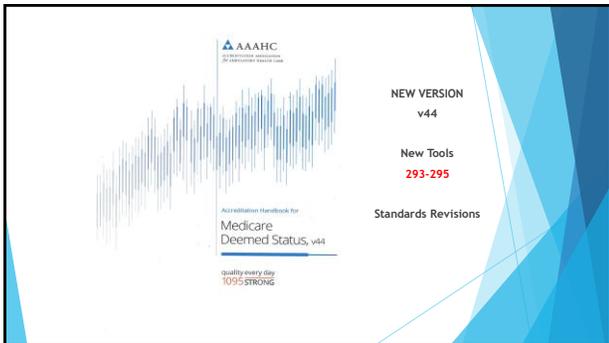


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3

AAAHC

- ▶ Well suited for outpatient settings
- ▶ Over 6700 facilities
- ▶ Established in 1979
- ▶ Diversified into education
- ▶ Awarded renewal of deemed status in December 2024



AAAHC v44

4

Deemed Status Mystery

- ▶ New licensed facility wanting to see and be reimbursed for Medicare patients
- ▶ Surveys look at compliance with the Federal Standards including life safety
- ▶ Success earns your CCN (Medicare) number

AAAHC v44

5

Notice of Accreditation Survey

- ▶ Must be posted
- ▶ Multiple places
- ▶ Stays up for 30 days



Notice of Accreditation Survey

Name of Organization:
 This has never been accredited or certified
 The facility already has _____ accreditation. (Specify the accrediting organization and a number or listing if you wish.)
NOTE: Accredited facilities are required to post this notice in a prominent location in the facility. Accredited facilities are required to post this notice in a prominent location in the facility. Accredited facilities are required to post this notice in a prominent location in the facility.

Accreditation Authority: Accreditation Association for Ambulatory Health Care, Inc.
 10000 Corporate Park, Suite 100, Dallas, TX 75243
 Telephone: 817-221-0000
 Fax: 817-221-0000

This Notice of Accreditation Survey is a condition of accreditation. AAAHC may terminate or suspend accreditation if the facility fails to comply with the terms of this notice. Accredited facilities are required to post this notice in a prominent location in the facility. Accredited facilities are required to post this notice in a prominent location in the facility.

Date This Notice Was Posted: _____
 State: _____
 Signature: _____ Title: _____

AAAHC v44

6

AAAHC/CMS

- ▶ CfC = Conditions for Coverage Federal Register 416.
- ▶ SOM = State Operations Manual = Appendix L
- ▶ IJ = Immediate Jeopardy Appendix Q not designed for ASCs but has good definitions
- ▶ POC = Plan of Correction
- ▶ SOR = Standards of Compliance
- ▶ EOC = Elements of Compliance

7

AAAHC/CMS

- ▶ BU = Business Unit
- ▶ PBU = Parent Business Unit = Owner of the ASC
- ▶ PEC = Physical Environment Checklist Based on NFPA 2012 Standards

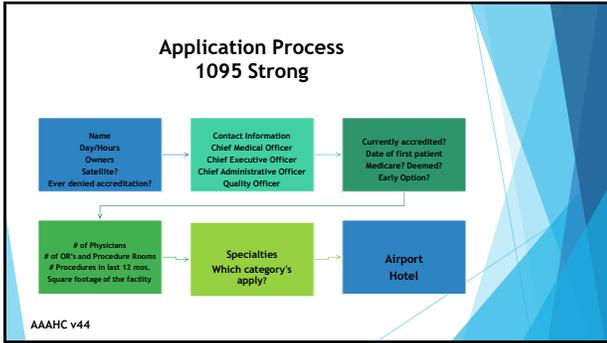


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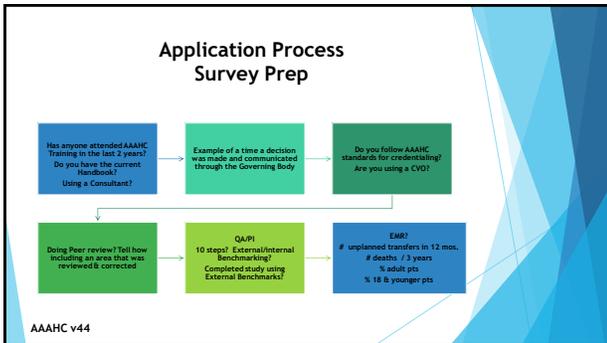
AAAHC / CMS

- ▶ 1095 Engage = Application Management Program - AAAHC creates a curated set of standards
- ▶ Application, Program Standards, POC, Annual Attestation, Change Notifications, Scope, Schedule, \$\$\$\$

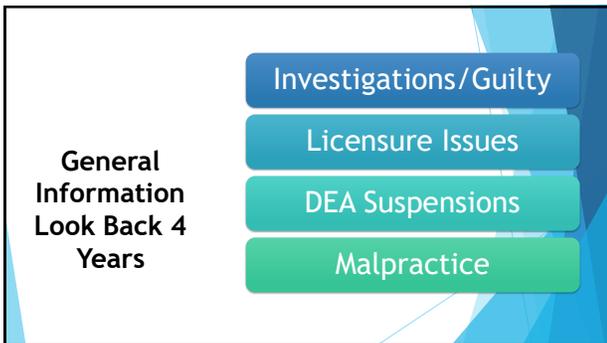
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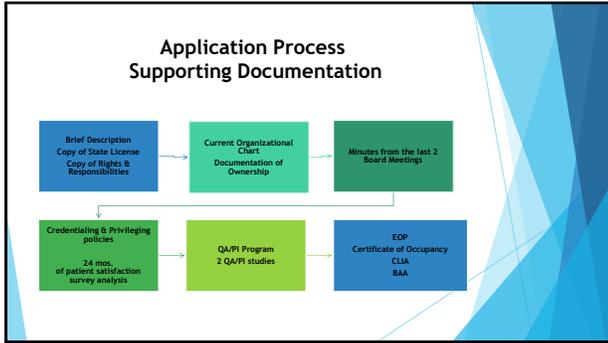
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11



12



13

Attestation & Payment

Chief Medical Officer

Chief Administrative Officer

\$800.00 to \$1425.00
Application fee only!

AAAHC v44

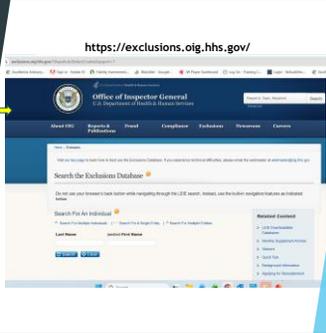
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- ### ADM Administration
- ▶ 15-day notification
 - ▶ AAAHC sign posted
 - ▶ GB approve all management policies & procedures
 - ▶ Personnel files complete including signed job description/completed in 30 days, locked up
 - ▶ Meeting min including education (annually)
 - ▶ Fiscal controls in place and backed up with policies & procedures
 - ▶ Mission and Goals
 - ▶ Training on adverse events, workplace violence, employee appraisals, I-9, orientation (safety program, exposure control, sharps injury, fire safety, EOP, HIPAA), Patients Rights, offer Hep B.

