written plans and performance improvement standards for the following areas:

- 01: Building Safety
- 02: Building Security
- 03: Hazardous Materials and Waste
- 04: Fire Safety Control
- 05: Medical Equipment Management
- 06: Utility Systems Management

Plans to be reviewed and approved at least once every 12 months by the organization’s committee that oversees safety in the environment. The annual review is documented.

### SCORING PROCEDURE

**DOCUMENT REVIEW, INTERVIEW, AND OBSERVATION**

- **Review the scores for this chapter with focus on the list of systems identified in 11.00.02 below.**
- **One surveyor should conduct survey of the Physical Environment; however, each surveyor, as he/she conducts his/her survey assignments, should assess the hospital’s compliance with this standard.**

**1 = Compliant**

**2 = Not Compliant**

This standard is not met as evidenced by:
**Building Safety:**

**11.01.01 Periodic Monitoring for Safety Issues.**

The physical environment of each facility used for treating or housing patients shall be inspected once every six months in patient care areas, and once every 12 months in non-patient care areas to identify safety related concerns and issues.

Inspections must be documented with date, initials or signatures of individuals participating in the inspection, and all deficiencies identified with the action item of said deficiencies.

**11.01.02 Building Safety.**

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients, visitors, and staff is assured.

§482.41(a)

All patient care areas of the facility are inspected at least once every six months and all non-patient care areas are inspected at least once every 12 months to identify safety related concerns and issues. Special care is given to ensure compliance with applicable codes, standards and regulations related to the physical environment.

Interior and exterior walking surfaces are to be inspected for tripping or slipping hazards. Electrical hazards, ergonomics, corridor clutter, fluid leaks, signage, egress lighting and paths of egress are of particular interest.

The hospital must ensure that the condition of the physical plant and overall hospital environment is developed and maintained in a manner to ensure the safety and well-being of patients, visitors and staff.

Routine and preventative maintenance on medical equipment is scored under 11.05.01, and utility (plant) equipment is scored under 11.06.09.

**DOCUMENT REVIEW, INTERVIEW AND OBSERVATION**

- Verify that records have been maintained demonstrating safety inspections were conducted once every six months in patient care areas and once every 12 months for non-patient care areas.

- Additional facilities associated with the hospital, either owned or leased must also be monitored for safety. Records demonstrating correction of actions should be reviewed. All items identified in the report should be reviewed for corrective action.

**SCORE**

1 = Compliant  2 = Not Compliant

This standard is not met as evidenced by:

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2017 - Prepublication

Healthcare Facilities Accreditation Program (HFAP)

Accreditation Requirements for Acute Care Hospitals
11.01.03 **Safety Committee.**
There is a Safety Committee that is developed to discuss the opportunities to improve all issues related to safety existing within the hospital.

Multi-disciplinary membership shall consist of individuals who have knowledge and authority of the operations within their own area / service.

**Membership includes a representative from administration, clinical, and support services. This team is responsible for all safety-related policies, procedures, and processes in the hospital.**

*The Safety Committee meets periodically, to review reports, analyze trends, discuss safety related issues in the physical environment, and identify opportunities to resolve physical environment safety issues.*

*The Safety Committee reports appropriate results of monitoring and committee actions and recommendations to leadership, Quality Assessment Performance Improvement (QAPI), and department managers.*

*HFAP does not specify the frequency of Safety Committee meetings, but meeting held less than once every two months require a risk assessment to indicate the effectiveness of less frequent meetings.*

**DOCUMENT REVIEW**
Review the appointment process, composition of, and duties of the Safety Committee and their performance.

Review minutes of committee meetings.
Determine if recommendations for action were made for specific safety issues.

Evaluate the frequency of the Safety Committee meetings. If less frequent than once every two months, then review risk assessment indicating the effectiveness of the less-frequent meetings.

Review reports of the Safety Committee to the governing body to determine effectiveness of the committee to make recommendations on physical environment issues.

This standard is not met as evidenced by:

11.01.04 **Safety Committee Chairperson.**
The Chief Executive Officer of the hospital shall appoint the chairperson of the Safety Committee.

The appointment must be documented.

*The role of the chairperson is to assure that concerns that are identified by the Safety Committee can receive administrative attention in an expeditious manner.*

Consideration should be made to limit the appointment of the chairperson to a 1-year term to allow a change in leadership. While this is not a requirement, it is suggested to rotate the chairperson’s role to prevent domination by one individual.

**INTERVIEW**
- Verify the appointment.

This standard is not met as evidenced by:
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<tr>
<td>11.01.05 <strong>Safety Officer.</strong></td>
<td>An individual is appointed by the chief executive officer to serve as the organization’s Safety Officer with responsibilities to intervene whenever conditions in the environment present a threat to the life and health of the occupants, or threaten damage to the physical environment. Authority to take any action needed relating to situations that pose immediate threat to life, health, and/or property shall be included in the appointment document. This appointment must be documented.</td>
<td>• Review the appointment process and content of the appointment document. • Verify the appointment has been reaffirmed annually.</td>
<td>□ 1 = Compliant  □ 2 = Not Compliant <strong>This standard is not met as evidenced by:</strong></td>
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<td>11.01.06 <strong>Not Applicable.</strong></td>
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<td>11.01.07 <strong>Not Applicable.</strong></td>
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<td>11.01.08 <strong>Review of Safety Policies / Procedures.</strong></td>
<td>People, processes, and characteristics change; therefore, all safety policies and procedures shall be reviewed at least once every 36 months and approved for appropriateness by the Safety Committee. The chairperson of the Safety Committee shall sign and date the policies.</td>
<td>• Verify that an appraisal has been documented at least once in the past 36 months within the Safety Committee minutes. • Verify that policies are current.</td>
<td>□ 1 = Compliant  □ 2 = Not Compliant <strong>This standard is not met as evidenced by:</strong></td>
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<td><strong>11.01.09 Smoking / Tobacco Products Policy.</strong></td>
<td>Smoking and the use of lighting material for smoking is also a fire hazard. Smoke in a hospital contaminates air in the central air system. Smoking is dangerous around oxygen. Active promotion is to be taken to promote a tobacco free environment in the healthcare hospital. The policy on smoking must address the requirements found in chapter 18/19.7.4 of the 2012 Life Safety Code, including information on: - Prohibited areas - Signage - Ashtray construction - Metal containers with lids for ash disposal The policy shall prohibit smoking by patients unless authorized to smoke by the attending physician. If permitted, smoking must be out of doors and away from entrances or air intakes. If permitted indoors, it must be confined to controlled smoking areas which prevent exposure to non-smokers, must not contaminate the central air system, and the smoke from the controlled area must be exhausted to the out of doors. Other patients and staff MUST be protected from exposure.</td>
<td><strong>DOCUMENT REVIEW AND OBSERVATION</strong>  - Verify policy and observe practice.</td>
<td>2 = Not Compliant</td>
</tr>
<tr>
<td><strong>11.01.10 Eyewash Stations and Emergency Showers.</strong></td>
<td>Where injurious corrosive materials exist, organizations must conduct a risk assessment to determine the need for ANSI Z358.1-2014 approved eyewash stations and/or emergency showers. ANSI Z358.1-2014 is the standard that must be</td>
<td><strong>DOCUMENT REVIEW AND OBSERVATION</strong>  - In areas where injurious corrosive materials are observed, review the organization’s risk assessment to determine the need for emergency eyewash or shower equipment.</td>
<td>N/A</td>
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2017 - Prepublication
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<tr>
<td>showers shall be provided within the work area for immediate emergency use.</td>
<td>followed for the proper design, installation and maintenance of emergency eyewash and shower equipment.</td>
<td>• Check logs to ensure plumbed emergency eyewash and shower equipment are activated weekly to verify operation and to ensure the flushing fluid is available. &lt;br&gt;• Examine emergency eyewash and shower equipment to ensure it complies with ANSI Z358.1-2014 standards for installation and operation.</td>
<td>met as evidenced by:</td>
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To purchase your own copy of the ANSI Z358.1-2014 standard, follow this link: [http://webstore.ansi.org/](http://webstore.ansi.org/)
### PHYSICAL ENVIRONMENT

