



Steven Hirsch & Associates

# Accreditation News

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## Steven Hirsch & Associates

This issue offers important updates on licensing issues that may impact your successful accreditation.

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## Accreditation and Licensing Requirements for Leased Spaces

By Steven Hirsch, MPA FACHE

During Mock Surveys we frequently visit off-site locations operated by our clients under their facility license or accreditation. These sites also have CMS Certification and generally provide clinic services, however in some cases interventional services (outpatient surgery, endoscopy, infusion services, pain management) and even inpatient services are provided.

While it can be challenging for the accredited organization (the tenant) to comply with Life Safety and Utility system inspection, testing and maintenance requirements in spaces that are not owned by them, the accredited tenant is accountable for compliance. In 2016 and updated in 2021, The Joint Commission published an FAQ that addresses the issue of inspection, testing and maintenance of Fire Systems that are surveyed under EC.02.03.05, which is applicable to all Healthcare, Ambulatory Healthcare, and Business Occupancies operated by the accredited organization. The FAQ states that "The Environment of Care chapter applies to all facilities where the organization's patients are seen or treated. This includes leased facilities and business occupancies."

The FAQ continues "In leased facilities, the lease agreement should include a requirement for the availability of documentation associated with all applicable elements of the EC chapter. There should also be a process for regular compliance reporting by the host organization to the leasing organization."

Further, the FAQ provides that "This standard does not require organizations to have the types of fire safety equipment and building features described by the elements of performance, however if these types of equipment or features exist within the building, then maintenance, testing, and inspection is to be conducted and documented." These systems must be provided if required under the Life Safety Code, NFPA 101-2012 Edition, or as required by local jurisdiction.

Fire drills should be conducted in these off-site locations specific to the spaces occupied by the accredited organization, and in accordance with the Organization's Fire Plan at least annually on each shift the space is occupied, or more frequently as required by licensing regulation or the local jurisdiction. The fire drills do not need to address areas of the building not occupied by the accredited organization. There should be documentation of assessment of staff response during each drill, based on the Fire Plan.

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## Accreditation and Licensing Requirements for Leased Spaces

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The Life Safety Chapter of The Joint Commission Manual 2022, contains standards specific to “Business Occupancies.” The accredited organization should provide “Basic Building Information” on The Joint Commission Intranet Site for these locations. There must be current Life Safety Drawings reflecting the structural features of fire protection for these sites, regardless of ownership.

Additionally, for off-site locations, including those located in leased space, the accredited organization must assume accountability for inspection, testing, and maintenance of utility system components serving the site. This would include water management, air balance, temperature and humidity in interventional settings and where sterile supplies are stored or sterile compounding is performed, emergency power systems if required, etc.

The accredited organization needs to work closely with the property owner/manager to assure that the required activities are performed in accordance with the requisite frequency, and that the accredited organization has immediate access to all documentation of the inspection, testing, and maintenance activities. Failure by the owner to assume accountability for these accreditation requirements can place the entire accredited organization’s accreditation decision, and potentially its CMS deemed status at risk.



### **ABOUT STEVEN HIRSCH & ASSOCIATES**

Steven Hirsch & Associates has been providing healthcare management consulting services including accreditation preparation services to hospitals and other healthcare related organizations throughout the United States since 1987. Beyond accreditation and licensure survey preparedness, our healthcare consulting team can provide assistance in a number of areas including Medicare certification, performance improvement, nursing management, infection prevention and control, Life Safety Code compliance, medical staff services (including credentialing and independent peer review), clinical lab management and compliance with HIPAA. For more information on how STEVEN HIRSCH & ASSOCIATES can assist you with accreditation and licensure preparedness, Medicare certification and other management challenges, please contact us at (800) 624-3750 or visit [www.shassociates.com](http://www.shassociates.com).

## A Team Approach for Your Infection Control Risk Assessment (ICRA)

By David Woodard, MSc, MT(AMT), CLS, CIC, FSHEA

The Infection Control Risk Assessment (ICRA) for construction and renovation has undergone a variety of changes and modifications since its recommended inception in the late 1990s. While the document has improved and has provided a baseline for leaders to monitor the workplace safety for its patients, visitors, staff, and physicians, it often does not penetrate the matrix of trades involved in the construction or renovation project.

The original intent of the ICRA was to provide a way for the hospital to ensure that the construction or renovation projects in the hospital did not create a harmful environment for anyone who may be present. The idea was that someone knowledgeable about infection control and prevention practices could evaluate a proposed construction or renovation project to identify and mitigate risk conditions prior to their occurrence. For example, removing the carpet from an ICU waiting room has the potential to disseminate mold spores that can be entrained in the air conditioning and spread via the airborne route and to infection susceptible patients who are “downstream” in the HVAC system; manipulation of the water distribution system can dislodge biofilm and increase the risks for legionella or other waterborne pathogens. The ICRA process has matured so that it now includes the floors or spaces above and below the target construction, as well as noise and dust.

One of the most common questions asked, surrounding the ICRA is, when does the ICRA need to be prepared? Recognize that the purpose of the document is to provide guidance to the trades on how to maintain a safe environment for all patients, staff, and visitors to the facility. While it is simple to answer this question when there are “huge” projects that obviously involve destruction and reconstruction of parts of the building that obviously will create dust and noise and other forms of disruption of day-to-day operations that an ICRA must be initiated, but what about the smaller and less obviously projects.

