

TSIG NEWS

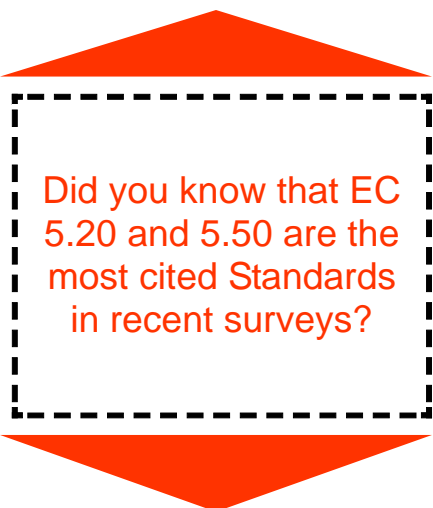
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Did you know that EC 5.20 and 5.50 are the most cited Standards in recent surveys?

HEALTHCARE SECURITY CHALLENGES

VT AFTERMATH

The recent shootings at Virginia Tech and NASA should serve as a wake up call for hospitals across the nation to re-evaluate their current security risk assessment and response plans for responding to similar volatile incidents within their own facility.

If these two horrifying experiences prove anything, it's that serious violent incidents can occur anywhere. In fact, several health care organizations immediately reacted after the Virginia Tech incident. "the first thing I did was contact out local law enforcement liaison to coordinate a meeting to review our communications and response plan" said Carmen Fascia, Director of Security at Mount Sinai Hospital Medical Center.

Fascia added: "We have developed an excellent relationship with law enforcement agencies and they have been very cooperative and supportive in helping meet our security needs. We provide them with our response plans for various security incidents including threats, abduction, elopements, physical assaults in an effort to ensure they not only approve our plans but to ensure that effective lines of communications are available to meet the needs of each specific scenario".

Violence within the healthcare setting is not surprisingly new. In fact healthcare workers, especially those working in high risk settings have long been recognized as having a high risk of work-related assault. In order to respond to high rates of violence, many hospitals have implemented violence prevention programs that include such approaches as administrative policies, physical security, and employee training.

Numerous efforts are in place that requires violence prevention programs be in place. For example, hospitals must show a written security plan that includes a risk assessment that includes violence prevention when reviewed by the Joint Commission. Several states now also have specific requirements. California, in particular, has been at the forefront of efforts to reduce healthcare facility violence. In 1993, the California Occupational Safety and Health Administration released "Guidelines for Security and Safety of Health Care and Community Service Workers," which was the first statewide effort to control violence in the health care setting. The federal Occupational Health and Safety Administration has published "Guidelines for Preventing Workplace Violence for Health Care and Social Services Workers" for employers. Included in these guidelines is information on an effective workplace violence prevention program.

Several studies indicate that violence often takes place during times of high activity and interaction with patients, such as at meal times and during visiting hours and patient transportation. Assaults may occur when service is denied, when a patient is involuntarily admitted, or when a health care worker attempts to set limits on eating, drinking, or tobacco or alcohol use.

HEALTHCARE SECURITY CHALLENGES (Continued)

In 1999 Bureau of Labor Statistics estimated 2,637 nonfatal assaults on hospital workers—a rate of 8.3 assaults per 10,000 workers. This rate is much higher than the rate of nonfatal assaults for all private-sector industries, which is 2 per 10,000 workers.

Although anyone working in a hospital may become a victim of violence, nurses and aides who have the most direct contact with patients are at higher risk. Other hospital personnel at increased risk of violence include emergency response personnel, hospital security personnel, and all health care providers. Violence may also have negative organizational outcomes such as low worker morale, increased job stress, increased worker turnover, reduced trust of management and coworkers, and a hostile working environment.

Hospitals must assess the common risk factors for hospital violence which include the following:

- Working directly with volatile people, especially, if they are under the influence of drugs or alcohol or have a history of violence or certain psychotic diagnoses
- Working when understaffed—especially during meal times and visiting hours
- Transporting patients
- Long waits for service
- Overcrowded, uncomfortable waiting rooms
- Working alone
- Poor environmental design
- Inadequate security
- Lack of staff training and policies for preventing and managing crises with potentially volatile patients
- Drug and alcohol abuse
- Access to firearms
- Unrestricted movement of the public
- Poorly lit corridors, rooms, parking lots, and other areas

To prevent violence in hospitals, employers should develop a safety & security program that includes management commitment, employee participation, hazard identification, safety and health training, and hazard prevention, control, and reporting. Employers should evaluate this program periodically. Although risk factors for violence are specific for each hospital and its work scenarios, employers can follow general prevention strategies.

