JCAHO & OTHER REGULATORY ISSUES IN LONG TERM CARE

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In today’s climate, health care organizations have diversified their services. Many that started in business as acute care hospitals now include long term care (LTC) organizations in their mix. In some cases, these are represented by stand-alone long term care facilities; in others, long term care units exist within the acute care building. Either way, the individual responsible for the environment of care may be one and the same for both programs.

While there are many similarities in the regulations, codes, and standards for acute and long term care, there are also some differences. This program will focus on the differences that exist in long term care compliance, based on knowledge of the regulation for acute care hospitals.

JCAHO Standards

The first issue that must be addressed is the standards under which a long term care facility will be surveyed by the Joint Commission on Accreditation of Healthcare Organizations. For a stand-alone LTC facility, the answer is straightforward: The Comprehensive Accreditation Manual for Long Term Care, which is valid for a two year period.

If a LTC facility exists within a hospital building, the facility has four options for its accreditation, based on the fact that long term care organizations are required to be Medicare/Medicaid certified regardless of JCAHO accreditation status. The options are:

- Comprehensive survey. This option may be elected for an organization classified by JCAHO as complex (that is with multiple settings accredited under one survey) or for a free-standing LTC affiliated with the hospital. This will be a survey lasting multiple days in the LTC, and can result in full accreditation of the LTC facility.
- Focused Skilled Nursing Facility/Nursing Facility accreditation. This option will involve a one day survey, with the JCAHO accreditation substantially based on the Medicare/Medicaid certification results.
- No review of LTC services. This option may be elected in any hospital-affiliated LTC situation, but will result in no JCAHO accreditation, regardless of the associated hospital’s JCAHO status.
- Survey under the hospital accreditation manual. Units of less than 20 beds will be surveyed under The Comprehensive Accreditation Manual for Hospitals.

The Environment of Care standards are essentially the same in both the hospital and LTC manual. There are some subtle differences in some standards, which will be discussed here, and significant differences in the standards of EC.8 (2004 numbering), Appropriate Environment. An obvious difference is that the individuals served are “patients” in the acute care standards and “residents” in those for LTC. Even with
identical standards, the scope and evidence of compliance will certainly differ for the different settings.

The JCAHO requirements for safety management still require a risk assessment process for buildings, grounds, equipment, occupants, etc. The word, “equipment,” is asterisked in the 2003 version of the standard, leading to a footnote that says that the equipment being assessed may include personal care equipment, such as lifts, bed scales, and wheelchairs, as well as personal items like televisions, radios, and hair dryers. It is unclear at the time of this writing whether these definitions will carry forward to the 2004 edition, however it would be reasonable to make these considerations.

The required non-smoking policy is similar for both settings. In long term care, however, the exception policy will be developed and approved by the organization’s leaders, rather than by criteria approved by the medical staff. Unlike hospitals, no written authorization is necessary for an individual to smoke under the exception policy. Inside smoking locations must be “separate from all resident care areas.” The list of exceptions for “longer term care” that is present in the hospital manual is absent for LTC.

The security management standards are identical in both manuals, but there will be substantial differences in compliance activities. Risk assessment considerations in long term care will often be centered around the needs of the resident and their limitations. One item specifically mentioned in the risk assessment intent is patient elopement, which may be a consideration in any setting, but perhaps particularly so in long term care, especially if the organization has a dementia unit. It is anticipated that workplace violence issues will be added to the 2004 standards. Security of chemicals and pharmaceuticals will take on a heightened importance, and these storage areas may become security sensitive.

As in hospitals, identification of residents, staff, and visitors must be considered. While the same identification bracelets that are used in hospitals may also be used in LTC, there may be some alternative approaches.

Traffic and crowd control are included in the long term care security requirements, but since most LTC organizations will not attract the traffic and crowds that could be expected in and around an emergency department during a community-wide disaster, the expectations would be downsized considerably.