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ADM Administration

- ▶ Run OIG report on staff
- ▶ Policy and training for laboratory specimens and biological products including logging, tracking, reports to providers
- ▶ Who is in-charge of the drugs? Is Medical Director a good choice?
- ▶ Students need written agreements - include definition of "close and adequate supervision"



16

ASG Anesthesia & Surgery



- ▶ Written policies address anesthesia including H&P, and patient examination?
- ▶ Patient selection process, post procedure care, how staffing is set up?
- ▶ Qualified staff person present until patient medically discharged ACLS?
- ▶ Deeper than intended level of sedation policy?
- ▶ Provider performing the procedure can not be the same person administering sedation, marking of the site can be done in presp. Staff, Practitioner, must prove qualifications prior to GB approval.
- ▶ Do you store blood or just transfer?
- ▶ Policy on time out? Include equipment/implants
- ▶ Pediatrics?

17

Surgical Services Areas of Concern



- ▶ Diverse of surgical services should be on the job description of the Medical Director
- ▶ Physician present or immediately available by phone if patient in facility
- ▶ Assessment for the risk of DVT
- ▶ Removal or covering of patients clothing, unless non-sterile procedures
- ▶ Scrubs from home
- ▶ Laser policies specific to unit and overseen by Medical Laser Safety Officer
- ▶ Complete documentation for lithotripsy

AAAHC v44

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ASG Anesthesia & Surgery

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Anesthesia Areas of Concern

- ▶ Equipment maintenance
- ▶ RN's officially trained on conscious sedation
- ▶ Pharmacy issues with providers
 - Counts
 - Single dose vials
 - Swabbing new vials
 - Pre-filling syringes

AAAHC v44

20

Anesthesia To Do's

- ▶ Double-check DOP
- ▶ Delegate who will oversee the program
- ▶ Consent completion
- ▶ Decide on emergency drugs and equipment; AED or defibrillator?
- ▶ Chart audits to match with policy
- ▶ Pain assessment plan
- ▶ 1 ACLS person on staff

AAAHC v44

21

CMC Care Management & Coordination

- ▶ Medication reconciliation
- ▶ Post op instructions
- ▶ Policy on assessment & management of acute pain
- ▶ Policy on informing patients re their evaluation/diagnosis/treatment prognosis/Discharge follow-up/preventive care.
- ▶ Record questions asked and answered.



22

CPV Credentialing/Privileging



- ▶ Process defined in either bylaws or policy
- ▶ Temporary privileges may not be the answer
- ▶ Governing Body **MAY** delegate the review of the credentialing applications, **not** the approval!
- ▶ Ongoing monitoring often problematic
- ▶ Solo practitioners often problematic
- ▶ Peer review expected per policy
- ▶ Ongoing monitoring expected, use for internal benchmarking
- ▶ DOP - Don't forget anesthesia oversight

AAAHC v44

23

CPV Credentialing/Privileging



- ▶ Must be specific to your facility
- ▶ Timing should be perfect
- ▶ AAAHC elements are very specific
- ▶ Applications must be dated and signed
- ▶ NPDB and AMA are great problem solvers
- ▶ References for Initial
- ▶ Peer review for renewals

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CRD Clinical Records

- ▶ Designated person in charge of records and or EMR
- ▶ Monitoring on a regular basis
- ▶ Security - unauthorized access EMR or paper (Policy)
- ▶ Release upon request (Policy)
- ▶ Destruction/retirement (Policy)
- ▶ Medications given
- ▶ Discharge diagnosis, disposition, instructions (signed by patient or driver)
- ▶ Missed or cancelled appointments, texts, phone calls all documented
- ▶ A summary page for 3 or more visits



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CRD Clinical Records



- ▶ Areas of Concern:
 - ▶ Timely transmission of reports to outside providers if they are elsewhere - this is a two-way situation
 - ▶ Most frequent citation - **allergies** without reactions
 - Must include medications, food, OTC, materials, environmental factors in a consistent location
 - Inconsistent use of NKDA vs NKA
 - Nurses and anesthesia don't always agree

AAAHC v44

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EMG Emergency Management

- ▶ Have an Emergency Operations Plan covering internal and external disasters
- ▶ Participate in community drills if possible
- ▶ Internal scenario drills quarterly
- ▶ CPR drill annually ACLS/PALS training includes hands on by an expert
- ▶ Airway mgt & defibrillator training hands on by an expert
- ▶ Written review and corrective actions if needed
- ▶ MH Drill annually and policies if triggering agents present
- ▶ Protocols posted for MH
- ▶ Emergency transfer plan



27

FAC Facilities and Equipment

- ▶ Occupancy certificate
- ▶ Policies for safety and security
- ▶ No smoking signs
- ▶ Facility is clean and well maintained
- ▶ Fire extinguishers present and being checked monthly
- ▶ Equipment being checked and documented per the instructions for use for each, dictated by policy

28

Facilities and Equipment

- ▶ The facility has the current copy of Appendix L (Rev. 215, 07-21-23) State Operations Manual
- ▶ The facility has the current copy of Appendix I (Rev. 12-09-22) Life Safety Codes
- ▶ The facility has a copy of AAAHC Handbook for Medicare Deemed Status v44
- ▶ Each OR is designed and equipped for the type of procedures performed
- ▶ The ASC has a separate recovery and waiting room

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GOV Governance

- ▶ Develops an organizational chart and approves all parties in their position
- ▶ Approves products sold to patients
- ▶ Designs the scope of services and population served (including anesthesia), annual review to assure goals & objectives are being met
- ▶ Designs risk management program
- ▶ Approves the Infection Control, safety program, policies, and QA/PI
- ▶ Annually reviews and approves all contracts
- ▶ Annually reviews AAAHC requirements
- ▶ Reviews patient satisfaction reports and necessary corrective actions
- ▶ Approves patient age
- ▶ Annually - Policies & Procedures, EOP, Rights & Responsibilities
- ▶ All treatments, procedures and hours of operation

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GOV Governance Appointees

- ▶ Governing Body Members
- ▶ Medical Director
- ▶ Privacy Officer
- ▶ Infection Preventionist
- ▶ Safety Officer
- ▶ Director of Nursing
- ▶ Interim for Medical Director/DON
- ▶ Director of surgical services
- ▶ Urologists to oversee lithotripsy
- ▶ Pharmacy Director
- ▶ Anesthesia Supervisor

