when it came time to begin designing a new, state-of-the-art patient care facility, the leadership at Rush University Medical Center in Chicago decided to go to the people who would be using it. Physicians, nurses, other hospital staff, and patients were asked for their input, which resulted in a facility design that is patient focused and will allow staff to provide high-quality, high-tech care in an efficient and effective way.

Rush is an academic medical center that encompasses a 600+ staffed-bed hospital (including Rush Children’s Hospital), the Johnston R. Bowman Health Center, and Rush University, which includes a medical school and a nursing college. A longtime fixture in the Chicago-area health care community, Rush began planning more than five years ago to determine how the existing campus should be transformed to help the organization meet its goals for the future. The result was a $1 billion, 10-year campus redevelopment plan called the Rush Transformation, which

Continued on page 2
A night view of the new Rush, looking northeast toward the city.
uals were not compensated, although dinner was provided, and parking and transportation costs were reimbursed.

The facility that was designed using the feedback from these groups is a 14-floor, $585 million, 806,000-square-foot building that will house Rush’s acute and critical care patients, as well as surgical, diagnostic, and therapeutic services utilizing the most advanced technology available. It will incorporate a concept called “the interventional platform,” with three floors devoted to surgery, imaging, and specialty procedures. Upper floors will contain 304 acute and intensive care beds, 72 neonatal intensive care unit beds, and 10 labor and delivery suites. The ground floor will house a new emergency department with unique capabilities to handle epidemics and mass casualties. In addition, it will be the first full-service “green” hospital in Chicago. (See “Protection Through Preparedness,” below, and “Greening a Hospital,” page 4, for more on the new ED and the green features.)

**Protection Through Preparedness**

To increase the region’s emergency preparedness capacity, the new Rush hospital will include the McCormick Foundation Center for Advanced Emergency Response—a facility that will be double the size of Rush’s current emergency department (ED).

“The McCormick Center for Advanced Emergency Response will bring an unprecedented level of preparedness to Chicago and the region in the event of immediate and widespread emergencies,” said Dr. Dino Rumoro, chairman of the Department of Emergency Medicine at Rush.

Scheduled to open in 2012, the new ED will house a bioterrorism response center as well as 56 treatment bays, isolation rooms with negative air flow, and double the recommended number of air exchanges. At 46,000 square feet, it will be able to handle 65,000 patient visits each year.

With decontamination space, surge capabilities, and the capacity to handle a sudden influx of ill or injured patients, Rush will collaborate with city, state, and federal authorities to detect and coordinate the region’s response to epidemics and crises of every sort, from seasonal influenza to the release of potentially dangerous biological agents.

The center will also offer advanced diagnostic equipment to facilitate more efficient patient throughput:

- Every room will have a cardiac monitor.
- Each of three patient treatment pods will have its own ultrasound unit and available bedside point-of-care blood testing.
- Radiology will be located in a fourth pod adjacent to the emergency department to reduce wait times for diagnostic imaging.

In addition, the waiting area will be divided into a general waiting area with vending machines and a separate pediatric waiting room to isolate sick children from the general population.

The following are some of the elements of the new hospital that were suggested by the patient and caregiver focus groups:

- All patient care rooms, in every unit, will be identical. Oxygen sources, electrical outlets, medical supplies, and other necessities will always be in the same place, so caregivers can always access them easily, regardless of the location of the patient room. This will also make the building easier to change and update over time.
- Patient care rooms will all be private, including those in critical care, and each will include a bathroom; every room except those in critical care will also have a shower. The rooms will each include a “family zone,” with a small couch that converts to a single bed for loved ones who wish to stay the night.
- The patient rooms will offer Internet access and 42-inch, flat-screen TVs that patients can use to watch television or movies on demand or to access facility information.
- Waiting areas and patient rooms will have additional electrical outlets so patients and families can charge their cell phones and computers.
- All areas will have multiple levels of lighting, with bright lights that can be used for medical exams and...
Of the People . . .
(continued)
Continued from page 3

softer, indirect lighting at other times. The lighting in the halls and other areas will also dim at night, as a reminder to staff and visitors that patients are sleeping. The lighting saves energy and improves the patient experience.