Long term care organizations will have hazardous materials and waste, but of a much smaller quantity and variety than their hospital counterparts. Regulated medical waste may be disposed of much less frequently. Hazardous chemical waste will be even smaller in volume, but be sure that it is not held longer than 180 days per EPA regulations. These smaller quantities and less frequent disposals point to increased attention to the space and equipment needed to manage these materials. As discussed above, the storage and holding areas should be secure. Be certain that they are constructed of a material that can be appropriately cleaned following any spills or leaks.
Some facilities may be using hazardous gases or vapors, such as ethylene oxide, formaldehyde, or glutaraldehyde, and therefore be concerned with their monitoring and disposal, but most will not, and this issue will not be included in the 2004 LTC requirements.

The emergency management standards are currently identical for long term care and acute care hospitals. Keep in mind that compliance with JCAHO standards is always as appropriate to the scope and role of the organization. It is therefore very important to define each LTC organization’s role in terms of participation with the hospital and in relationship to a community event.

Consider whether the long term care facility will receive patients that have been discharged from the hospital to clear acute care beds. If so, they play a role with the hospital and community, and that role should be drilled at least annually. If not, the LTC may be able to provide supplies, equipment, or staff to assist in the community response. It is important to ask the community planners if they have incorporated the LTC into the plan as a resource. Typically, LTC facilities will continue to provide resident services during a disaster situation, but there may be some exceptions.

A new emergency management requirement for 2004 will be for input into the management plan by the administrator, medical director, nursing leader, and other clinical leaders of the facility.

The cooperative planning requirement, first scored this year, requires that, like hospitals, LTC organizations share information with other LTC’s in the community about their command structures, control centers, and the individuals who staff them. They will need to identify assets and resources they may be able to share with one another and other health care organizations impacted by a community event. Furthermore, a system must be developed to provide the names of victims at the facility to expedite location and identification within the impacted community, as well as share information with community emergency response agencies.

Like hospitals required emergency management plan components include:

- Hazard vulnerability analysis
- Community coordination
- Incident command
- Evacuation
- Alternate source of essential utilities
- Drills

Again, remember the organization’s role. While equally vulnerable to natural disasters, there may be other man-made or technological disasters that will have an entirely different impact on a long term care facility. The participation in drills involving an influx of volunteer or simulated patients will depend on the LTC role and interaction with the hospital and the community.
The Fire Safety Management Plan is the same for long term care and hospitals – both are defined as health care occupancies, and are therefore under the same NFPA requirements.

In most long term care facilities, the type and amount of medical equipment is significantly less than in an acute care hospital. The requirements are essentially the same for inventories and maintenance. Because of the decreased quantity of equipment, it may be more likely for a LTC to opt to include all equipment in the program rather than risk-stratify the inventory. As for hospitals, maintenance strategies and their intervals are required in the management plan. If dialysis services are provided in the LTC setting, there is a requirement for chemical and biological testing of dialysis water. No performance testing of sterilizers is required, but it would certainly be prudent to do so if this equipment is used.

Mirroring medical equipment, there are no differences in the requirements for utilities management. Do note that both plans now address maintenance strategies instead of the previously-required annual maintenance. Again, the LTC facility must determine whether to risk-stratify the utilities inventory or include all equipment. Many LTC organizations will not have piped medical gas. Mapping of utility systems is required, as for hospitals. The requirement for the reduction of the potential of nosocomial infections with respect to airborne contaminants and waterborne pathogens is the same as for hospitals. In the LTC environment, patient risk factors and specially designed areas may differ, and should be evaluated as appropriate. An emergency power source is required, but the applications differ for this setting.

There are substantial differences between programs in the EC.8, Appropriate Environment standards. This stands to reason because of the very nature of long term care. Some of the things that are itemized in the intent statements for hospitals with “long lengths of stay” (over 30 days) are omitted from the LTC standards because all stays are long.

Emphasis is placed on the dining environment in long term care, as this time is conducive to social interaction. Selection of seating must be permitted, and there must be room to accommodate any necessary medical equipment. It is expected that the dining facilities provide small group settings, and that they be attractive, well-lit, and well-ventilated.

EC.8.30 references the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities or other applicable standards for LTC, just as it does for hospitals. Also identical is the requirement for the pre-construction risk assessment to address infection control issues associated with construction, demolition, or renovation. The risk factors of the populations will differ between settings.

The same patient safety requirements that hospitals must manage in the Environment of Care became effective in long term care settings this year. They basically require communication between the environment of care safety function and the patient safety...
function. A Safety Committee, or “multidisciplinary improvement team” is also required in LTC.