The ICRA process must be done anytime construction, renovation, demolition, and repair projects are being planned! An easy rule of thumb is anytime someone has a tool and is planning to use it in the hospital environment, disrupting the environment, a “pre-construction” ICRA should be developed and maintained on file. This does not include most routine scheduled or planned maintenance, although there are times such a changing of filters on the HVAC system, that an ICRA should be developed. (This can be a standard document that provides the conditions of work and precautions necessary for each occurrence of the event.)

Another “simple” guiding example would be anytime an outside contractor arrives to do business, including cabling for IT, cleaning of specialized areas, changing out critical systems or equipment where there is any possibility of disruption to the fabric of the environment, an ICRA should be conducted. Remember it can be a simple document for a simple project.

The ICRA must address a variety of issues, including evaluation of the impact of the construction or renovation in the target area as well as in the adjoining spaces. It also must include an evaluation of the dust generated, ventilation, HVAC (air pressures), vertical shafts, noise, vibration, as well as systems impacted including data, mechanical, medical gases, and water.

In addition to the infection control risks, the pre-construction risk assessment process must also take into consideration the life safety components of the construction or renovation project. This includes the need for interim life safety measures (ILSM), and “hot work.”

The ICRA should identify:

- Who is responsible for all the components of the project, from the initial decommissioning of the utility services (if necessary) to the final clean-up at the conclusion of the project,
- Which tasks are the responsibility of the contractor versus those that are the responsibility of the owner, and
- Within the “owner” section, which departments will bear the burden of completion and recommissioning.

The ICRA is a joint document to be used by both the contractor and the owner (Hospital) as the statement of fact regarding reducing infection prevention risks, as well as other risks to the organization. It must be agreed to prior to the initiation of the project, and any changes in the construction process (Change Orders) must be vetted by the same process as the original document.

To develop a complete and comprehensive ICRA, there must be a meeting conducted to review the scope of work with all the players: Hospital Facilities/Engineering personnel, departmental end-users, Infection Prevention, EVS, and Hospital Administration.

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## A Team Approach for Your Infection Control Risk Assessment (ICRA)

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- Management of the Environment of Care (including Life Safety Assessment)

Once the owner (Hospital) has had their planning meeting, the same committee should meet with the Contractor(s) and, if at all possible, the leads for all the subcontractors, Facilities staff, end-users, Administration, and EVS to review the ICRA and the various areas of responsibility (decommissioning of the area, noise control, dust control, supplies such as sticky mats, fire-life safety requirements including fire extinguishers, hospital security requirements to include the clear identification of all contractors and their employees). Employee Health Services may also be included for long-term projects to guide any needed immunizations and tuberculosis testing based on risks identified during the development of the ICRA.

The analysis of the project should be done using a matrix (download at no charge: <https://www.ashe.org/icra2>) that defines the activity type "A" – limited, "B" small scale, "C" large scale, and "D" major demolition. The organization must then also determine the patient risk group from "Low (non-patient care areas)" to "Highest (immunosuppression, surgery)". Together these two are placed on a grid and the project risk can be ascertained.

The construction site should be inspected at pre-agreed intervals with the Contractor, Hospital, Facilities, Infection Prevention, and EVS to ensure that the agreed upon levels of cleanliness and safety are being maintained. The ICRA may require modifications based on the pace of work, expansion of scope of work, progress of work, or unexpected additional requirements.

Disseminate to and review the ICRA with all Sub-Contractors. This task can be assigned to the project superintendent, but it is essential that the Infection Preventionist (IP) follow-up to ensure that it was done and that the sub-contractors have a clear understanding of their role. The IP should work with the Contractor(s) and Sub-Contractors to determine key points of contact and ensure that all these individuals are familiar with the ICRA document and the impact the document may have on their scope of work.

Conduct regular, unscheduled walk-through inspections of the construction site with Facilities, Infection Prevention, and Administration. Clearly identify those individuals (by job title) who have the authority to intervene in the process or to "red tag" the project for non-compliance with the ICRA, general safety, or other critical violations of the construction process. Although the IP can intervene up to and including a cease-and-desist order, it is recommended that this be done by the Facility Administrator in consult.

The IP, in consultation with the Facilities department, must develop and implement a checklist to be used daily. The decision to monitor on weekends and holidays is dependent on the scope of work and the risks associated with the project. Such risks may include improper airflow, tanks of liquid that can leak, off gassing of chemicals, or potential leaks in the water and sewage system.

Finally, all the inspection data should be condensed and presented at each of the Environment of Care Committee meetings as well as the Infection Prevention Committee on a regular basis. The report should include all inspection data as well as interventions. Any significant variances must be brought to the attention of the appropriate authority when identified, not waiting for a committee meeting.

Special thanks to Joann Saporito, RN, MBA and Linda Paternie, RN, BS, MHA, CJCP, of Steven Hirsch & Associates, for their contributions to this article. It is important to recognize that documents like the ICRA cannot be developed in a silo. It requires support and input from the entire hospital team.

**For more information about Infection Control Risk Assessment (ICRA), contact STEVEN HIRSCH & ASSOCIATES at (800) 624-3750.**