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IPC Infection Control Areas of Concern



- ▶ IP training not current or relevant to sterilization or cleaning, especially when using pouches
- ▶ Failure to follow IFU's
- ▶ Construction Risk Assessment - FGI <https://fpiguidelines.org/resource/chd-safety-risk-assessment-toolkit/>

AAAHC v44

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IPC Infection Prevention & Control

- ▶ Sharps program - secure sharps containers
- ▶ References for policies & procedures
- ▶ Infection control plan and risk assessment (annually)
- ▶ Cleaning policy and vendor training
- ▶ Hand hygiene and surgical scrub policy
- ▶ Policies re identification of persons authorized to be in patient care areas, adequate surveillance to minimize sources of infections, list of reportable diseases. Patients with possible communicable illness may need isolation and or a referral
- ▶ Attire for those in the OR is outlined as well as patient attire

33

LRD Lab & Radiology

- ▶ CLIA certificate/waiver
- ▶ All staff trained on equipment and a competency performed
- ▶ Quality Controls per IFU being performed
- ▶ New equipment is validated prior to patient use
- ▶ If your facility does not perform lab or radiology, state so in a GB meeting or a policy. If you do, make sure you have the proper signage in place and pregnancy testing available



34

MED Medication Management



- ▶ Policy defines processes for safe handling and administration
- ▶ Policy, procedures, and monitoring high alert and confused drug names
- ▶ If you have high alert drugs, keep the reversal agent in the same area
- ▶ Policy should indicate no pre-signed prescriptions for meds
- ▶ Storage of meds is a secure area with very limited access
- ▶ Written policy on how to label a syringe not expected to be used within 4 hours
- ▶ Vaccine storage must have a policy and follow nationally recognized standards

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MED Medication Management

- ▶ A policy exists that defines the processes used for the safe handling, storage, and administration of medications following acceptable standards of practice
- ▶ Drug security including recordkeeping to ensure control and prevent diversion
- ▶ Pre-signed prescription pads or 222 forms are not allowed, neither are post dated pads. All forms are secured from unauthorized access
- ▶ Electronic prescribing systems are controlled and secured
- ▶ High alert and confused drug lists provided

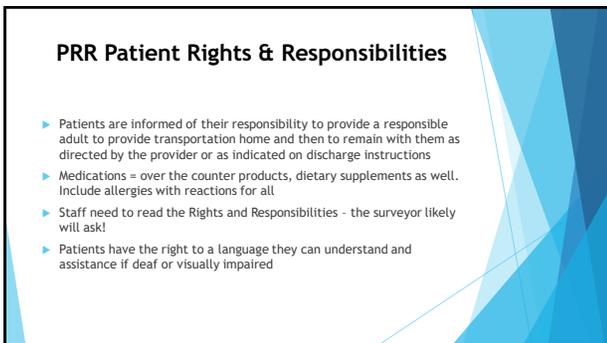
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MED Medication Management Triggering Agents

- ▶ Inhaled general anesthetics
 - ▶ Halothane
 - ▶ Desflurane
 - ▶ Enflurane
 - ▶ Ether
 - ▶ Isoflurane
 - ▶ Sevoflurane
 - ▶ Succinylcholine

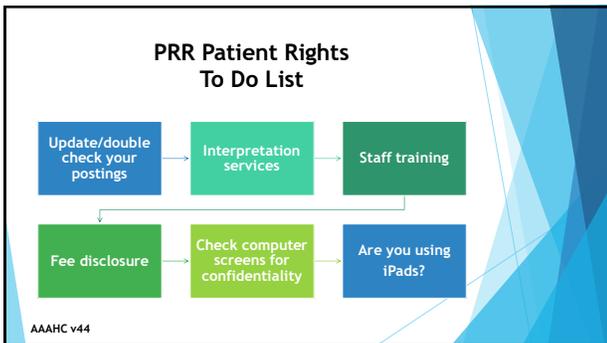
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PRR Patient Rights & Responsibilities

- ▶ Patients are informed of their responsibility to provide a responsible adult to provide transportation home and then to remain with them as directed by the provider or as indicated on discharge instructions
- ▶ Medications - over the counter products, dietary supplements as well. Include allergies with reactions for all
- ▶ Staff need to read the Rights and Responsibilities - the surveyor likely will ask!
- ▶ Patients have the right to a language they can understand and assistance if deaf or visually impaired

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PRR Patient Rights To Do List

```

    graph LR
      A[Update/double check your postings] --> B[Interpretation services]
      B --> C[Staff training]
      C --> D[Are you using iPads?]
      D --> E[Check computer screens for confidentiality]
      E --> F[Fee disclosure]
      F --> A
  
```

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QUA Quality

- ▶ Must have a written program that is evaluated annually, follows best practices,
 1. Statement of Purpose/Objectives
 2. One physician or dentist on the committee
 3. Describe Data including quality indicators
 4. Show Data
 5. Analysis of Data
 6. Compare to internal benchmarks include problem and/or improvement opportunities.
 7. Corrective Action
 8. Remeasure on an ongoing basis
 9. Additional Corrective Action may be needed
 10. Communicate results to GB



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QUA Quality

- ▶ Peer review is now a big part of the AAAHC Quality Program as is infection control and risk management
- ▶ It is expected to utilize patient satisfaction reports, marking of the surgical site, time out practices just to name a few ideas. Obviously, incident reports and employee concerns would be very much involved
- ▶ Quality Reporting

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QA/PI Areas of Concern

- No annual review
- Not just quality activity
- Unclear goals
- No Benchmarking
- Re-measurement not applies to apples

AAAHC v44

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QUA Quality Benchmarking Opportunities



<https://www.ascquality.org/qualityreport>

- Burns, falls, transfers, admissions
- ▶ State organizations
- ▶ AAAHC
- ▶ Associations

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QUA Quality Risk Management



- ▶ Risk management program includes written policies.....
 - Patient dismissal from care
 - Incapacitated HCW/HCP
 - Impaired HCW/HCP
 - After hours care and documentation
 - Observers - patient consent

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QUA Quality Risk Management



- Reportable events
- Facility/HCP litigation/insurance co
- Patient complaints
- Review of clinical records and policies
- Near miss/adverse events

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45

Overnight Care and Services



- ▶ A few things to remember.....
- Governing Body to appoint a physician to supervise the program (DOP)
- Providers who admit patients must have been approved by the Governing Body to do so (DOP)
- Must have a transfer agreement or ASC admitting physicians must also have hospital admitting privileges.