**OSHA Ergonomics**

Although the OSHA Ergonomics Standard has been withdrawn, the agency has begun to develop industry and task-specific guidelines, rather than pursue additional regulation. Along with those guidelines comes their enforcement strategy, and outreach and assistance program, and support for additional ergonomics research.

The first industry-specific guidelines that have been developed are for nursing homes. They provide specific actions that may be taken to reduce the potential for musculoskeletal disorders arising from workplace injuries. Labor Secretary Elaine Chao believes that this industry merits particular attention due to the nature of the workers and the fact that many are unable to take action in their own defense. It is certainly common knowledge that back injury rates are high within the LTC industry.

“Ergonomics: Guidelines for Nursing Homes” was published by OSHA in March of this year. While intended specifically for long term care organizations, the document states that the information may also be applicable to other related industries, including hospitals. It provides definitions of three major ergonomic stressors found in nursing homes:

- **Force:** the amount of physical effort to perform a task or maintain control during its performance
- **Repetition:** continuous or frequent performance of any one task
- **Awkward postures:** those that produce stress on the body

OSHA recommends that manual lifting of residents should be eliminated, or at least minimized. Furthermore, employers must develop and implement a process to identify and resolve ergonomic issues as a matter of course. The OSHA guidelines on ergonomics are fairly typical in their requirements: processes for protection of workers, engineering controls for lifting and other activities, and training. This document is unique in that it provides flow charts for resident needs requirements for lifting and pictures and explanations of 33 different engineering controls.

The key point made in these guidelines is that engineering controls must be available and accessible when and where they are needed or they and the program will be ineffective.

It must be noted that this OSHA ergonomics document is guidance rather than standard, and thus is not subject to enforcement. Any citations will be made under the General Duty Clause. Critical to the process is employer effort, not in terms of specific solutions, but rather based on efforts to reduce the hazards and provide appropriate and effective solutions.
FDA Bed Rails

In 1999, the Food and Drug Administration formed a working group to examine the issue of entrapments and associated deaths in “hospital” bed systems. In this case, the term, “hospital,” applies to all medical beds, including those within long term care organizations. Those most at risk for entrapment incidents include populations significant in the LTC industry, the elderly, frail, and confused. FDA statistics show that 85% of the bed-rail related deaths and injuries occur in the population over 65 years of age. 62% of the incidents occur in settings that are non-acute care.

Three documents will be forthcoming from the Hospital Bed Safety Workgroup.

The Clinical Guidance document, currently available on the FDA website, addresses issues concerning resident needs and associated risk assessment based on clinical issues. Issues of restraint will be contrasted with those of safety. This document is a publication of the workgroup itself.

Unlike the Clinical Guidance, the Dimensional Guidance will be published by the FDA in the Federal Register in the near future. This is not enforceable regulation, but rather guidance in the design of new bed systems. It is anticipated that this document will also be used to assess the safety of legacy (existing) bed systems in various health care settings. Two tools have been developed based on anthropomorphic data so that they are sized and weighted to represent appropriate dimensions of a small resident. These tools will be available for purchase by health care organizations. Based on records of incidents, four primary zones of entrapment have been identified, and the tools will be used to measure the spacing and gaps in these zones.

A third document, again a work group publication, will be issued as Corrective Guidance. This document suggests various alternatives for non-compliant bed systems such as manufacturer retrofits (at a charge), lowering or removing bed rails, “stuffers,” mattress replacements, and accessories. It further suggests an ongoing monitoring program.
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JCAHO LTC ACCREDITATION

• JCAHO LTC manual valid for 2 years
• Stand-alone LTC facility
  – Comprehensive Accreditation Manual for LTC
• LTC within a hospital
  – 4 options
LTC ACCREDITATION OPTIONS

• Comprehensive survey
  – Complex organization or free-standing LTC
  – Multi-day survey
  – Full Accreditation

• Focused SNF/NF Accreditation
  – Complex organization or free-standing LTC
  – Medicare/Medicaid certified SNF/NF
  – One day survey
  – Accreditation substantially based on certification
LTC ACCREDITATION OPTIONS