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<td>Building Security:</td>
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<tr>
<td>11.02.01 Building Security.</td>
<td>The organization shall have policies and other measures in effect to identify and minimize security risks to patients, visitors, and staff.</td>
<td><strong>DOCUMENT REVIEW AND INTERVIEW</strong></td>
<td>1 = Compliant 2 = Not Compliant</td>
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| | Patients, visitors, and staff shall be protected from security concerns. Policies, procedures, and systems shall be developed to monitor and reduce adverse outcomes. Examples of security issues include theft of personal or commercial items, abduction, and assaults of individuals in and outside the facilities. | - Determine if policies, procedures and systems are in place. Review documents to determine if the security program is effective or if there are security concerns.  
- Review security risk assessments for frequency and thoroughness of assessments, and follow-through on recommended actions.  
- Interview staff to determine if security and safety is an issue. |
| | Security risks must be identified and action taken to minimize the risk to patients, visitors and staff. | This standard is not met as evidenced by: |
| 11.02.02 Security Management. | Smaller facilities may have full time or part time security staff that reports to an administrative staff person. Larger facilities may have their own security department and security officers. | **INTERVIEW** | 1 = Compliant 2 = Not Compliant |
| | Consideration should be given how to process supplement security resources in the event of a disaster. This may be accomplished with Memorandums of Understanding (MOU). | - Interview various hospital employees to determine if they can identify the person or department responsible for security issues.  
- Does adequate staff and supervision exist?  
- Review security reports for occurrences of security problems. Are security issues handled quickly and thoroughly? Is follow-up appropriate? |
| | The hospital has established a relationship with the local police department to facilitate timely response if external police assistance is required. External support for security is available on a timely basis from the local police department. | This standard is not met as evidenced by: |
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<td>11.02.03 Not Applicable.</td>
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<td>11.02.04 Security Sensitive Areas.</td>
<td>The hospital identifies areas that they believe to be security sensitive and have control systems in place to protect the areas and contents.</td>
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<td>These security sensitive areas are documented.</td>
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<td>There are many different types of areas in a hospital that can be considered security sensitive, such as nurseries, pharmacies, cashiers box, medical records, etc. The organization must first identify these areas and then have systems in place to control and protect these areas.</td>
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<td>Note: Control systems can be physical locks on doors, observation systems, as well as special response plans. Any locks on doors must comply with the Life Safety Code, 2012 edition.</td>
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<td>The hospital reviews the list of security sensitive areas on an annual basis, to determine accuracy and whether additional locations need to be added.</td>
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<td>11.02.05 Security Incident Procedures.</td>
<td>The hospital has written procedures that they must adhere to in the event of a security incident.</td>
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<td>Security incidents may include an infant abduction, VIP visit, civil disobedience, bomb threat, or unruly patient or guest. The hospital must have written procedures that their security staff must follow in the event of a security incident.</td>
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<td>DOCUMENTATION AND INTERVIEW</td>
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<td>Review list of security sensitive areas. Evaluate if all sensitive areas are included.</td>
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<td>Determine through interview if security control system is sufficient to protect identified areas.</td>
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<td>Review list of written procedures for security incidents. Evaluate if the list adequately covers procedures for staff to follow in the event of an incident.</td>
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<td>Interview staff to determine if they received training on Security Incident Procedures.</td>
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<td>1 = Compliant</td>
<td>2 = Not Compliant</td>
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<td>This standard is not met as evidenced by:</td>
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### Hazardous Materials and Waste

#### 11.03.01 Hazardous Materials & Waste Program

There shall be a system to identify, handle, process, and dispose of hazardous materials and wastes. Each service area within the hospital shall develop and maintain a list of the hazardous materials and wastes housed in the area and/or used by staff.

A hazardous material is defined as any substance or material that could adversely affect the safety of the public, handlers or carriers during use, transportation, storage, or disposal.

Aspects of the physical environment are designed and maintained to contain, neutralize, or destroy potentially harmful materials and wastes. Examples of hazardous waste include but are not limited to chemotherapy waste, chemical waste, infectious waste, waste gas, and radioactive waste.

The hospital designates in writing an individual to be responsible for the coordination of activities to ensure procedures are written, approved (by the appropriate committee), and implemented for response to spills, accidents, and emergency in-house decontamination for patients of the emergency department.

#### 11.03.02 Storage & Disposal Of Trash

The hospital must have procedures for the proper routine storage and prompt disposal of trash.

The term trash refers to common garbage as well as bio-hazardous waste. The storage and disposal of trash must be in accordance with Federal, State and local laws and regulations (i.e., EPA, OSHA, CDC, State environmental, health and safety regulations).