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SAF Safety

- ▶ Tags to the risk management program
- ▶ Process to identify hazards, threats, near misses, safety concerns (risk assessment). The risk management program must include policies
- ▶ Examples include medication errors, falls, skin & tissue injury
- ▶ Risk assessment for hazardous materials and waste
- ▶ Recall policy? Include sources.
- ▶ Temperature monitoring for OR's, med room, medication fridge etc.
- ▶ We have discussed fire drills and a bit of fire safety, are the fire extinguishers blocked by a wheelchair or a cabinet that someone would have to reach over?
- ▶ Out dates policy
- ▶ Hazardous waste policy



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SAF Safety

- ▶ Program in place to assess and reduce risks associated with occupational chemical exposures
- ▶ Risk assessment is required in general
- ▶ Written policies for each device, Safety Officer should be involved and approve
- ▶ Safety measures and fire protection measures for lasers must be in place
- ▶ Written policies in place for lithotripsy and imaging services
- ▶ Policy addresses the management of potential hazardous energy sources
- ▶ Warning signs re MRI's for patients with metal implants, pacemakers, internal defibrillators, cochlear implants, stints, insulin pumps or nerve stimulators

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SAF Safety Adverse Event Definition

- ▶ Any clinical or non-clinical event not consistent with routine care
- ▶ Include patients, visitors, employees, medical staff
- ▶ Near miss events
- ▶ Death, serious physical, or psychological injury or illness
- ▶ Process variation
- ▶ Breaches in medical care
- ▶ Outcomes that is not consistent with your standard of care
- ▶ Events involving reactions to drugs and materials

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SAF Safety Areas of Concern

- ▶ Hallways not clear
- ▶ Drill documentation is weak, so the value of the drill is often diminished
- ▶ Monthly fire extinguisher check not logged
- ▶ Is emergency lighting being checked
- ▶ Do the exit signs light up in case the lights go out
- ▶ Is the parking lot clear so a senior can safely get in their car
- ▶ How closely are you monitoring expiration dates on medications, reagents, solutions and supplies
- ▶ Medical devices should be cleaned prior to sending out for service

AAAHC v44

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PEC Physical Environment Checklist

Expectations for compliance with NFA 101 for Life Safety code and NFA 99 for Health Care Facilities

Construction approved before 7/5/16 is considered EXISTING

Construction approved after 7/5/16 is considered NEW

The 2012 edition is the only edition recognized by CMS

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CON LSC Construction

- ▶ Cover up or remove fire safety or life safety design that are not required yet visible to the public. Otherwise, this can cause confusion NFA 101: 4.6.12.3
- ▶ The building should not have non-health care occupancies with high hazard contents in use or storage NFPA101: 20.1.3.7
- ▶ If the building provides a basement level, at least one of the following condition must be met:
 - ▶ The floor system between the discharge level and the basement is of 1-hour fire rated construction. NFA 101: 20.1.1.6
 - ▶ The basement is under the control of the ASC and any hazardous areas. NFA 101: 20.1.6
- ▶ 2 hr. fire wall used on all stories that are physically attached to an ASC. That includes parking structures if attached to ASC NFA 101: 20.1.1.4
- ▶ When open air parking is attached, best to have the parking area sprinklered. Vehicles are at least 10 feet away from garage openings NFA 101: 20.1.1.4

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CON LSC Construction

- ▶ Fire sprinklers are inspected annually by your vendor, if you are in a multi tenant building all should be doing this. You should be looking at them daily, weekly and monthly & quarterly but check with the IFU as well as your sprinkler expert at time of install. NFPA 25 offers a loophole "as applicable to the system design and components" NFPA 101: 9.7 NFPA25: 15
- ▶ If there is a concern when you do your checks, initiate a fire watch and call your vendor NFPA 101: 9.7 NFPA25: 15
- ▶ A stock of spare sprinklers (at least 6 but it depends on the size of your facility) should be on site with the appropriate wrench
- ▶ There should be an 18 inches clearance from the top of storage
- ▶ Sprinklers should be installed no closer than 4 inches from the wall




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CON LSC Construction

- ▶ The total combined area of bulletin boards, posters, and paper attached to walls does not exceed 20% of the wall surface and not in the sterile corridor / rooms NFA 101: 10.2.5.3
- ▶ Unprotected misc. openings (mail slots, pass thru windows) should be less 20 sq inches in any given room NFA 101: 20.3.6.2
- ▶ Again, best advice....ALWAYS vet you architect and project manager, even if you are doing an add on or repair! Feel free to share with them this chapter so they can reference the actual codes to know what needs to be done

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EGR LSC Means of Egress

- ▶ Section goal : provide a safe unobstructed passageway for exiting in case of an emergency NFPA 101: 20.2.4.2 & 21: 2.4.2
- ▶ You must have at least 2 exits regardless of size, if you are in a shared space, this refers to the ASC space
- ▶ These 2 exits need to be remote from each other to minimize the possibility both could be blocked in an emergency situation
- ▶ These exits can **not** be behind a locked door (storeroom, restroom, etc.)
- ▶ The distance to either exit may vary by the size of you ASC and if sprinkled or not
- ▶ Signage to the exits should be obvious and inspected monthly to make sure they would light up

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<EXIT> EGR LSC Means of Egress

- ▶ No portion of a required exit access involves passage through a kitchen, storeroom, restroom, workroom, electrical mechanical room or any room subject to being locked. NFPA 101: 7.5.2
- ▶ Egress corridors do not pass through intervening rooms other than lobbies or areas permitted to be open to the egress corridor. NFPA 101: 7.5.2.1
- ▶ Distance travelled between any point in the building to get to an exit corridor leading to 2 different egress directions cannot exceed 75 ft, when not protected by a sprinkler system. NFPA 101: 38.2.5.3
 - ▶ If protected by a sprinkler system, or in ASCs of less than 3,000 sq ft, the distance can be 100 ft.
- ▶ Maximum distance of any occupied room to a nearby exit cannot be greater than 150 ft. when not fully protected by sprinklers. NFPA 101: 20.2.6.2
 - ▶ Maximum distance would be 200 ft. if protected with sprinklers.

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EGR LSC Means of Egress
Exit Doors

- ▶ Must comply with NFPA 101: 20.2, 101:21.2, 101:38.2.2, 101:39.2.2 AND 101:7
- ▶ Locked egress can be manual or electric as long as the manual doors has a release bar on the departing side of the egress door.
 - ▶ The manual release device shall be located on the egress side, 40 in. to 48 in. (1015 mm to 1220 mm) vertically above the floor, and if electric push button within 60 in. (1525 mm) of the secured door openings.
 - ▶ The manual release device shall be readily accessible and clearly identified by a sign that reads as follows: PUSH TO EXIT.
 - ▶ When operated, the manual release device shall result in direct interruption of power to the lock – independent of the locking system electronics – and the lock shall remain unlocked for not less than 30 seconds.
- ▶ If electric, the following must comply:
 - ▶ A sensor shall be provided on the egress side, arranged to unlock the door leaf in the direction of egress upon detection of an approaching occupant.
 - ▶ Door leaves shall automatically unlock in the direction of egress upon loss of power to the sensor or to the part of the access control system that locks the door leaves.
 - ▶ Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the door leaves in the direction of egress, and the door leaves shall remain unlocked until the fire-protective signaling system has been manually reset.