• No review of LTC services
  – Complex organization or free-standing LTC
  – Medicare/Medicaid certified SNF/NF
  – No survey, no accreditation

• Survey under hospital manual
  – Applicable only if average daily census <20
  – Accreditation includes LTC services
ENVIRONMENT OF CARE

• Standards essentially the same as for hospitals
• Patients vs. residents
• Variations in EC.8, “Appropriate Environment”
  – Formerly “Other Environmental Considerations”
• Differences in scope of compliance
• Same survey process
SAFETY MANAGEMENT

• Based on 2003 language
• Risk assessment – buildings, grounds, equipment*, occupants, etc.
• *Equipment may include
  – Personal care equipment
    • Lifts, bed scales, wheelchairs
  – Personal items
    • TVs, radios, hair dryers
SMOKING

• May have exception policy
  – Criteria developed & approved by organization leaders
  – No written authorization

• Locations separate from all resident care areas

• No list of exceptions for “longer term care”
SECURITY MANAGEMENT

• Differences in compliance activities
  – Risk assessment considerations
    • Resident elopement
    • Workplace violence
  – Identification considerations
  – Security sensitive areas
    • No infant or pediatric abduction
  – Traffic & crowd control
    • No vehicular access to urgent care
HAZARDOUS MATERIALS & WASTE MANAGEMENT

• Differences in scope of program
  – Quantity
  – Variety

• Waste disposal frequency

• Space and equipment

• No requirements:
  – Hazardous gases and vapors
EMERGENCY MANAGEMENT

• Essentially same requirements as hospitals
• Appropriate to scope and role of the organization
  – Clearly define
LTC EMERGENCY ROLE

- Admissions from hospital?
- Provision of supplies and/or staff?
- Community resource?
- Continue to sustain resident population?
EMERGENCY MANAGEMENT PLAN

• Management plan input:
  – Administrator
  – Medical Director
  – Nursing leader
  – Other clinical leaders
COOPERATIVE PLANNING

• LTC organizations share information about:
  – Elements of command structures & control centers
  – Names, roles, phone numbers in command structures
  – Resources & assets to share
  – Names of victims
  – Information to be shared with community emergency response agencies
EMERGENCY MANAGEMENT

- Hazard vulnerability analysis
- Community coordination
- Incident command
- Evacuation
- Essential utilities
- Drills
FIRE PREVENTION

• LTC is a health care occupancy
• Requirements identical to hospital
MEDICAL EQUIPMENT

• Differences in scope of program
  – Type of equipment
  – Numbers
• Inventory inclusion
• Preventive maintenance & strategies
  – No performance testing of sterilizers
UTILITIES MANAGEMENT

• Differences in scope
• Inventory inclusion
• “Specially designed areas” include:
  – Rooms for airborne communicable diseases
  – Protective isolation
  – Laboratories
  – Pharmacies
  – Sterile supply
• Medical gas standard applies
EMERGENCY POWER SOURCE

- LONG TERM CARE
  - Electrically powered life support
  - At least one elevator (for non-ambulatory residents)
  - Medical air compressors
  - Medical and surgical vacuum
  - Special care units

- HOSPITAL ADDITIONS
  - Blood, bone & tissue storage
  - Emergency/urgent care
  - Operating rooms
  - Post-op recovery
  - Obstetrical delivery rooms
  - Newborn nurseries
EC.8.10: APPROPRIATE ENVIRONMENT

• Rationale
  – Functional environment
  – Promotes caring
  – Contributes to relieving loneliness, boredom, hopelessness
  – Encourage independence
  – Promote quality of life
APPROPRIATE ENVIRONMENT

- Omit normalization of living environment
- Omit access to grounds, parks, etc.
- Outside areas used during appropriate seasons
- Spaces for safe wandering & exploring
- Subacute: appropriate electrical systems
EC.8.20: DINING ENVIRONMENT

- Encourages eating & socialization
- Small group settings
- Attractive
- Well-lit
- Ventilated
EC.8.20: DINING ENVIRONMENT

- Appropriate size
- Free from noise distractions
- Room for medical equipment
- Selection of seating
EC.8.30: DESIGN CRITERIA

• Pre-construction risk assessment
  – Same as for acute care
  – Risk factors of population
PATIENT SAFETY

• Effective in LTC 1/1/03
• Same EC requirements as hospitals
  – EC.9.10: Safety officer directs integration
  – EC.9.20: Safety issues communicated
  – EC.9.30: Results of measurement reported
SAFETY COMMITTEE

• EC.9.20: Multidisciplinary improvement team
ERGONOMICS
OSHA ERGONOMICS

• Industry and task-specific guidelines
  – First for nursing homes
• Enforcement strategy
• Outreach and assistance program
• Additional research
WHY NURSING HOMES?