■ Every patient room will have an integrated, ceiling-mounted lift device for patients with mobility issues. This will improve safety for both patients and staff.

■ With input from infectious disease staff, sinks and other surfaces were designed to prevent the spread of infection. Materials that do not hold bacteria easily will be used. In addition, the physical structure of the sinks was changed during the planning process, based on a recently released study; now the sink countertop will be completely separate from the countertop where medications are prepared.

■ Nurses and other caregivers will wear sophisticated communications devices that will allow them to communicate directly with the patient when a call button is pressed. This will allow them to respond to patient needs more quickly.

■ Studies have found that minimizing noise and activity around patient rooms may reduce the need for pain medication and shorten length of stay by making patients more relaxed. Therefore, the facility design includes features such as carpeted hallways and indirect lighting (described above) to provide a more calming environment.

“When we began this process, we didn’t want to ask ourselves, ‘How can we get a new building for Rush?’” Dwyer says. “We decided that the better question was, ‘How do we want a new building to work for us, now and in the future?’ Because of that, we ended up with a better, more useful, more efficient building design that will result in enhanced care and an overall improved patient experience.”

Greening a Hospital

The new Rush facility is being designed with sustainable building materials and includes features to help reduce waste and conserve energy and water. Rush is seeking Leadership in Energy and Environmental Design (LEED) certification, which recognizes organizations that design and construct environmentally responsible and efficient buildings.

“Seeking LEED certification enables Rush to add a green lens to the eye through which our campus transformation is designed and created, fostering environmental responsiveness through resource efficiency,” says Joseph DeVoss, assistant vice president, Capital Transformation, Office of Transformation.

The “green” features of the new hospital include the following:

Engineering
■ Use of 95% recycled steel
■ Use of 40% fly-ash concrete
■ Use of recycled building products everywhere, from structural concrete to interior finishes and furniture
■ Local production (within 500 miles of Chicago)
■ Central power plant’s use of low-CFC chillers and boilers greater efficiency
■ Meeting American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) standards for energy efficiency

Water Conservation
■ Multiple “green” roofs for slow release of rainwater into city storm sewers
■ Use of air conditioner condensation to water gardens (water savings from condensate recycling is 1.3 million gallons per year—filling roughly two Olympic-sized swimming pools)
■ Collection of rainwater in special planters for watering trees
■ Use of microfiber mops (very absorbent, lint-free synthetic fiber), which will save 500,000 gallons of water per year

Energy Conservation
■ Use of passive solar light to brighten waiting rooms
■ Use of energy-efficient systems for heating and cooling, as well as energy-efficient lighting fixtures and bulbs
■ Testing of energy-efficient plumbing fixtures for use in public areas and patient rooms
■ Preferred parking for those who drive energy-efficient vehicles or who car pool, plus additional bicycle racks

Environmental Friendliness
■ Use of environmentally preferable housekeeping products, along with ongoing evaluation of cleaning practices and equipment
■ Comprehensive campus recycling program
■ Indigenous landscaping
■ Operating room–quality air throughout entire new building
Conducting the Fire Watch of Standard LS.01.02.01

Joint Commission life safety standard LS.01.02.01, Element of Performance (EP) 1, discusses how ambulatory care, behavioral health care, critical access hospital, home care, hospital, and long term care organizations must respond to a situation in which the fire alarm system or sprinkler system is out of service for more than 4 hours in a 24-hour period. This EP requires an organization to conduct and document a fire watch* that includes, at a minimum, the following actions:

- Notifying the fire department, fire marshal, or other appropriate emergency response group and documenting when that notification occurs.
- Conducting rounds of the area affected by the outage and documenting those rounds.

With the reorganization of the Life Safety Code®–related standards into the standalone “Life Safety” (LS) chapter in the 2009 accreditation manuals, organizations have had questions about when exactly a fire watch is required during scheduled outages and what the phrase “out of service” means.