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EGR LSC Means of Egress

- ▶ Exit ramps should be at least 44 inches wide in new space and 30 inches in existing space NFPA 101: 20.2, NFPA 38.2.2
- ▶ Ramps with a rise of greater than 6 inches have handrails on both sides
- ▶ Handrails should not have projections that could catch on loose clothing
- ▶ Handrails may not be less than 34 inches not higher than 38 inches from the walking surface for new and 30 inches -38 inches for existing
- ▶ Clearance of the rail from the wall should be at least 2 ¼ inches



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EGR LSC Means of Egress Exit Path Safety

- ▶ Compliance to NFPA 101: 7.5.1
- ▶ Exits shall be located, and exit access shall be arranged, so that exits are readily accessible at all times.
- ▶ No portion of the exit egress requires passage through a hazardous area.
- ▶ At least two exits are accessible from each smoke compartment of the ASC
- ▶ All portions of the exit pathway are at all times kept free from physical and visual obstructions such as signs, decorations or furniture.
- ▶ No mirrors are allowed that have potential to confuse the direction of egress.
- ▶ Exit doors are clearly recognizable with Exit signs and not obstructed by anything.



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LAB LCS Laboratory Related Requirements

- ▶ Compliance to NFPA 99: 6.3.2.3
- ▶ This category is specific those of you who may have areas that are used for testing and analysis involving chemicals that could be flammable, combustible or hazardous. Very short and likely won't apply to many of you
- ▶ Duplex receptacles installed 39.8 inches on center in lab instrument usage areas at least 3.15 inches above the counter
- ▶ Policies and procedures describe testing intervals NFPA 99: 10.5.5
- ▶ Annually inspect the appliances power cords
- ▶ Install appliances according to the units IFU
- ▶ Shutoff valves are clearly labeled

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HAL LSC Hazardous Area Protection

- ▶ Compliance to NFPA 101: 20.3.2.1 and NFPA 101: 3.3.21.4
- ▶ Safe storage for flammable, combustible, noxious or corrosive materials
 - ▶ Placed on bottom shelf to avoid drippage on other supplies/ plastic shelf liner
 - ▶ Proper signage for each respective materials (ie; flammable, combustible, etc.)
 - ▶ Hazardous material Spill kits as well as cleaning supplies
- ▶ Doors must automatically close, these are 45 min fire doors
- ▶ 1 Hour fire rated walls and ceiling
- ▶ Fire sprinklered
- ▶ ABHS installed in corridors are at least 6 feet wide, spaced no closer than 4 ft, and NEVER directly over an outlet (at least 1 inch away)
- ▶ ABHS max size is 1.2 liters (.32 gals) /room or corridor. Can be 2 liters in a suite; 2.0 liters (0.53 gallons). Total ABHR, including, for example, stored supplies, cannot exceed 10 gallons per smoke compartment
- ▶ Mounting: Dispensers should be mounted between 42 and 48 inches above the floor.



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GAS LSC Medical Gases Piped & Portable NFPA 99.11.3

- ▶ Piped medical gas system outside the building can have quantities up to 300 cubic feet; tanks must be secured with chains and non-flammable wall connection. (O2 & med air)
 - ▶ Sign: **"CAUTION: MEDICAL GASES-NO SMOKING NO OPEN FLAME"**
- ▶ Tanks can be stored separately from the pipe medical gas system room. In this scenario, quantities on nonflammable gases greater than 300 cubic ft and less than 3000 cubic ft can be stored internally or externally.
 - ▶ Sign: **"CAUTION: OXIDIZING GAS(ES) STORED WITHIN- NO SMOKING"**
- ▶ Door must be locked and accessible by authorized staff.
- ▶ Oxidizing gases (oxygen, nitrous oxide, compressed air) cannot be stored with combustible materials or gases (hydrogen, methane, propane)
- ▶ Do not have any electrical machinery operating in this room such as compressor/vacuum equipment
- ▶ Room should be fire wall rated with Sprinkler system; Vented



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GAS LSC Medical Gases-Portable Storage of Tanks NFPA 99.11.3

- ▶ Interior storage or supply room should not vent or open into critical patient care areas, locations storing flammables, rooms containing open electrical contacts or machinery, kitchens, open flames or spark potential.
- ▶ Room temperature maintained below 130F; Nitrous maintained below 125F
- ▶ If storing compressed gas(es) other than O2 and medical air, consider room may have insufficient oxygen before entering.
 - ▶ Sign: **"CAUTION: POSITIVE PRESSURE GASES-NO SMOKING or OPEN FLAME- MAY HAVE INSUFFICIENT OXYGEN-OPEN DOOR AND ALLOW ROOM TO VENTILATE BEFORE ENTERING"**
- ▶ Interior locations enclosed in 1-hour rated fire wall & non-combustible finishes
- ▶ Doors secure and locked and accessible by authorized personnel. Vent openings at the base of each freestanding wall to allow free circulation
- ▶ Room is vented to the outside by natural or mechanical means
- ▶ All cylinders must be chained to racks whether full or empty and made of non-combustible materials.
- ▶ Supply room door must have a 60-minute rating if new (45 minute if Existing facility)



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Essential Electrical Systems (EES) Descriptions

NFPA 99:6.3.2.2.10

- ▶ Category 1 (Type 1 EES) serves critical care areas where failure is fatal, or serious injury is possible; requiring three branches (Life Safety, Critical, Equipment).
- ▶ Automatic Transfer Switches (ATS) must transfer to backup power within 10 seconds of a normal power failure.
- ▶ Category 2 (Type 2 EES) serves general care areas, needing only two branches. Light to moderate sedation and risk of patient injury is low.
- ▶ Category 3/4 spaces (basic care/support) generally do not require a formal EES. (clinics)

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EES LSC Electrical System Category 1 EES Panels

Category 1 EES is required for facilities doing general anesthesia; Basic care rooms and non-patient rooms do not need to be served by EES