The procedures for proper routine storage and disposal of trash must be written, and reviewed by the Safety Committee once every 3 years.
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<td><strong>11.03</strong> Program Minimizes Exposure.</td>
<td>Policies and procedures should address the prevention and response to spills, slips, falls, and accidents.</td>
<td><strong>DOCUMENT REVIEW AND OBSERVATION</strong>&lt;br&gt;• Review hazardous waste plans for various waste products. Determine compliance.</td>
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<tr>
<td><strong>11.04</strong> Labels, Inventory &amp; SDS.</td>
<td>Hazardous products are appropriately labeled according to regulations and NFPA standards. Safety Data Sheets (SDS) are maintained (or are available within 10 minutes) in an area that is always available to the staff for every hazardous material for which they may come in contact. Hazardous materials that must be included on the inventory are those whose storage, use or handling are regulated by standards or laws. The inventory is updated annually. Safety Data Sheet information may be stored electronically, or obtained through the internet or a fax-back service. However, paper copies of the Safety Data Sheets of all hazardous products must be maintained on the premise of the facility, in the event the electronic copies are not available. Copies of the SDS may be maintained on CDs or flash-drives in lieu of paper copies, provided a battery-operated computer is available to display them.</td>
<td><strong>DOCUMENT REVIEW AND OBSERVATION</strong>&lt;br&gt;• Review the Hazardous Materials and Waste Management Plan. &lt;br&gt;• Check hazardous materials during building tour looking for proper labeling, use, disposal and storage. &lt;br&gt;• Ask staff to provide you a Safety Data Sheet for random selected materials. &lt;br&gt;• Confirm paper copies of the Safety Data Sheets are available to the hospital staff, or copies in CDs or flash-drives provided a battery-operated computer is available to display them. &lt;br&gt;• Review inventory of hazardous materials and confirm that it is updated annually.</td>
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| **11.03.05  Personal Protective Equipment (PPE).** | Appropriate Personal Protective Equipment (PPE) is provided, as necessary, to staff to ensure against possible exposure to hazardous materials and wastes. | **OBSERVATION**  
- Review the hazardous materials and waste program for exposure to risk content. Look for evidence of use of PPE.  
- Is PPE available? | □ 1 = Compliant  
□ 2 = Not Compliant  
This standard is not met as evidenced by: |
| **11.03.06  Hazardous Materials – Routine Monitoring.** | Monitoring of hazardous materials and wastes is conducted to reduce the exposure potential to harmful agents. | **DOCUMENT REVIEW AND OBSERVATION**  
- Review documented routine monitoring of hazardous materials.  
- Observations will be made of the storage containers (which may range from labeling the container to the use of explosion proof cabinets), the availability and use of personal protective equipment, and staff knowledge of the hazardous materials and wastes program. | □ 1 = Compliant  
□ 2 = Not Compliant  
This standard is not met as evidenced by: |
Fire Safety Control

11.04.01  Written Fire Control Plans.

The hospital must have written fire control plans that contain provisions for:

- Prompt reporting of fires
- Extinguishing fires
- Protection for patients, personnel and guests
- Evacuation
- Cooperation with fire-fighting authorities

§482.41(b)(5)

The written fire control plans must describe the roles expected of staff at the area or location of the fire, and in areas and locations away from the fire. Plans must include how and when to activate the alarm, the proper method to contain smoke and fire, the correct method on when and how to use a fire extinguisher and when and where to evacuate patients.

The fire control plan must meet the requirements of chapter 18/19.7.1.1 of the 2012 Life Safety Code, including but not limited to:

- Plan must be made available to all personnel
- Plan must be available at the telephone operator position(s) or the continuously manned security center
- Provide instruction in fire-safety procedures and devices to all staff

The plan must also include instructions on how to evacuate the building when instructed to do so by a person of authority. The term ‘staff’ includes all individuals, whether employees, volunteers, students or contract workers who are performing their job requirements within the facility.

DOCUMENT REVIEW AND INTERVIEW

- Review the hospital’s written fire control plans to verify they contain the provisions identified.
- Verify that hospital staff reported all fires as required.
- Interview staff throughout the hospital to verify their knowledge of their responsibilities during a fire.

This standard is not met as evidenced by:
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| 11.04.02 Fire Drills - Quarterly | Fire drills shall be conducted at least quarterly on all shifts in all buildings classified as healthcare occupancy or ambulatory healthcare occupancy. For buildings classified as business occupancy (or other occupancies), fire drills are conducted annually on all shifts. All fire drills are documented. | DOCUMENT REVIEW  
- Participation is based upon staff’s role in accordance with the Fire Control Plan, which may be at the point of alarm and away from the point of alarm.  
- Review logs to ensure each healthcare occupancy and each ambulatory healthcare occupancy had one drill per shift per quarter.  
- Review logs to ensure off-site business occupancies have had annual fire drills on each shift. | 1 = Compliant  
2 = Not Compliant  
This standard is not met as evidenced by: |
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| **11.04.03 Fire Drill - Critique.** | Each fire drill shall be evaluated by observers located in strategic areas to record the responses of the staff and the processes being followed. Each fire drill critique is documented. Detailed documentation of critiquing of the drills shall be maintained. A proper critique must include:  
- the staff’s response to the alarm;  
- the building’s response to the alarm; and  
- the fire alarm response. This information is to be used by the Safety Team to improve hospital fire response systems.  
Actual fire alarms (non-drills) may be used in lieu of planned fire drills provided all areas of response are properly critiqued. | **DOCUMENT REVIEW**  
- Review records of the analysis of the fire drill implementations.  
- Review Safety Team/Committee minutes to determine if they evaluate fire drills to improve the hospital’s fire response. |  | 1 = Compliant  
2 = Not Compliant  
This standard is not met as evidenced by: |
| **11.04.04 Approval by State & Local Fire Agencies.** | The hospital must maintain written evidence of regular inspection and approval by state or local fire control agencies.  
§482.41(b)(6) | **DOCUMENT REVIEW**  
- Examine copies of inspection and approval reports from state and local fire control agencies to verify evidence of inspections and correction of any deficiencies.  
- Examine documentation from state or local fire control authorities where they refuse to provide inspections. |  | 1 = Compliant  
2 = Not Compliant  
This standard is not met as evidenced by: |
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<td><strong>11.04.05</strong>  Minimize the Risk of Danger from Fire.</td>
<td>The hospital must take a proactive approach to reduce the risk of harm and danger to the occupants of the facility, from the harmful effects from fire, smoke and the products of combustion. This standard does not require the hospital to install fire safety features that are not required by any applicable code, standard or regulation.</td>
<td>OBSERVATION During the building tour, identify situations that exist which may present a danger to the occupants from the harmful effects of fire, smoke and the products of combustion.</td>
<td>□ 1 = Compliant □ 2 = Not Compliant</td>
</tr>
<tr>
<td><strong>11.04.06</strong>  Fire Response – Staff Training.</td>
<td>Self-Explanatory.</td>
<td>DOCUMENT REVIEW AND INTERVIEW • Review training records to ensure staff receives fire response training.</td>
<td>□ 1 = Compliant □ 2 = Not Compliant</td>
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Medical Equipment Management.