Environmental Designs

- Develop emergency signaling, alarms, and monitoring systems.
- Install security devices such as metal detectors to prevent armed persons from entering the hospital.
- Install other security devices such as cameras and good lighting in hallways.
- Provide security escorts to the parking lots at night.
- Design waiting areas to accommodate and assist visitors and patients who may have a delay in service.
- Design the triage area and other public areas to minimize the risk of assault.

HEALTHCARE SECURITY CHALLENGES (Continued)

- Provide staff restrooms and emergency exits.
- Install enclosed nurses' stations.
- Install deep service counters or bullet-resistant and shatterproof glass enclosures in reception areas.
- Arrange furniture and other objects to minimize their use as weapons.

Administrative Controls

- Design security response procedures including emergency evacuation plans.
- Design staffing patterns to prevent personnel from working alone and to minimize patient waiting time.
- Restrict the movement of the public in hospitals by card-controlled access.
- Develop a system for alerting security personnel when violence is threatened and maintaining hazard awareness.

Behavior Modifications

- Develop and train staff to take self preservation measures to protect themselves and others.
- Provide all workers with training in recognizing and managing assaults, resolving conflicts, and maintaining hazard awareness.

Even assessing the needs above may not prove enough- recent security audits at multiple hospital locations uncovered that many hospitals have taken some steps to reduce violence. Although many of these hospitals have some form of violence prevention programs, many of the programs were found severely deficient. Based on these findings, we have several recommendations:

Hospitals could benefit greatly from improved surveillance and reporting. Many hospitals do not have written procedures to track and learn from reported violent events. Other hospitals had multiple, independent reporting systems that could not provide an overall picture of the violent events that had occurred. Ongoing examination of reported violent events is the best method to develop evidence-based and tailored programs that work well in each specific hospital environment.

Enhanced efforts should be made to encourage coordination between health care and security staff. Medical and security staff rarely train together, and medical staff often report dissatisfaction with security staff. The few hospitals that have coordination between medical and security staff reported very high satisfaction rates. Strategic planning should be coordinated with representative from all effected groups.

Training programs need to be tailored to the specific hospital environment. Specifically, they should include a review of trends in violent events and information on hospital policies, procedures, and security equipment. While most programs address the major issues in violence prevention and response, the information was predominantly from an outside source with no integration with specific hospital information. We recommend that systematic evaluations of these training programs be evaluated to identify the most effective and efficient methods to deliver workplace violence training, including training content, length, modality, and trainer fidelity.

Although all hospitals train the majority of personnel in the ED and Psychiatric units, few hospitals train all employees regularly. Consider training all staff in all areas.

(Continues on Page 4)

HEALTHCARE SECURITY CHALLENGES (Continued)

Workplace violence training often occurs on a recurring schedule, and sometimes only once per year. Employees hired just after one of the scheduled training sessions may work in their unit for a very long time before receiving any formal training. Ensure that all employees attend new employee orientation and receive department-specific training once they begin work.

Many hospitals have installed security equipment and make attempts to control the physical environment. While some of these efforts are highly sophisticated, some are found to be uncoordinated and insufficient to protect the unit. We recommend that security equipment be installed in response to specific risk assessments conducted by trained security personnel in conjunction with their unit staff, and that scientific evaluations be conducted to identify the most effective equipment within different hospital settings.

Seldom is it discovered that hospitals have actively reached out to local law enforcement agencies to review and approve their plans. This combined with the overall lack of effective pre-planned communications between the hospital and law enforcement agency could prove a serious consequence during a volatile security incident. Hospitals should be encouraged to invite the participation of these agencies to establish effective communication measures, command locations, identify high risk locations and even serve to critique security drills.

Few hospitals have effective systems to communicate and alert staff about the presence of violent patients. The most common system involved writing information within the patient's chart, which is not accessible to non-medical personnel, including security personnel.

Health care workers often times are not aware of existing sources of information about reducing the potential risk or the protective measures afforded. However, those that are trained on the risk assessment process will be more likely to be aware and to use them.

TSIG Consulting has extensive experience with conducting comprehensive security risk assessments for both acute care facilities and behavioral health settings. Feel free to contact us at: info@tsigconsulting.com

Additional resources:

A CDC/NIOSH article publication: Violence, Occupational Hazards in Hospitals can be obtained at: <http://www.cdc.gov/niosh/2002-101.html>

OSHA provides a eTool titled: Workplace Violence, Healthcare Wide Hazards Module can be found at: <http://www.osha.gov/SLTC/etools/hospital/hazards/workplaceviolence/viol.html>

OSHA also publishes: Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers.

Surviving JCAHO's New Life Safety Survey Process Is your Team Ready?