When to Conduct a Fire Watch

An organization experiencing a compromising situation (as described above) must implement a fire watch until the fire alarm system or sprinkler system has been returned to service or is stable. In many situations, this distinction comes down to whether an event or activity is scheduled or unscheduled.

A scheduled activity would be an event known to and under the knowledge of and control of organization staff, such as a construction project or servicing or upgrading the fire alarm system or sprinkler system. All other situations would typically be considered unscheduled activities, including a contractor stepping outside the defined boundaries of a contracted service or activity or staff covering an alarm near a cooking area.

The checklist in the box on page 10 is intended only to provide guidance regarding the phrase “out of service”; each organization needs to assess each situation to determine its status and responsibilities. In many cases, even if a fire watch is not required, the organization must evaluate whether its procedures for interim life safety measures (ILSM) should be implemented.

For example, if a fire watch is not required, the organization must evaluate whether its procedures for interim life safety measures (ILSM) should be implemented.

Who Conducts a Fire Watch

Just who can conduct a fire watch? An annex of the National Fire Protection Association (NFPA) 101-2000 explains:

A fire watch should at least involve some special action beyond normal staffing, such as assigning an additional security guard(s) to walk the areas affected. These individuals should be specially trained in fire prevention and in occupant and fire department notification techniques, and they should understand the particular fire safety situation for public education.

In 1998, the NFPA's Healthcare Interpretations Task Force agreed that the clinical staff in an area affected by a fire alarm impairment or a sprinkler system impairment can be used to

Continued on page 10
Mitigating Life Safety Deficiencies with ILSM

Examining the “Life Safety” (LS) Chapter, Part 3

This is the third in a series of articles exploring and explaining the new “Life Safety” chapter in the 2009 standards manuals. The first article appeared in the February 2009 issue of Environment of Care® News and the second in the May 2009 issue. Look for continued discussion of and tips for how to comply with this important chapter in coming issues of EC News.

Suppose for a moment that your organization is installing a new computer system, and an installer inadvertently breaks through a fire-rated barrier. Or perhaps your organization is under construction and the entire sixth floor is busy with the upgrade. What if your sprinkler system has a malfunction and is knocked out of service for half a day? Do you know how to respond to these and other events that result in Life Safety Code® deficiencies that cannot be immediately addressed?

EC News is spending some time over the next few months taking a close look at the “Life Safety” (LS) chapter and its requirements. The goal is to provide clear direction to organizations as they work toward compliance with the standards and ultimately toward improved patient safety and quality of care. This month, the focus is on interim life safety measures (ILSM). These are activities in which organizations can engage to protect patients, staff, visitors, and others within a health care organization during periods when the Life Safety Code is not met, as in the examples posed above. The Joint Commission addresses the topic of


Ensuring Safety During Critical Life Safety Code Deficiencies

The first two EPs of LS.01.02.01 address activities that organizations must do when there are specific lapses in the Life Safety Code.

Alarms and Sprinklers. EP 1 discusses how an organization must respond to a situation in which the alarms or sprinklers are out of service for more than 4 hours in a 24-hour period. The EP requires an organization to notify the fire department, fire marshal, or other appropriate emergency response group and document when that notification occurs. In addition, the organization must conduct a fire watch. See “Conducting the Fire Watch of Standard LS.01.02.01,” on page 5. A typical fire watch involves conducting rounds of the area affected by the outage and documentation of those rounds. “The Joint Commission called out this activity as separate from other ILSM because of the critical importance of maintaining vigilance during a sprinkler or alarm outage and the potential harm to occupants if organizations do not maintain such

* Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.
† The LS chapter is applicable to health care, ambulatory, and residential occupancies. Business occupancies are surveyed for fire safety under the “Environment of Care” (EC) standards.