11.05.01 Medical Equipment & Systems – Maintenance.

There is an established, scheduled preventive maintenance program for medical equipment relating directly or indirectly to patient care, and shall be maintained and tested periodically in accordance with the manufacturer’s recommendations.

As an alternative approach, hospitals may choose to employ alternative maintenance activities and/or schedules provided they develop, implement, and maintain a documented Alternate Equipment Management (AEM) program, to minimize risks to patients and others in the hospital associated with the use of medical equipment.

The definition of ‘medical equipment’ is a device intended to be used for diagnostic, therapeutic, or monitoring of care to a patient in a hospital. All medical equipment (electrical and non-electrical) shall be included in the process for preventive maintenance. There shall be written testing criteria for each type of equipment included in the preventive maintenance system. For hospitals that elect to perform equipment maintenance in accordance with the manufacturer’s requirements, the hospital must maintain documentation of the manufacturer’s recommendations as well as the hospital’s maintenance activities.

The organization may use an alternative method of communication to staff on medical equipment inspections, in lieu of stickers applied to medical equipment identifying the next inspection due date.

Alternate Equipment Management (AEM) Program

A hospital may, under certain conditions, use equipment maintenance activities and frequencies that differ from those recommended by the manufacturer, provided the activities and frequencies do not reduce the safety of the equipment. Hospitals that choose to employ alternate maintenance activities and/or schedules must develop, implement, and maintain a documented AEM program to minimize risks to patients and others in the hospital associated with the use of medical equipment. The

DOCUMENT REVIEW AND INTERVIEW

- Review records and/or equipment for evidence of routine inspections and documentation of the hospital’s biomedical preventive maintenance program.
- Are inspections conducted in a timely manner? Are past-due inspections common or rare?
- Can the staff recognize whether the equipment they are using has been inspected or is due for inspection? **While stickers applied to the medical equipment identifying the next inspection due date are not a requirement of this standard, there must be some form of effective communication to the staff on the current preventive maintenance of that equipment.**
- Is the preventive maintenance process one that alerts the staff to potentially unsafe equipment?

If the hospital is utilizing an AEM program for inspection, testing and maintenance activities, then the following activities need to be reviewed:
- Review the documentation for the AEM program. Determine if it addresses the requirements for equipment to have...
AEM program must be based on generally accepted standards of practice for medical equipment maintenance, such as ANSI/AAMI EQ 56:1999/(R) 2008, *Recommended Practice for a Medical Equipment Management Program*.

The determination of whether it is safe to perform medical equipment maintenance without following the equipment manufacturer recommendations must be made by qualified personnel, regardless of whether they are hospital employees or contractors. In the case of medical equipment, a clinical or biomedical technician or engineer would be considered qualified.

The hospital must maintain records of the qualifications of hospital personnel who make decisions on placing equipment in an AEM program, and must be able to demonstrate how they assure contracted personnel making such decisions are qualified.

In determining whether or not to include equipment in an AEM program, and which maintenance strategies to use in developing maintenance activities and frequencies for particular equipment, the hospital must take into account the typical health and safety risks associated with the equipment’s use. Note that the risk may vary for the same type of equipment, depending on the patient care setting within the hospital where it is used.

A hospital is expected to identify any equipment in its AEM program which is “critical equipment,” for which maintenance activities and frequencies less than the manufacturer’s recommendations.

- Is the determination of the alternative maintenance activities and frequencies being performed by qualified individuals?
- Verify that the hospital has documented maintenance activities and frequencies for all equipment included in the AEM program.
- Verify the hospital is evaluating the safety and effectiveness of the AEM program on an annual basis.
- If the hospital has identified equipment as having such a very low level of risk that it has determined it can use a broad interval range or departmental ‘sweeps’, ask the hospital for the evidence used to make this determination, and determine if it is reasonable.
- Of the critical equipment that is included in the AEM program, ask the hospital to explain how the decision was made to place this critical equipment in the program.
- Of the equipment that is included in the AEM program, ask the hospital to describe the methodology for applying maintenance strategies and determining alternative maintenance activities and/or frequencies.
there is a risk of serious injury or death to a patient or staff person should the equipment fail.

Multiple factors must be considered, since different types of equipment present different combinations of severity of potential harm and likelihood of failure. The hospital is expected to be able to demonstrate to a surveyor the factors it considered in its risk assessment for equipment placed in its AEM program.

Some equipment may not be eligible for placement in the AEM program, for one or more of the following reasons:

- Other Federal or State laws that may require the hospital to inspect, test and maintain their equipment strictly in accordance with the manufacturer’s recommendation;

- Other CMS Conditions of Participation which require adherence to manufacturer’s recommendations which preclude their inclusion in the AEM program;

- Imaging and radiologic equipment, whether used for diagnostic or therapeutic purposes, must be maintained in accordance with the manufacturer’s recommendations;

- Medical laser devices;

- New equipment for which sufficient maintenance history, either based on the hospital’s own or its contractor’s records, or available publicly from

- If the hospital is utilizing the AEM program, review the annual evaluation to determine they address:
  - How the equipment is evaluated
  - How incidents of equipment malfunction are investigated
  - The use of performance data

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<td>PHYSICAL ENVIRONMENT</td>
<td>there is a risk of serious injury or death to a patient or staff person should the equipment fail. Multiple factors must be considered, since different types of equipment present different combinations of severity of potential harm and likelihood of failure. The hospital is expected to be able to demonstrate to a surveyor the factors it considered in its risk assessment for equipment placed in its AEM program. Some equipment may not be eligible for placement in the AEM program, for one or more of the following reasons: - Other Federal or State laws that may require the hospital to inspect, test and maintain their equipment strictly in accordance with the manufacturer’s recommendation; - Other CMS Conditions of Participation which require adherence to manufacturer’s recommendations which preclude their inclusion in the AEM program; - Imaging and radiologic equipment, whether used for diagnostic or therapeutic purposes, must be maintained in accordance with the manufacturer’s recommendations; - Medical laser devices; - New equipment for which sufficient maintenance history, either based on the hospital’s own or its contractor’s records, or available publicly from</td>
<td>- If the hospital is utilizing the AEM program, review the annual evaluation to determine they address: - How the equipment is evaluated - How incidents of equipment malfunction are investigated - The use of performance data</td>
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</table>
nationally recognized sources, is not available to support a risk-based determination, must not be immediately included in the AEM program.