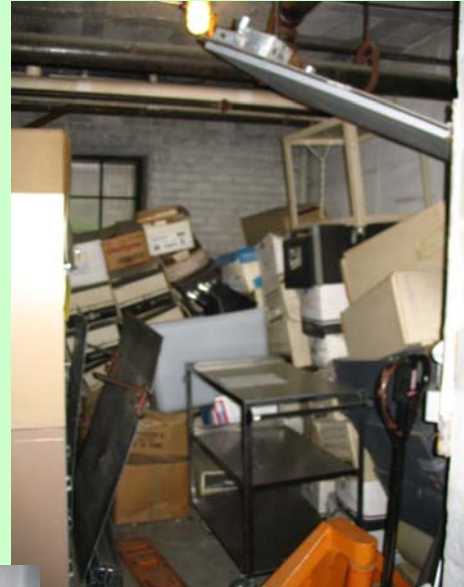
Save The Date

Friday June 8th, 2007 @ The Marriott
Hartford Downtown
200 Columbus Blvd, Hartford CT
Registration and Continental Breakfast
8:00 a.m.—8:30 a.m.
Program Time
8:30 a.m.—12:00 p.m.

Register on Line @ <http://www.tsigconsulting.com>

Corridors Look Familiar

Most healthcare organizations have the problems illustrated below. TSIG Consulting can tour your facility and advise you how to remedy this problem. Sometimes it takes an outsider to help the decision process!



Reducing the Risk of Patient Suicide

One significant way of assuring patient safety in a behavioral health environment is by assessing suicidal behaviors in hopes of reducing the risk of suicide. This is a primary concern among not only clinicians who evaluate and treat suicidal behavior, but now an established patient safety goal with the Joint Commission. The fact exists that sometimes in the course of treatment a patient commits suicide. In fact, according to Joint Commission statistics, suicide is one of the leading causes of deaths in their sentinel event database. Patient suicides can be a devastating event for the patient's family friends and the treatment team, as well as one of the most frequently defined cause of lawsuits against behavioral health professionals.

Improving patient safety for those at risk of suicide is an important goal when the personal, professional and monetary costs are so high. Therefore, the American Psychiatric Association has developed a risk management strategy that has the potential to support patient safety and reduce the liability of health care organizations. The methodology set out by experts for improving patient safety involves identifying errors, analyzing the causes of preventable errors and developing better processes and systems to prevent those problems and errors in the future. This five-step risk management process is designed to reduce the lethal means and methods of self harm as a patient safety measure for patients with suicidal behaviors.

STEP 1 Identify current & potential risks

The potential for self harm by a patient with suicidal ideation exists through their evaluation and treatment. The risk that a patient will commit suicide is highest when the patient is most vulnerable and least able to protect themselves. The accessibility of lethal means and methods of self harm increases the risk of self destructive behavior.

STEP 2 Evaluate the risk

It is important to recognize the frequency and severity of patient suicides. Some of the most frequently reported means of suicide within a hospital are suffocation, medication overdose and falls Reducing the risk requires a systematic approach.

STEP 3 Choose a risk management strategy

Restricting access to lethal methods of self harm can be an effective strategy to prevent self destructive behaviors.

Some of risk management strategies for reducing the risk might include:

During the evaluation of the patients with suicidal behavior, ask about suicide plans and whether a method has been considered. Inquire as to any history of previous attempts and the methods used.

Documents the evaluation of the risk of access to lethal means and methods of self harm, plans for restricting access and instruction to the patient and family members.

STEP 4 Implement the strategy

Incorporate the evaluation of lethal means and methods of self harm as a standard part of the assessment and treatment of patients with suicidal behaviors. Take appropriate action to restrict access to lethal methods.

STEP 5 Evaluate the strategy

Incorporate the continuous evaluation and improvements of these strategies for reducing suicide risk for patients in your hospital.

In our next newsletter we will describe how to implement this strategy and provide specific recommendations for the prevention of patient suicide while outlining some practical approaches toward assuring a safe environment by assessing the risk and implementing safeguard measures.

Emergency Management Survey Process

Some of the most significant changes in Joint Commission standards for 2007 are in the area of Emergency Management plan testing, EC 4.20.

Although hospitals are still required to conduct at least two exercises of the emergency plan each year, the Joint Commission no longer requires a separation time between the two. Gone is the requirement: “at least 4 months apart and no more than 8 months apart”. This change appears to be rational especially when it would prove ridiculous for hospitals that have just responded to several actual events would be expected to plan for their next exercise. Imagine being a hospital in Louisiana after Hurricane Katrina and having to be concerned about planning your next drill for compliance purposes when you still haven’t recovered from the actual disaster.