Interim life safety measures are used when exits such as these are compromised.
“Life Safety” Chapter Outline

I. Administrative Activities
   A. Statement of Conditions (LS.01.01.01)
   B. Interim Life Safety Measures (LS.01.02.01)

II. Health Care Occupancy
   A. All Health Care Occupancy Buildings
      1. General Building Requirements (LS.02.01.10)
      2. Means of Egress Requirements (LS.02.01.20)
      3. Protection (LS.02.01.30)
         a. Fire Alarm (LS.02.01.34)
         b. Extinguishment (LS.02.01.35)
      4. Special Provisions (LS.02.01.40)
      5. Building Services (LS.02.01.50)
      6. Operating Features (LS.02.01.70)

III. Ambulatory Health Care Occupancy
   A. All Ambulatory Health Care Occupancy Buildings
      1. General Building Requirements (LS.03.01.10)
      2. Means of Egress Requirements (LS.03.01.20)
      3. Protection (LS.03.01.30)
         a. Fire Alarm (LS.03.01.34)
         b. Extinguishment (LS.03.01.35)
      4. Special Provisions (LS.03.01.40)
      5. Building Services (LS.03.01.50)
      6. Operating Features (LS.03.01.70)

IV. Residential Occupancy
   A. Lodging or Rooming Houses
      1. Means of Escape Requirements (LS.04.01.20)
      2. Protection Requirements (LS.04.01.30)
      3. Building Services (LS.04.01.50)
   B. Hotels and Dormitories
      1. Means of Egress Requirements (LS.04.02.20)
      2. Protection Requirements (LS.04.02.30)
      3. Special Provisions (LS.04.02.40)
      4. Building Services (LS.04.02.50)

Note: Please see your Comprehensive Accreditation Manual for specific applicability.

During any situation in which a Life Safety Code violation cannot be immediately corrected, such as when a computer equipment installer compromises a fire-rated barrier or when part of the organization is under construction. “In the past, organizations focused on the use of ILSM during construction, but the ILSM policy must also take into consideration any time there is a Life Safety Code deficiency that cannot be immediately addressed,” says Mills.

This EP is the lynchpin for the entire ILSM process, as all the subsequent EPs depend on an organization having a comprehensive, written, and regularly reviewed ILSM policy. If an organization does not have such a policy, it can receive an adverse decision during survey. “It is important that organizations spend time creating, enforcing, and reviewing their ILSM policy,” says Mills. “This ensures that building occupants—patients, staff, visitors, and so forth—are protected from the threats posed by fire.”

An ILSM policy does not have to outline exactly which measures will be used in every situation, but it should describe options to preserve life safety and be broad enough to respond to any deficiencies and construction-related activities. The policy should be written and accessible to all individuals responsible for implementing ILSM during Life Safety Code deficiency situations.

When implementing the policy, designated staff members—such as the

Continued on page 11
Preventing and controlling illness is important to employee safety in any work environment, and it is particularly crucial in health care organizations. Clinical settings, laboratory settings, and infectious disease research facilities present significant opportunities for employees to contract and spread infections. Such infections are not only hazardous to staff but increase the likelihood of infectious spread to patients and the community. In addition, when patient care staff are absent due to illness, the work demands and associated stressors on remaining staff lead to errors, including safety lapses. Health care employers are well positioned to provide timely clinical response to worker illness but may overlook some administrative measures that could improve worker health and safety, such as attention to accurate maintenance and use of aggregate data.

**Injury and Illness Records**

Employees use reviews of health and safety records such as the Occupational Safety and Health Administration’s (OSHA’s) Form 300, *Log of Injuries and Illnesses*, and OSHA’s Form 301, *Injury and Illness Incident Report*, to implement or improve safety and health programs. The analysis of records on illness is a widely recognized method for discovering workplace health and safety problems and for tracking progress in solving those problems.

This process may provide a mechanism to evaluate a health event that may signal underlying preventable exposures. Such events may include a case of unusual disease, disability, or untimely death, whose occurrence may signal a need for preventive intervention in the workplace. In addition, the review of aggregate information on illness as it relates to worker location or duty assignment may reveal a group effect that would not be detected through individual case review.