• Secretary of Labor Elaine Chao 4-18-02
  – Low wage earners
  – Low skilled
  – Many women
  – Many immigrants with language barriers
  – Difficult to take steps on their own to protect themselves
NURSING HOME GUIDANCE

- “Ergonomics: Guidelines for Nursing Homes”
- Final document published 3-13-03
- May be applicable to other related industries
  - Hospitals
  - Assisted living
  - Homes for disabled
ERGONOMIC STRESSORS IN NURSING HOMES

• Force: amount of physical effort to perform task or maintain control
• Repetition: continuous or frequent performance of same task
• Awkward postures: produce stress on body, i.e. reaching above shoulders, kneeling, bending, squatting, lifting
OSHA RECOMMENDATIONS

• “Manual lifting of residents should be minimized in all cases and eliminated when possible.”

• “Employers (should) implement a systematic process for identifying and resolving ergonomics issues, and incorporate this process into its overall program to recognize and prevent work-related injuries and illnesses.”
FIVE SECTIONS

• Process to protect workers
• Problems & solutions for resident lifting and repositioning
• Problems and solutions for other activities
• Training
• Additional information sources
PROCESSES TO PROTECT WORKERS

- Management support
- Employee involvement
- Problem identification
- Implementing solutions
- Addressing injury reports
- Providing training
- Evaluating efforts
RESIDENT LIFTING & REPOSITIONING

• Variety of information sources
  – OSHA 300 log
  – Workers’ compensation
  – Accident reports

• 22 suggested solutions for specific situations
  – Equipment
  – Work practices

• Resident needs assessment
  – Flow charts
TRAINING

• Charge nurses and supervisors
• Designated program managers
• Nursing assistants
• Others
CONTROL MEASURES

• 33 controls analyzed
  – Type of work
  – Equipment description
  – When to use
  – Storage space
  – Parts and service
  – Power requirements
  – Size
KEY POINT

• “If resident lifting equipment and controls are not accessible when they are needed, it is likely that other aspects of the ergonomics process will be ineffective.”
REGULATORY IMPACT

• Guidance vs. Standard
• Employer effort
  – Not based on specific solutions
  – Efforts to reduce hazards
  – Effective solutions
• Citations under General Duty Clause
BED RAILS
FDA WORK GROUP

• Deaths and entrapments in “hospital” bed rails

• Most at risk:
  – Elderly
  – Frail
  – Confused
FDA STATISTICS

• 1985 – 2001
  – 439 Entrapment Incidents
  – 271 Deaths
  – 98 Non-Fatal Injury
  – 70 No Injury due to Staff Intervention
  – 85% Deaths and Injuries in population over 65
  – 38% Incidents in Acute Care Hospitals
  – 62% In all other settings
ANNUAL STATISTICS

- 27.4 Entrapment Incidents
- 16.9 Deaths
- 62.4 Non-Fatal Injuries
LTC STATISTICS

- Assume other settings primarily represent LTC
- 17 Entrapment Incidents Annually
- 10.5 Entrapment Deaths Annually
- 38.7 Non-fatal Incidents Annually
CLINICAL GUIDANCE

• Patient/resident risk assessment
• Patient/resident needs
• Restraint vs. safety
• Fall prevention not included in scope
DIMENSIONAL GUIDANCE

- Federal Register publication
  - 90 day comment period
- Design of bed systems
- “Legacy” systems
- Anthropomophic data
- Measurement tool(s)
- Zones of entrapment
CORRECTIVE GUIDANCE

- Manufacturer retrofits
- Lowering/removing bed rails
- “Stuffers”
- Mattress replacements
- Accessories
- Ongoing monitoring