Life Safety Branch (LS) (L)	Critical Branch (CB) (C)	Delayed Alternate Connection	Equipment Branch (EB) (E)	Essential Power System
All functions other than the following: • Maintenance of critical systems • Emergency medical equipment (eg, ventilators, monitors, infusion pumps, etc.) • Medical equipment • Life support • Medical equipment systems, when used for life support or emergency response • Patient care • Patient transport • Patient monitoring • Patient communication for general anesthesia • Patient communication for critical care • Patient communication for building safety	All functions other than the following: • Patient care areas • Patient transport • Patient monitoring • Patient communication for general anesthesia • Patient communication for critical care • Patient communication for building safety • All other functions	All functions other than the following: • Patient care areas • Patient transport • Patient monitoring • Patient communication for general anesthesia • Patient communication for critical care • Patient communication for building safety • All other functions	All functions other than the following: • Patient care areas • Patient transport • Patient monitoring • Patient communication for general anesthesia • Patient communication for critical care • Patient communication for building safety • All other functions	All functions other than the following: • Patient care areas • Patient transport • Patient monitoring • Patient communication for general anesthesia • Patient communication for critical care • Patient communication for building safety • All other functions

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EES LSC Electrical System Category 3 & 4 facilities

- ▶ Compliance to NFPA 99:6.3.2.2.10
- ▶ Category 3 & 4 facilities do not need a Category 1 EES but must provide at minimum alternate power required for LS SYSTEMS including emergency egress lighting, exit Signs and fire alarm system.

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EES LSC Electrical System the Generator VS the Alternate Battery Power System

GENERATOR

- ▶ AAAHC guidelines state under EES.140.10
- ▶ The alternate source of power for emergency and Standby Power Systems (EPS) is a generator set qualifying as
 - ▶ Type 10
 - ▶ Class X
 - ▶ Level 1
 - ▶ Per the NFPA 99:64.1.1.6.1, NFPA 99: 6.4.1.2



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BATTERY SYSTEM

- ▶ AAAHC guidelines-EES.140.20
- ▶ The alternate source for battery power systems meets with:
 - ▶ NFPA 111 and Article 700 of the 2011 Edition of NFPA 70, National Electric Code.
 - ▶ Per the NFPA 99:64.1.1.6.1, NFPA 99: 6.4.1.2



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EES LSC Electrical System Emergency & Standby Power System-EPS



- ▶ Dedicated room for the EPS and the room is locked and secure.
- ▶ Separated from the rest of the building with a 2-hour fire rating or located in an exterior building
- ▶ Room must be free from possible flooding or rain damage, sewer backup
- ▶ 36 inches clearance area on all sides allowing for technical workers
- ▶ Temperature per manufacturer instructions; same with airflow
- ▶ Labeled remote STOP button outside the generator housing or somewhere else in the surgery center convenient for staff access
- ▶ Generator annunciator located inside the ASC by nursing station or workstation

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EES LSC Electrical System Emergency & Standby Power System-EPS

- ▶ At least 2 sets of generator instruction manuals; 1 safely stored in or near the generator cabinet. The 2nd located in the ASC
- ▶ Weekly inspections:

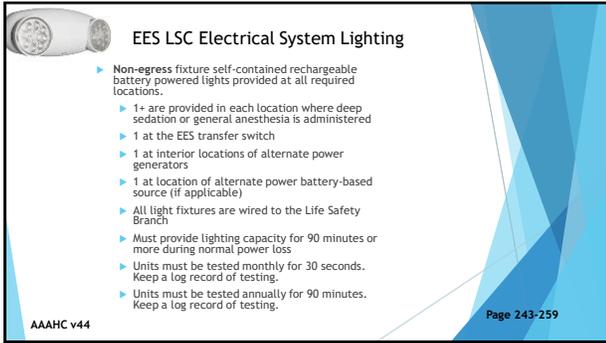
Fuel Level
Coolant Level
Oil Level
Oil Temp
Visual Inspection: Hoses, connectors, obstructions, leaks
Ventilation: free from debris
Battery cover: if in freezing areas of US
Exhaust System
Exhaust Temp
Battery System: look for corrosion
Battery Test CCA #
Electrical: chewed wiring, loose wires, circuit breakers and fuses
External Lighting: flashlight
- ▶ Monthly and annually:

MONTHLY
30 Min Load test; NFPA 110 8.4.2
Generator Transfer Switch exercised monthly.
Annually
Load Test: 50%, 30 min; 75%, 1 hour; total 1.5 hr; NFPA 110 8.4.2.2
Fuel Testing



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EES LSC Electrical System Lighting

- ▶ Non-egress fixture self-contained rechargeable battery powered lights provided at all required locations.
 - ▶ 1+ are provided in each location where deep sedation or general anesthesia is administered
 - ▶ 1 at the EES transfer switch
 - ▶ 1 at interior locations of alternate power generators
 - ▶ 1 at location of alternate power battery-based source (if applicable)
- ▶ All light fixtures are wired to the Life Safety Branch
- ▶ Must provide lighting capacity for 90 minutes or more during normal power loss
- ▶ Units must be tested monthly for 30 seconds. Keep a log record of testing.
- ▶ Units must be tested annually for 90 minutes. Keep a log record of testing.

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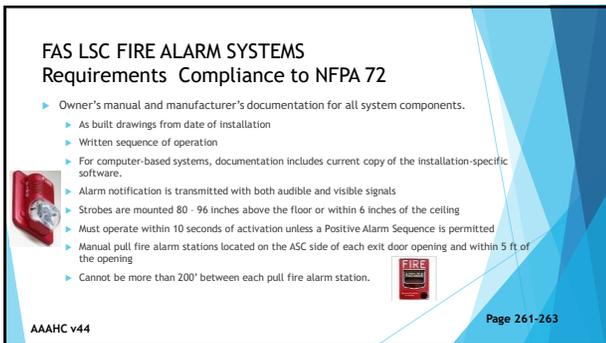


Electrical Checks & Exit Signs

- ▶ Receptacle testing for polarity and tension pull
 - ▶ GFCI checked each month
 - ▶ Medical/hospital grade (red) check annually
 - ▶ Keep a receptacle check log sheet
- ▶ Circuit panels must be labeled as to EES1, EES2, EES3; individual circuits labeled
- ▶ Fire system circuit locked with device

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FAS LSC FIRE ALARM SYSTEMS Requirements Compliance to NFPA 72

- ▶ Owner's manual and manufacturer's documentation for all system components.
 - ▶ As built drawings from date of installation
 - ▶ Written sequence of operation
 - ▶ For computer-based systems, documentation includes current copy of the installation-specific software.
- ▶ Alarm notification is transmitted with both audible and visible signals
- ▶ Strobes are mounted 80 - 96 inches above the floor or within 6 inches of the ceiling
- ▶ Must operate within 10 seconds of activation unless a Positive Alarm Sequence is permitted
- ▶ Manual pull fire alarm stations located on the ASC side of each exit door opening and within 5 ft of the opening
 - ▶ Cannot be more than 200' between each pull fire alarm station.