Identification of a group health effect may signal a problem with hazard control that can be remedied, such as laboratory protocols that cause aerosolization of infectious samples that lead to respiratory illnesses in workers. Health data analysis should also include communication of those findings so that workers become educated about risks they face and ways to reduce those risks.

**Purpose of OSHA Records**

The Occupational Safety and Health Act of 1970 requires the secretary of labor to produce regulations requiring employers to keep records of occupational deaths, injuries, and illnesses. The records are used for several purposes: OSHA uses injury and illness statistics to help direct its programs and measure its own performance; OSHA inspectors use the data during inspections to help direct their efforts to the hazards that are hurting workers; and the records provide data to the Bureau of Labor Statistics Annual Survey of Occupational Injuries and Illnesses, the nation’s primary source of occupational injury and illness data.

The OSHA log serves as an official record of work-related injuries and illnesses for a given workplace. All employees, former employees, their personal representatives, and their

Analyzing records of illness can help uncover workplace safety and health problems.
union representatives can review the log. A separate log must be kept for each site or establishment, and a summary must be posted in a visible location. A work-related injury or illness must be recorded if it results in one or more of the following:

- Death
- Days away from work
- Restricted work or transfer to another job
- Medical treatment beyond first aid
- Loss of consciousness
- A significant injury or illness diagnosed by a physician or another licensed health care professional

It should be noted that certain exceptions apply to OSHA log entries; for example, employers are not required to record cases of the common cold or flu. For additional information, refer to The OSHA Recordkeeping Handbook at http://www.osha.gov/recordkeeping/handbook/index.html.

Errors and Misconceptions

Patricia Bray, M.D., M.P.H., medical officer, Office of Occupational Medicine, OSHA, states that OSHA investigations related to worker illnesses and record-keeping omissions generally occur as a result of employee complaints or “media referrals,” meaning that a significant workplace health and safety problem was reported by a major news source.

In some cases, OSHA investigations have determined that record-keeping personnel didn't recognize that occupational contributions to illness and injury must be noted in the OSHA log. Health conditions often have occupational and non-occupational components; for example, individuals who are predisposed to asthma are more susceptible than others to respiratory irritants encountered at work. However, the known occupational exposure contributing to an asthma attack at work must be recorded on OSHA Form 300.

Likewise, outbreaks of illness in workers may arise from occupational exposures, community exposures, or a combination of both. “When it is more likely than not that a workplace infectious exposure led to a worker's illness, that illness should be recorded on the OSHA Log 300,” Bray says.

The determination of an occupational component is often made by an occupational medicine practitioner, infectious disease specialist, or epidemiologist. The employer must enter each case on the OSHA Log 300 and OSHA Form 301 within seven calendar days of receiving information that a recordable injury or illness has occurred. Employers may later revise an entry simply by crossing it out or amending it if further information justifying the revision becomes available.

Record-keeping personnel should be aware that OSHA's definition of a work-related illness or injury is related to where it occurred, not to the activity being performed. If an injury or illness results from an event or exposure in the work environment, it is considered work related for OSHA record-keeping purposes. Under this definition, there are cases that should be recorded even if they are not a direct result of work activities. For example, injuries that result from horseplay or violence at an employer's establishment may not be considered work related from the employer's point of view but are considered so under OSHA's definition and therefore should be recorded in the log.

Recordable versus Reportable Illnesses

The use of the common terms for recordable and reportable for different regulatory purposes is often confusing. The types of worker illnesses that employers are required to record on OSHA Log 300 are far more inclusive than the reportable illnesses that clinicians must report to state health departments in order to comply with mandatory reporting of infectious diseases.

In addition, OSHA has the following reporting requirement: Within eight (8) hours after the death of any employee from a work-related incident or the inpatient hospitalization of three or more employees as a result of a work-related incident, employers must orally report the fatality/multiple hospitalization by telephone or in person to the area office of OSHA, U.S. Department of Labor, that is nearest to the site of the incident. Employers can also use the OSHA toll-free central telephone number, 800-321-OSHA (800-321-6742).