The hospital may use one or more maintenance strategies for its AEM program in order to determine the appropriate inspection, testing and maintenance activities and frequencies, based upon the nature of the equipment and the level of risk it presents to patient or staff health and safety. The risk to patient health and safety that is considered in developing alternative maintenance strategies must be explained and documented in the AEM program.

In developing AEM maintenance strategies, hospitals may rely upon information from a variety of sources, including, but not limited to:

- Manufacturer’s recommendations
- Nationally recognized expert associations
- Hospital’s own experience
- Contractor’s own experience
- Other materials

For each type of equipment subject to the AEM program, there must be documentation indicating:

- The pertinent types and level of risks to patients or staff health and safety;

- Alternative maintenance activities and the differences from the manufacturer’s recommendations when they are known;

- The date when AEM program maintenance
activities were performed and what actions, if any, were taken;

- Documentation of equipment failures and identifying if any harm resulted to an individual.

The AEM program must be compliant with these requirements at all times, and must have written policies and procedures that address the effectiveness of the program. The hospital must have a written annual evaluation of the AEM program that addresses the following factors:

- How equipment is evaluated to ensure there is no degradation of performance;

- How incidents of equipment malfunctioning are investigated, including whether or not the malfunction could have been prevented; what steps will be taken to prevent future malfunctions; and how a determination is made whether or not the malfunction resulted from the use of an AEM strategy;

- The process for the removal of equipment from service determined to be unsafe or no longer suitable for its intended application;

- The use of performance data to determine if modifications in the AEM program procedures are required.
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<tr>
<td>11.05.02 Medical Equipment Inventory</td>
<td>The inventory shall include all medical equipment used directly or indirectly for patient treatment and care. All equipment must be inspected, tested and maintained to ensure safety, availability and reliability. In addition, all equipment, regardless of whether it is leased or owned, and regardless of whether it is maintained in accordance to manufacturer recommendations or is in an AEM program, is listed in an inventory which includes a record of maintenance activities. If the hospital is using an AEM program, the equipment managed through that program must be separately identified on the equipment inventory from that equipment which is managed though the manufacturer’s recommendation program. Critical equipment, whether in an AEM program or not, must also be readily identified as such. To facilitate effective management, a well-designed equipment inventory contains the following information for all equipment included. However, hospitals have the flexibility to demonstrate how alternative means they use are effective in enabling them to manage their equipment. • A unique identification number; • The equipment manufacturer; • The equipment model number; • The equipment serial number; • A description of the equipment; • The location of the equipment; • The identity of the department considered</td>
<td>DOCUMENT REVIEW AND OBSERVATION</td>
<td>□ 1 = Compliant □ 2 = Not Compliant</td>
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- Review inventory list. Compare with field observed equipment to ensure all medical equipment is included.
- If the hospital utilizes the AEM program, does the inventory for the AEM program contain any equipment which is not eligible for the AEM?
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| **11.05.03** *Patient Call System.* The hospital maintains a means by which patients can summon help. | The hospital maintains a patient call system so patients can summon assistance. A backup system should be available to cover this need during power outages. **Patient call systems are not required in psychiatric nursing units, or psychiatric hospitals that do not serve acute-care patients.** | **OBSERVATION AND INTERVIEW** • Observe patient care areas to verify that such a system is in place and operational. Verify that there is a backup plan in place for periods of power outage. | 1 = Compliant 2 = Not Compliant 
This standard is not met as evidenced by: |
| **11.05.04** *Safe Medical Device Act (SMDA).* The hospital has taken actions to comply with the Safe Medical Device Act (SMDA). | Facilities shall demonstrate through the development and implementation of policies and procedures that they have addressed the issues and spirit of this act. | **DOCUMENT REVIEW AND OBSERVATION** • Review organization policies and procedures, tracking systems, and their ability to demonstrate compliance. | 1 = Compliant 2 = Not Compliant 
This standard is not met as evidenced by: |
| **11.05.05** *Medical Equipment Procurement.* The hospital obtains information and opinions when acquiring new medical equipment from the individuals who operate and service the equipment. | Self-explanatory. | **DOCUMENT REVIEW AND OBSERVATION** • Review organization policies and procedures, tracking systems, and their ability to demonstrate compliance. | 1 = Compliant 2 = Not Compliant 
This standard is not met as evidenced by: |
Utility Systems Management.

11.06.01 Emergency Power & Lighting.
There must be emergency power and lighting in at least the operating, recovery, intensive care, emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights shall be available.

§482.41(a)(1)


This provision requires emergency lighting for a period of 1½ hours in health care facilities, enabling those inside to move about safely in an emergency.

Facilities are free to expand the coverage of emergency power and lighting based on the size, complexity, and patient care services offered.

11.06.02 Emergency Power Electrical System.
Hospitals must have a Type I essential electrical system power source powered by a generator set equipped with a transfer switch, in accordance with NFPA 99, (2012 edition).

For all essential electrical systems constructed, modernize or renovated since 1983, the functions of patient


The emergency power system is a separate electrical system that is divided into two major systems:
- the emergency system; and
- the equipment system.

INTERVIEW AND OBSERVATION
- Verify that the hospital has a Type I Essential Electrical System powered by generator with an automatic transfer switch
- Verify that there is an emergency power system in place that is subdivided into two branches, the life safety branch and the critical branch for systems installed or modified since January 1, 1984.