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FAS LSC FIRE ALARM SYSTEMS
Testing

- ▶ Frequency of testing the fire alarm system-per AAAHC-more stringent
 - ▶ Weekly- FAS.240.10 monitoring company
 - ▶ Monthly- FAS.240.20 You - includes generator set, or battery backup
 - ▶ Quarterly- FAS.240.30 -usually done by service providers in most contracts- includes signal for pressure, water level, water temperature and room temperature. Also, you are doing a quarterly fire drill required.
 - ▶ Semi-annually - FA.240.40 Service provider-battery-related testing, fire detectors, valve switches, waterflow devices
 - ▶ Annually - done by the service provider - all internal electronic components
- ▶ Some providers offer automated testing of system through a remotely monitored FACP and could replace your onsite testing, except for quarterly fire drills.

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FAS LSC FIRE ALARM SYSTEMS
System Failures

- ▶ When the fire alarm is out of service for 4 or more hours in a continuous 24-hour period
 - ▶ Fire alarm company has to be alerted
 - ▶ The building has to be evacuated or
 - ▶ Initiate a Fire Watch
 - ▶ A "Position of Impairment Coordinator" is designated to an ASC employee who is knowledgeable and able to step in to fulfill requirements of this position.



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FAS LSC FIRE ALARM SYSTEMS
Further Documentation

- ▶ A Record of Completion document is completed upon installation as well as when changes to the system across time are completed. You must maintain a copy at the ASC.
- ▶ If not at the ASC, it must be kept at the FACP and easily accessed when needed.
- ▶ The documents should be kept in the fire cabinet or a separate cabinet with label as: "FIRE ALARM DOCUMENTS".
- ▶ Documentation should be kept on all weekly, monthly, quarterly, semi-annually and annual inspections.
- ▶ Per NFPA 72:14.6, all testing documents must contain the date, frequency, Name and address of facility, individual's name performing the testing, Name and address of the testing agency and a specific information pertaining the activity performed.

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SFP LSC Smoke and Fire Protection

- ▶ If you have a neighbor that is next to you, you must be separate and distinct and totally separated by a 1-hr fire wall. NFPA 101: 20.3.7.1
- ▶ If this wall has any doors, they must be fire doors (1 3/4 inch thick), self closing, self-latching, remained closed, and controlled by the ASC
- ▶ No propping open doors
- ▶ Air dampers must be installed where air ducts penetrate smoke or fire barriers with a fire resistance rating of 2 hours or more. Automatic closing during a fire. NFPA 101: 8.3.5.7, NFPA 90A: 5.3
- ▶ All fire walls and smoke barriers have to be free from openings. Openings must be filled with fire-rated caulk (red)
- ▶ Couplers used to connect piping or conduit must be fire-stopped or sealed at each end of the connection through the firewall.
- ▶ Double check after each outside vendor does work above the ceiling tiles on fire walls (ie: running cable, wiring, repairs, etc.)



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SFP LSC Smoke and Fire Protection

- ▶ Vision Panels must be fire rated
- ▶ Doors must be at least 1 3/4" thick, solid-bonded wood core
- ▶ ASC's that are 5000 square feet or larger should have 2 smoke compartments. This should be drawn on your plans
- ▶ Annual door inspection of fire doors by certified inspector or staff member that has been trained to do so. Keep log book.



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FIRE DOOR INSPECTION TOOLS NFPA 101: 20.3.7

Annual Inspection of Existing Fire Door Assemblies

Inspector Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Inspection Item	Yes	No	Comments
1. Is the door assembly a fire-rated door assembly?			
2. Is the door assembly a solid-bonded wood core door assembly?			
3. Is the door assembly a fire-rated door assembly?			
4. Is the door assembly a fire-rated door assembly?			
5. Is the door assembly a fire-rated door assembly?			
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18. Is the door assembly a fire-rated door assembly?			
19. Is the door assembly a fire-rated door assembly?			
20. Is the door assembly a fire-rated door assembly?			

ACCURATELY MEASURE

Door Assembly Clearance Requirements - NFPA 101

These measures describe the gap between the top of the door and the frame, and the meeting point of doors in pairs and for glass or vision panels in fire doors.

Where the bottom of the door is more than 3/8" above the finished floor the clearance under the bottom of the door shall be a maximum of 3/8" (or 1/2" for Glass Doors).

All Clearances shall be maintained from both face of doors.

\$32.50

www.Redteamtools.com

\$12.00

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handout

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FIRE DOOR INSPECTIONS NFPA 101: 20.3.7




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SFP LSC Smoke and Fire Protection

NFPA 101: 20.2.2.4, NFPA 101:8.3,
NFPA 80: 17



Self closing doors (stairway enclosures, exits, smoke barriers or hazardous areas) must be self-closing and not propped open

They must latch fully and stay closed

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PFE LSC Portable Fire Extinguishers

Compliance to NFPA 10: 5.4, NFPA 101: 20.3.5.3

Fire Extinguisher Classes

- ▶ Class A puts out ordinary combustible fires (wood, paper, plastic, etc.)
- ▶ Class B puts out flammable liquid fires (oil, gas, petroleum, etc.)
- ▶ Class C puts out electrical fires.
- ▶ Class D puts out combustible metal fires (magnesium, titanium, potassium sodium, etc.)

How to Read a Fire Extinguisher Rating

4-A: 60-B: C

The "C" only adds that the chemical agent used for extinguishing is not conductive and is safe for electrical fires, see the A and/or B numbers to determine the size of the handle

Indicates the square footage coverage for Class B Fires. 60B means that as long as you sweep the nozzle side to side, there is enough extinguishing agent inside the canister to cover 60 square feet

Represents water equivalency for Class A Fires, each number represents 1 1/2 gallons of water. 2A means the extinguisher is just as effective as 2 1/2 gallons of water. 4A is equivalent to 5 gallons of water.

- Fire extinguisher must be present and up to date inspection
- Minimum rated single extinguisher is 2-A
- Maximum permitted floor area per unit is 1500 sq ft
- An extinguisher rated 10-B will be located within 30 ft from any point in a room with 1 - 5 gallons of flammable liquids
- 40-B extinguisher for 5+ gallons of flammable liquids/room
- Maximum travel distance between A- extinguisher is 75 ft.