OSHA Log 300 and Workers’ Compensation

The OSHA record-keeping standard, 29 CFR Parts 1904 and 1952 states, “Recording or reporting a work-related injury, illness, or fatality does not mean that the employer or employee was at fault, that an OSHA rule has been violated, or that the employee is eligible for workers’ compensation or other benefits.” Many cases that are recorded in the OSHA record-keeping system are also compensable under the state workers’ compensation system, but many others are not.

The OSHA record-keeping system is intended to collect and analyze uniform nationwide data on occupational injuries and illnesses. The workers’ compensation system, in contrast, is intended to provide medical coverage and compensation for workers who are killed, injured, or made ill at work. The terms of workers’ compensation coverage varies from one state to another. When an injury or illness occurs to an employee, the employer must independently analyze the case in light of both the OSHA recording criteria and the requirements of the state

Continued on page 10
**Health Care–Associated Illnesses and Record-keeping (Continued)**

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workers’ compensation system to determine whether the case is recordable, or compensable, or both.

**OSHA Log Accuracy**

Many factors influence whether entries to the OSHA Log 300 are maintained in an accurate and complete fashion. Robert K. McLellan, M.D., M.P.H., past president of the American College of Occupational and Environmental Medicine, described the complexities of occupational record-keeping to the U.S. House of Representatives Health Education and Labor Committee in June 2008. He noted that the OSHA log has “grown to serve many purposes beyond that for which it was designed,” sometimes resulting in “efforts to make the log look good, rather than placing attention on reducing risks that lead to injury and illness,” and distracting from the primary goal of prevention. McLellan reported that “some employers exerted pressure on occupational physicians to alter treatment and/or return-to-work statements in ways likely to minimize OSHA recordability.” However, other employers choose to record all injuries and near-misses in order to better detect opportunities for prevention. It was noted that, overall, most medical personnel and managers are working to maintain accurate health and safety records.

Properly maintained injury and illness records can help employers and workers analyze the safety and health environment of their workplaces. OSHA resources are available to assist in this process. A detailed injury and illness record-keeping Web site (http://www.osha.gov/recordkeeping/) provides links to The OSHA Record-keeping Handbook, training presentations, applicable Federal Register notices, a variety of Frequently Asked Questions and OSHA’s record-keeping-related Letters of Interpretation.

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This article was developed through cooperative efforts of OSHA and The Joint Commission/Joint Commission Resources Alliance.

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**Fire Watch (continued)**

Continued from page 5

satisfy the requirements for a fire watch, provided that there is adequate staffing to continuously patrol the affected area and staff have the means to give proper notification to other occupants in the event of a fire.

For questions about conducting a fire watch, please contact the Standards Interpretation Group, at 630-792-5900 or SIGInquires@jointcommission.org.

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### Defining “Out of Service” Responsibilities

<table>
<thead>
<tr>
<th>Service Situation</th>
<th>Fire Watch Required</th>
<th>ILSM Evaluation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Putting a shield over one smoke detector to prevent dust/false alarms for more than 4 hours</td>
<td>No</td>
<td>Recommended</td>
</tr>
<tr>
<td><strong>Rationale</strong>: Other features of fire protection are not compromised during the event, such as additional smoke detectors or sprinkler heads in the affected area.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Covering all smoke detectors during a controlled event, such as only during the time contractors are working in an affected area, although after hours the entire area is fully operational</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Rationale</strong>: During a controlled event, the organization would be managing the deficiency. The area would be continually monitored, and ILSM should be implemented as per policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Shutting off a zone valve to the sprinkler system or disabling a fire alarm zone for more than 4 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Scheduled event (that is, working on, servicing, or upgrading fire alarm system or sprinkler system)</td>
<td>Not in all cases</td>
<td>Yes (emphasis on occupant notification)</td>
</tr>
<tr>
<td><strong>Rationale</strong>: During a controlled event, the organization would be managing the deficiency. The area would be continually monitored, and ILSM would be implemented as per policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Unscheduled event (that is, shutting off a zone valve to the sprinkler system or disabling a smoke zone for more than 4 hours in response to a system failure)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Mitigating Life Safety Deficiencies with ILSM (continued)
Continued from page 7