This standard is not met as evidenced by:
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<td>care depending on lighting or appliances that are permitted to be connected to the emergency system are divided into two mandatory branches, the life safety branch and the critical branch, and must comply with NFPA 99 (1999 edition) chapter 3 requirements.</td>
<td>The emergency system is subdivided into the two branches in accordance with NFPA 99, 2012 edition: 1) The life safety branch. 2) The critical branch.</td>
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<td>Prior to the development of NFPA 99 standard Health Care Facilities, life safety branch and the critical branch were allowed to be one branch and not separated. Therefore, essential electrical systems that were installed, renovated, or modernized after 1983, must comply with NFPA 99 (2012 edition) requirements.</td>
<td>Consideration should be given on generator failure solutions, processes for repair, and how to connect external resources during an emergency.</td>
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<td>11.06.03  Not Applicable. (Relocated to 13.05.04)</td>
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<td>11.06.04  Not Applicable. (Relocated to 13.05.05)</td>
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<td>11.06.05  Not Applicable. (Relocated to 13.05.06)</td>
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<td>11.06.06  Not Applicable. (Relocated to 13.05.07)</td>
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<td>11.06.07  <strong>Potable Water.</strong></td>
<td>Potable water is tested annually and treated as necessary.</td>
<td><strong>DOCUMENT REVIEW</strong></td>
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<td>Test is documented.</td>
<td>If potable water is tested by other entities, the results of this test must be available for review during a survey.</td>
<td><strong>FIGURE</strong></td>
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<td>Results of test are forwarded to the organization’s Safety Committee for their review.</td>
<td><strong>DOCUMENT REVIEW</strong></td>
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<td>11.06.08  <strong>Not Applicable.</strong> (Relocated to 13.05.08)</td>
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<td>11.06.09  <strong>Plant Equipment &amp; Systems - Maintenance.</strong></td>
<td>There is an established, scheduled preventive maintenance program for plant equipment and systems, and shall be maintained and tested periodically in accordance with the manufacturers’ recommendations.</td>
<td><strong>DOCUMENT REVIEW</strong></td>
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<tr>
<td>As an alternative approach, hospitals may choose to employ alternative maintenance activities and/or schedules provided they develop, implement, and maintain a documented Alternate Equipment Management (AEM) program, to minimize risks to patients and others in the hospital associated with the use of facility equipment.</td>
<td>Plant equipment is defined as devices intended to support the physical environment of the hospital. Such equipment includes, but is not limited to, boilers, natural gas, HVAC system and related vents and filters, electrical power / equipment, and fans, plumbing and the potable water supply. Plant equipment is not limited to utilities only.</td>
<td><strong>DOCUMENT REVIEW</strong></td>
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<td>For hospitals that elect to perform equipment maintenance in accordance with the manufacturer’s recommendations, the hospital must maintain documentation of the manufacturer’s recommendations as well as the hospital’s maintenance activities.</td>
<td>For hospitals that elect to perform equipment maintenance in accordance with the manufacturer’s recommendations, the hospital must maintain documentation of the manufacturer’s recommendations as well as the hospital’s maintenance activities.</td>
<td><strong>DOCUMENT REVIEW</strong></td>
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<td>All equipment (electrical and non-electrical) that is used to support the physical environment shall be included in the process for preventive maintenance. There shall be written testing criteria for each type of equipment included in the preventive maintenance system.</td>
<td>All equipment (electrical and non-electrical) that is used to support the physical environment shall be included in the process for preventive maintenance. There shall be written testing criteria for each type of equipment included in the preventive maintenance system.</td>
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<td>If the hospital is utilizing an AEM program for inspection, testing and maintenance activities, then the following activities need to be reviewed:</td>
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<td>• Review the documentation for the AEM program. Determine if it addresses the requirements for equipment to have</td>
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**Alternate Equipment Management (AEM) Program**

A hospital may, under certain conditions, use equipment maintenance activities and frequencies that differ from those recommended by the manufacturer, provided the activities and frequencies do not reduce the safety of the equipment. Hospitals that choose to employ alternate maintenance activities and/or schedules must develop, implement, and maintain a documented AEM program to minimize risks to patients and others in the hospital associated with the use of facility equipment. The AEM program must be based on generally accepted standards of practice for facility equipment maintenance, such as ASHE 2009, *Maintenance Management for Health Care Facilities*.

The determination of whether it is safe to perform facility equipment maintenance without following the equipment manufacturer recommendations must be made by qualified personnel, regardless of whether they are hospital employees or contractors. In the case of facility equipment, a facilities management professional would be considered qualified.

The hospital must maintain records of the qualifications of hospital personnel who make decisions on placing equipment in an AEM program, and must be able to demonstrate how they assure contracted personnel making such decisions are qualified.

In determining whether or not to include equipment in an AEM program, and which maintenance strategies maintenance activities and frequencies less than the manufacturer’s recommendations.

- Is the determination of the alternative maintenance activities and frequencies being performed by qualified individuals?

- Verify that the hospital has documented maintenance activities and frequencies for all equipment included in the AEM program.

- Verify the hospital is evaluating the safety and effectiveness of the AEM program on an annual basis.

- If the hospital has identified equipment as having such a very low level of risk that it has determined it can use a broad interval range or departmental ‘sweeps’, ask the hospital for the evidence used to make this determination, and determine if it is reasonable.

- Of the critical equipment that is included in the AEM program, ask the hospital to explain how the decision was made to place this critical equipment in the program.

- Of the equipment that is included in the AEM program, ask the hospital to describe the methodology for applying maintenance strategies and determining alternative maintenance activities and/or frequencies.
to use in developing maintenance activities and frequencies for particular equipment, the hospital must take into account the typical health and safety risks associated with the equipment’s use. Note that the risk may vary for the same type of equipment, depending on the patient care setting within the hospital where it is used.

A hospital is expected to identify any equipment in its AEM program which is “critical equipment,” for which there is a risk of serious injury or death to a patient or staff person should the equipment fail.

Multiple factors must be considered, since different types of equipment present different combinations of severity of potential harm and likelihood of failure. The hospital is expected to be able to demonstrate to a surveyor the factors it considered in its risk assessment for equipment placed in its AEM program.

Some equipment may not be eligible for placement in the AEM program, for one or more of the following reasons:
- Other Federal or State laws that may require the hospital to inspect, test and maintain their equipment strictly in accordance with the manufacturer’s recommendation;
- Other CMS Conditions of Participation or NFPA codes and standards which identify specific intervals, or require adherence to manufacturer’s recommendations which preclude their inclusion in the AEM program;
New equipment for which sufficient maintenance history, either based on the hospital’s own or its contractor’s records, or available publicly from nationally recognized sources, is not available to support a risk-based determination, must not be immediately included in the AEM program.

The hospital may use one or more maintenance strategies for its AEM program in order to determine the appropriate inspection, testing and maintenance activities and frequencies, based upon the nature of the equipment and the level of risk it presents to patient or staff health and safety. The risk to patient health and safety that is considered in developing alternative maintenance strategies must be explained and documented in the AEM program.