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PFE LSC Portable Fire Extinguishers Installation

- ▶ Gross weight no more than 40 lbs and installed so top is not more than 60 inches above the floor
- ▶ If greater than 40 lbs, to be installed so top is not more than 42 inches from the floor but a floor clearance of 4 inches. Exception: wheeled extinguishers
- ▶ Temperature - not to exceed temperature shown on the manufacturer label
- ▶ Cannot be hidden or obscured. Additional wall signage needed if visual of extinguisher is partially hidden.
- ▶ Located along normal walking pathways. No further than 75 ft apart from each. They are needing to be protected from damage. Installed on hangers or wall cabinets.
- ▶ Must be kept unlocked if in cabinets or provided with emergency access easily

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PFE LSC Portable Fire Extinguishers The Examination - NFPA 10

- ▶ Inspected every 30-days; make record on log sheet; if service provider does inspection, record on tag but also note on log sheet for surveyors
- ▶ Safety seals provided on initial delivery and/or service. Not to be broken until used.
- ▶ Gauge should show "full"; verify also by lifting and shaking
- ▶ Examination for obvious physical damage, corrosion, leakage, clogged nozzle
- ▶ If locked, make sure key is there
- ▶ If obstructed, move obstruction (wheelchairs, boxes, supplies, etc)
- ▶ If removed for maintenance, it must be immediately replaced with comparable rating extinguisher

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BLD LSC BUILDING SERVICES Considerations Compliance to NFPA 101: 20.5.1

- ▶ Maintain HVAC according to manufactures guidelines (MIFU)
- ▶ Change HVAC filters quarterly, periodically or according to MIFU
- ▶ If NEW facility or installing new HVAC, make sure installation is compliance with 2008 ASHRAE 170, <https://www.ashrae.org/technical-resources/standards-and-guidelines/standards-addenda/addenda-to-standard-170-2008>
- ▶ System complies with ASC mandated temperature and humidity guidelines for facility and storage of equipment and supplies. 68-75 degrees and 30-60% humidity
 - ▶ NFPA 99.9.3.1, ASHRAE 170
- ▶ Considerations: positive and negative air pressure relationships per room, total air changes per hour, spaces requiring 100% exhaust, space permitted to recirculate room air through room units, specific room temperature and humidity requirement like the operating rooms and sterile supply room
- ▶ Contracts in place for 1 year smoke and damper inspection after installation and every 4 years thereafter unless reasons otherwise.
- ▶ Mandated Annual air flow testing

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FEP LSC FIRE EMERGENCY PLANS
Compliance to NFPA 101: 20.7.1

- ▶ ASC must develop a written plan for protection of all persons
 - ▶ All supervisory personnel have access to copies of the written plan
 - ▶ All employees are periodically instructed on the plan and their respective duties during the emergency
 - ▶ A continually staffed person with direct phone access must have the plan
 - ▶ Employees are trained and familiar with locations of all fire extinguishers or devices in case of fire
- ▶ Fire drills are conducted quarterly. If different shifts, then fire drills have to be performed for those shifts
- ▶ Fire drills include transmission of audible and visual fire alarm signals and the simulation of emergency fire conditions. Scenario should be documented.
- ▶ Each drill should vary the situation in order to familiarize staff totally

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FEP LSC FIRE EMERGENCY PLANS
Documentation

- ▶ Use of a code phrase; others taught to know phrase
- ▶ Transmission of the alarm to dispatching authority ie: manual pull
- ▶ Requires isolation of the fire ie; close doors
- ▶ Requires evacuation of the immediate area of the fire
- ▶ Requires evacuation of the smoke compartment(s) and/or facility
- ▶ Requires inspection and assurance that egress is not obstructed
- ▶ Requires simulation of extinguishing the fire (if small)
- ▶ Requires post-analysis in team meeting and documentation

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FEP LSC FIRE EMERGENCY PLANS
NO SMOKING

- ▶ Prohibit smoking in the ASC and make sure rigid enforced
- ▶ Sign: NO SMOKING at all major entrances to the ASC
- ▶ Be sure to check with city/county ordinances on distance restrictions of smoking outside the ASC entrances. Post signage accordingly
- ▶ Regulations require cigarette disposal containers outside in the permissible smoking areas.
- ▶ Smoking regulations do not permit patients who are classified as "not responsible" to smoke without direct staff supervision

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FRN FURNISHINGS AND DECORATIONS

NFPA 701-Standard Methods of Fire Tests for Flame Propagation of Textiles & Films

- ▶ Curtains must be labeled to be fire-retardant. If not directly tagged, ASC must secure manufacturer/supplier's documentation specifically identifying the installed curtains/drapes as being compliant
- ▶ Except in buildings protected by fire sprinkler system, furniture purchased after July 6, 2016 must be Class 1 per NFPA 260, or per ASTM E 1353 regarding standard tests for cigarette ignition resistance.
- ▶ Except in buildings protected by fire sprinkler system, mattresses have a char length ≤ 2 inches per 16 CFR 1632
- ▶ Combustible decorations should not be used (poster, paper on walls, pictures) unless rendered flame-retardant
- ▶ Trash and soiled linen containers not to exceed 32-gallon capacity
- ▶ Trash and soiled linen confined to ½ gallon per sq foot.
- ▶ Mobile trash/soiled linen collection carts with over 32-gallons are not left unattended outside of areas protected as hazardous areas. (Exception: Rooms large than 64 sq ft and protected as hazardous areas enclosed in a 1-hour fire barrier of sprinklered.)

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Handout- Suggested Life Safety Binder Index

YOUR SURGERY CENTER LIFE SAFETY LOGBOOK

1. Risk Checklist (Include items)
2. All Fire Test Results
3. Risk Floor Test - Circumstances
4. Disaster DRM - Quarterly
5. Health Protection Agency (HHS) Medical - Annual/Biennial
6. Emergency Lights - Monthly / Annually
7. Emergency Evacuation Drills - Monthly / Annually
8. Fire Alarm - Monthly / Quarterly
9. Fire Alarm System - Quarterly / Annually/semi
10. Fire Extinguishers - Monthly / Annually/semi
11. Fire Drills - Quarterly
12. Fire Marshal - Annual
13. Fire Department - Annual/semi
14. Generator Log (NFPA 704/Annex A)
15. Generator - Yearly/semi
16. Generator Transfer Switch - Weekly / Month
17. HAZOP Risk Change - Quarterly
18. Medical Gas Piping - Monthly
19. Medical Gas Testing - Annual
20. NFPA Risk Assessment - Annual
21. Smoke Detector - Quarterly/semi
22. Smoke Detector System - Monthly
23. Smoke Detector - Monthly
24. Equipment INSPECTED - Check off maintenance
25. Equipment INSPECTED - Yearly report
26. VPP Report - Annual

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Feel free to contact me for further discussion or questions.

cathy@excellentiagroup.com
roger@excellentiagroup.com

Excellentia Advisory Group, LLC
 1-636-875-5088 ext. 102 -Cathy



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