facility manager or safety officer—have the freedom to choose what activities will address and reduce the level of risk. Such activities do not have to apply to the entire floor or building, unless the entire floor or building is affected by the Life Safety Code deficiency. In most cases, the deficiency applies to one or two areas within an organization, and those areas are where the ILSM must be in force.

Additional ILSM

To determine which activities to include in its ILSM policy, an organization should look to LS.01.02.01, EPs 4–14. These EPs outline the different ILSM options an organization can use to preserve life safety during times of deficiency.

As previously mentioned, organizations do not have to implement all these ILSM options when a Life Safety Code deficiency or construction project is present. They should, however, consider the specifics of the deficient situation and implement the appropriate and applicable ILSM.

The EPs describe the following possible ILSM activities:

- Inspect exits in affected areas on a daily basis (EP 4).
- Provide temporary but equivalent fire alarm and detection systems for use when a fire system is impaired (EP 5).
- Provide additional fire-fighting equipment (EP 6). "Organizations should make sure this equipment is properly and safely stored within the affected area, so that the equipment itself does not present a life safety hazard," says Mills.
- Use temporary construction partitions that are smoke tight, or made of noncombustible or limited-combustible material that will not contribute to the development or spread of fire (EP 7).
- Increase surveillance of buildings, groups, and equipment, giving special attention to construction areas and storage, excavation, and field offices (EP 8). "This surveillance must be maintained even during off hours or on weekends," says Mills. "Engaging in surveillance activities during business hours only will not meet the intent of this EP."
- Encourage storage, housekeeping, and debris-removal practices that reduce the building’s flammable and combustible fire load to the lowest feasible level (EP 9). "Basically, this EP means that organizations must ensure that no storage and debris block safe passage through the building," says Mills.
- Provide additional training on the use of fire-fighting equipment to those who work in the organization (EP 10). "In other words, those who use the equipment must be qualified and trained to do so," says Mills.
- Conduct additional fire drills (EP 11). "These do not need to be organizationwide but must apply to the affected areas," says Mills. For critical access hospital, hospital, long-term care, and home care programs, this EP requires an additional fire drill per shift per quarter.
- Inspect and test temporary systems monthly (EP 12). Organizations must document the dates when tests are completed.
- Conduct education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety (EP 13).
- Train those who work in the organization to compensate for impaired structural or compartmental fire safety features (EP 14).†

“When implementing any of these ILSM, organizations should document when and how they implemented the measures,” says Mills. "Although only EP 12—inspect and test temporary systems monthly—requires documentation, documenting implementation efforts associated with any of the EPs would illustrate compliance during an internal review or Joint Commission survey."

To help ensure appropriate and consistent use of ILSM, organizations may want to conduct regular and routine rounds. These can reveal whether designated ILSM are in place—for example, whether daily rounds occur as expected, whether construction partitions remain standing and intact, and whether fire safety equipment is stored safely.

ILSM are not meant to be merely a task that organizations complete to achieve compliance with the LS standards. These measures, when implemented appropriately, can mean the difference between a safe environment amid fire safety risks and an environment where risks could significantly impact the safety of organization occupants. Each organization should work to develop and implement an ILSM policy to ensure that appropriate and targeted actions are applied in situations in which lapses in Life Safety Code compliance exist.

† Compartmentalization is the concept of using various building components (for example, fire-rated walls and doors, smoke barriers, fire-rated floor slabs) to prevent the spread of fire and the products of combustion, such as to provide a safe means of egress to an approved exit. The presence of these features varies, depending on the building occupancy classification.
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