In developing AEM maintenance strategies, hospitals may rely upon information from a variety of sources, including, but not limited to:

- Manufacturer’s recommendations
- Nationally recognized expert associations
- Hospital’s own experience
- Contractor’s own experience
- Other materials

For each type of equipment subject to the AEM program, there must be documentation indicating:

- The pertinent types and level of risks to patients or staff health and safety;

- Alternative maintenance activities and the differences from the manufacturer’s
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recommendations when they are known;

- The date when AEM program maintenance activities were performed and what actions, if any, were taken;

- Documentation of equipment failures and identifying if any harm resulted to an individual.

The AEM program must be compliant with these requirements at all times, and must have written policies and procedures that address the effectiveness of the program. The hospital must have a written annual evaluation of the AEM program that addresses the following factors:

- How equipment is evaluated to ensure there is no degradation of performance;

- How incidents of equipment malfunctioning are investigated, including whether or not the malfunction could have been prevented; what steps will be taken to prevent future malfunctions; and how a determination is made whether or not the malfunction resulted from the use of an AEM strategy;

- The process for the removal of equipment from service determined to be unsafe or no longer suitable for its intended application;

- The use of performance data to determine if modifications in the AEM program procedures are required.
11.06.10 **Plant Equipment Inventory.**
The hospital maintains a written inventory of all plant equipment available for use.

The inventory shall include all plant equipment used directly or indirectly for the healthcare facility.

All equipment must be inspected, tested and maintained to ensure safety, availability and reliability. In addition, all equipment, regardless of whether it is leased or owned, and regardless of whether it is maintained in accordance to manufacturer recommendations or is in an AEM program, is listed in an inventory which includes a record of maintenance activities.

If the hospital is using an AEM program, the equipment managed through that program must be separately identified on the equipment inventory from that equipment which is managed through the manufacturer’s recommendation program. Critical equipment, whether in an AEM program or not, must also be readily identified as such.

To facilitate effective management, a well-designed equipment inventory contains the following information for all equipment included. However, hospitals have the flexibility to demonstrate how alternative means they use are effective in enabling them to manage their equipment.

- A unique identification number;
- The equipment manufacturer;
- The equipment model number;
- The equipment serial number;

**DOCUMENT REVIEW AND OBSERVATION**

- Review inventory list. Compare with field observed equipment to ensure all plant equipment is included.
- If the hospital utilizes the AEM program, does the inventory for the AEM program contain any equipment which is not eligible for the AEM?

This standard is not met as evidenced by:
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<tr>
<td>• A description of the equipment;</td>
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<td>• The location of the equipment;</td>
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<td>• The identity of the department considered to “own” the equipment;</td>
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<td>• Identification of the service provider;</td>
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<td>• The acceptance date;</td>
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<td>• Additional identification deemed useful</td>
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11.06.11  Not Applicable.
(Relocated to 13.05.10)

11.06.12  **Water Temperature Control.**
The hospital takes precautions to control the temperature of hot water used by patients.

Precautions shall be taken to assure that patients are protected against scalding or burning from domestic hot water.

The hospital is required to be in compliance with state and local standards regarding domestic hot water temperatures.

**DOCUMENT REVIEW AND INTERVIEW**

- Interview maintenance director to determine if domestic hot water is within limits set by state and local authorities.
- Does maintenance check water temperature periodically to assure that temperature is within limits?
- Review patient incident reports and talk to the hospital risk manager to determine the frequency of such incidents and what steps are or have been taken to reduce or eliminate such incidents.

11.07.01 Adequate Facilities and Supplies.

The hospital must maintain adequate facilities for its services.

§482.41(d)

Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

§482.41(d)(2)

The extent and complexity of facilities shall be determined by the services offered.

§482.41(d)(3)

Diagnostic and therapeutic facilities must be located for the safety of patients.

§482.41(d)(1)

Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016 the sill height must not exceed 36 inches.

The hospital shall provide facilities adequate to serve the needs of the patients served at the hospital.

Diagnostic and therapeutic facilities must be located in rooms or areas specifically designed for the purpose intended.

Adequate facilities means the hospital has facilities that are:

- Designed and maintained in accordance with federal, state, and local laws, regulations and guidelines; and
- Designed and maintained to reflect the scope and complexity of the services it offers in accordance with accepted standards of practice.

Facilities must be maintained to ensure an acceptable level of safety and quality.

Supplies are to be stored in such a manner to ensure the safety of the stored supplies (protection against theft or damage, contamination, or deterioration), as well as, that the storage practices do not violate fire codes or otherwise endanger patients (storage of flammables, blocking passageways, storage of contaminated or dangerous materials, safe storage practices for poisons, etc.). Additionally, “supplies must be maintained to ensure an acceptable level of safety” would include that the hospital identifies the

OBSERVATION, INTERVIEW, AND DOCUMENT REVIEW

- Observe the hospital layout and determine if the patient’s needs are met. Toilets, sinks, specialized equipment, etc. should be accessible.
- Discuss with members of the medical staff and department heads the adequacy of the facilities to meet the needs of the patients being treated at the hospital.
- Has the hospital identified supplies that are likely to be needed in emergency situations?
- Has the hospital made adequate provisions to ensure the availability of those supplies when needed?
- Verify through observation that the physical facilities are large enough and properly equipped for the scope of services provided and the number of patients served.
- Are facilities appropriate to meet the needs of hospital patients? Discuss with members of the medical executive committee, members of the medical staff (team captain); nursing staff (RN surveyor), and department heads (ADM surveyor) to determine if the

1 = Compliant
2 = Not Compliant

This standard is not met as evidenced by:
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<td><strong>above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.</strong></td>
<td>supplies it needs to meet its patients’ needs for both day-to-day operations and those supplies that are likely to be needed in likely emergency situations such as mass casualty events resulting from natural disasters, mass trauma, disease outbreaks, etc.; and that the hospital makes adequate provisions to ensure the availability of those supplies when needed.</td>
<td>- Verify that x-ray, physical therapy, and other specialized services are provided in areas appropriate for the service provided and provide appropriate safety and security for all persons.</td>
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<td><strong>The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.</strong></td>
<td>Physical facilities must be large enough, numerous enough, appropriately designed and equipped, and of appropriate complexity to provide the services offered in accordance with Federal and State laws, regulations and guidelines and accepted standards of practice for that location or service.</td>
<td>- Discuss with members of the medical staff and department heads the adequacy of safety in service placement in the hospital.</td>
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<td><strong>The sill height in special nursing care areas of new occupancies must not exceed 60 inches.</strong></td>
<td>In each area of diagnostic and/or therapeutic facilities, consideration shall be given to safety and security of equipment, persons and their personal property.</td>
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<td>§482.41(b)(9)</td>
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<td>§482.41(b)(9)(i)</td>
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<td>§482.41(b)(9)(ii)</td>
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<td><strong>11.07.02 Not Applicable.</strong></td>
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<td><strong>11.07.03 Ventilation, Light, &amp; Temperature Controls.</strong></td>
<td>Excessive humidity in the operating room is conducive to bacterial growth and compromises the integrity of wrapped sterile instruments and supplies. Humidity levels in operating rooms must comply with NFPA 99 (2012 edition) of 20% RH or greater. RH levels must be monitored and timely corrective actions taken when necessary.</td>
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<tr>
<td>§482.41(d)(4)</td>
<td>Acceptable standards such as from the Association of</td>
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<td>2017 - Prepublication Healthcare Facilities Accreditation Program (HFAP) Accreditation Requirements for Acute Care Hospitals</td>
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### PHYSICAL ENVIRONMENT

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<td>Operating Room Nurses (AORN) or the Facility Guidelines Institute (FGI) should be incorporated into hospital policy.</td>
<td>with hazardous chemical, surgical areas, and other areas where hazardous materials are stored.</td>
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<td>Organization staff should obtain and be aware of current Guidelines for Design and Construction of Health Care Facilities from the Facility Guidelines Institute (FGI) and current guidelines from the Center for Disease Control (CDC).</td>
<td>• Verify that food products are stored under appropriate conditions (e.g., time, temperature, packaging, location) based on nationally-accepted sources such as the United States department of Agriculture, the Food and drug Administration, or other nationally-recognized standard.</td>
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<td>There must be proper ventilation and air-pressure relationships to surrounding areas in at least the following areas: 1. Areas using ethylene oxide, nitrous oxide, glutaraldehyde, ethylene, pentamidine, or other potentially hazardous substances; 2. Locations where oxygen is transferred from one container to another; 3. Isolation rooms and reverse isolation rooms (both must be in compliance with Federal and State laws, regulations, and guidelines such as OSHA, CDC, NIH, etc.); 4. Pharmaceutical preparation areas (hoods, cabinets, etc.); 5. Laboratory locations; 6. Soiled utility rooms; 7. Clean utility rooms;</td>
<td>• Verify that pharmaceuticals are stored at temperatures recommended by the product manufacturer.</td>
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<td>• Verify that each operating room has temperature and humidity control mechanisms.</td>
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<td>• Review monitoring records for temperature to ensure that appropriate levels are maintained.</td>
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<td>• Review humidity maintenance records for anesthetizing locations to ensure, if monitoring determined humidity levels were not within acceptable parameters, that corrective actions were performed in a timely manner to achieve acceptable levels.</td>
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<td>• While temperature and humidity tracking logs are not mandatory, the organization</td>
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8. Sterile processing rooms;


There must be adequate lighting in all the patient care areas, and food and medication preparation areas.

1. Temperature, humidity and airflow in the anesthetizing locations must be maintained within acceptable standards to inhibit microbial growth, reduce risk of infection, control odor, and promote patient comfort.

2. Each operating room should have separate temperature control.

3. The hospital must ensure that an appropriate number of refrigerators and/or heating devices are provided and ensure that food and pharmaceuticals are stored properly and in accordance with nationally accepted guidelines (food) and manufacturer’s recommendations (pharmaceuticals).

needs to have documentation that clearly indicates they are tracking the temperature and humidity settings of critical areas (such as Building Automation Systems), and taking appropriate action when a reading is out of proper range. In lieu of alternative documentation methods, review temperature and humidity tracking log(s) to ensure that appropriate temperature and humidity levels are maintained.

- Interview department heads to determine if they feel that their areas have proper and adequate ventilation, light, and temperature control. What guidelines are used in food preparation area? How often is monitoring conducted?

11.07.04 Not Applicable.

11.07.05 Not Applicable.
### 11.07.06 Assessing Risk Prior to Construction

When the hospital plans for renovation and construction, a written assessment is made to reduce the risk to the organization.

Prior to demolition, construction and renovation activities a risk assessment is conducted on utility requirements, air quality requirements, infection control, vibrations, noise, and other hazards that could affect patients, staff and visitors.

**DOCUMENT REVIEW AND OBSERVATION**
- Review organization policies and procedures on risk assessment conducted prior to construction activities.
- Review documented risk assessments for current renovation activities.

**SCORE**

- 1 = Compliant
- 2 = Not Compliant

This standard is not met as evidenced by:

### 11.07.07 Monitoring the Physical Environment

A process is established by the hospital to continuously monitor the physical environment. Hazardous surveillance inspections shall be conducted semi-annually in all patient care areas, and annually in all non-patient care areas.

Investigations are made and reports are submitted to the appropriate committee for safety on:

1. Injuries to patients
2. Occupational illnesses and staff injuries
3. Incidents involving damage to the facility or property of others
4. Security incidents involving staff, patients or others within the facility
5. Spills and exposures of hazardous

The appropriate committee for safety may be different depending on the issue, and patient confidentiality. When legal processes are followed, opportunities to make improvements on care, treatment and services or to prevent the same or similar incident from occurring, is not lost.

Where confidentiality is required, a summary of the incident must be shared with the individual(s) designated to coordinate safety management activities.

Reports are reviewed and appropriate action recommended by the committee(s) responsible for safety activities. The committee is responsible for follow-up activities to ensure all reported incidents are properly resolved.

**DOCUMENT REVIEW AND OBSERVATION**
- Review organization’s documentation on hazardous surveillance inspections to ensure all areas are properly inspected.
- Review the minutes from the appropriate committee on safety issues to determine if incidents are being investigated and reported, and if follow-up activities are being tracked.

**SCORE**

- 1 = Compliant
- 2 = Not Compliant

This standard is not met as evidenced by:

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2017 - Prepublication  Healthcare Facilities Accreditation Program (HFAP)  Accreditation Requirements for Acute Care Hospitals  11-36
<table>
<thead>
<tr>
<th>STANDARD / ELEMENT</th>
<th>EXPLANATION</th>
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<tr>
<td>6.</td>
<td>Deficiencies and failures of the fire safety management systems</td>
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<tr>
<td>7.</td>
<td>Problems, failures and user errors on medical equipment; laboratory equipment; and utility equipment</td>
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materials and waste