However, other requirements have remained the same, such as:

- ⇒ exercises can be either a planned event or the actual response to a true emergency situation.
- ⇒ hospitals designed as designated receiving stations must perform one exercise involving an influx of real or simulated patients.
- ⇒ each hospital should take part in at least one community wide exercise per year.

Some of the biggest changes that you can expect surveyors to validate during survey now include:

EC.4.20.7 requires that an independent evaluation is overseen by an objective individual who is not directly involved in the plan. This provides an opportunity to objectively critique the performance of response plan without having to be also be concerned about their own role in said plan. The person(s) serving in this capacity can be either an employee, physician or even someone from the outside who is familiar with the goals of your plan. A sound recommendation might be swapping a member of your facility with another from a local hospital and or utilizing your local Office of Emergency Management and/or Emergency Agency to have a member serve to critique your response. ‘Outside Eyes’ can often lend to new ideas from a different perspective. An example of this might be to include your local FBI office or Police Department representative critique your Infant Abduction Drill. It is critical that you ensure to document who serves in this role (as ‘observer’) for each of your two exercises.

EC.4.20.8 thru 11 now requires when conducting each disaster exercise, the following performance areas must be monitored:

- ⇒ Event Notification
- ⇒ Communication
- ⇒ Resource Mobilization
- ⇒ Patient Management

Since each of these areas were probably evaluated in some fashion during your past drills, this should not be too difficult to achieve. However, it is imperative that organizations incorporate each of the performance measures into your critique form / document to assure there is an illustrative record that can be effectively communicated to surveyors come time of survey.

EC.4.20.14 requires hospitals to modify their emergency management plan- based on those deficiencies or “lessons learned”, uncovered during the time of each exercise. In other words, not only must you critique each exercise but there must now be some effort by the organization to refine and improve their response plans based on said critique.

EC.4.20.15 requires a reevaluation of those changes implemented from the time of your last exercise (as described above). These two changes make perfect sense considering the fact that far too often hospitals do a great job at evaluating and critiquing their planned exercises, but often times fall far short of making the necessary changes for improving upon them. These new requirements force hospitals into assuring that corrective measures are not only implemented but also re-measured to assess the effectiveness. Even if similar or worse outcome is measured during your next exercise, Joint Commission will be seeking to assure you are practicing basic quality improvement.

Since the tracer methodology now permeates the survey agenda, it is now evident that Emergency Management takes the lead in serving as the primary EC Tracer. Currently, as part of the EC Interview, a surveyor will allocate approximately 1.5 hrs. to present a scenario wherein a hypothetical disaster to test the ability of your hospital disaster team to respond. This process is similar in design to a table-top / Q&A exercise. The surveyor wants to see the function of the command center and how the organization responds. Numerous questions will be asked, such as how do you secure additional staff, how are alternative water and utility systems secured, what is the role of the security staff vs. the community police department, how is the news media kept informed and managed, etc. Hospitals should have a small committee ready to deal with this aspect of the survey, and mock interviews are highly recommended on an annual basis to assure continuous readiness. Preparation is a team work affair, and the more involvement from hospital departments the better for safety and for optimal Joint Commission survey outcomes.

Should you need a sample of a sound critique form that incorporates all the changes identified under EC.4.20 or you would like a list of sample questions asked during the Emergency Management EC Tracer Interview, please feel free to email us your request at: info@tsigconsulting.com

Recent Survey Experience

In our ongoing effort to share with our readers critical information pertaining to the Joint Commission survey process, we are now providing periodic updates of recent survey experiences, emphasizing the focus on Environment of Care issues. Please be advised that although these summary reports contain valuable information to better prepare your organization for your next survey, some of the questions and comments made by the survey team members are subjective in nature and do not reflect actual standard and/or code requirements. Should you have any questions, please free to contact us via email at: info@tsigconsulting.com

This summary describes a three-day survey that took place in February of this year for a 25 bed acute care (+10 bed behavioral) hospital and this survey was a critical access survey.

The following documents were requested at the start of the survey:

- PI Data from the past 12 months
- IC surveillance data from the past 12 months
- Analysis from a high-risk process
- EOC data including the SOC from the last survey
- Plans for Improvement
- Mgmt plans and annual evals & EOC minutes for the 12 months prior to survey
- IC Plan (w/ risk assessment)
- Organization chart
- Map of organization
- List of all sites eligible for survey
- List of departments/areas/programs/services within the organization
- List of patients incl. Name, location, age, diagnosis and LOS
- List of scheduled surgeries & special procedures
- List of unapproved abbreviations
- Key contact person who can assist in planning tracer selection
- MOS identified in plan of action(s) from PPR
- Oryx data
- Organ donation and procurement conversion rates
- Medical record delinquency data
- Any agreement with another facility that you share medical record information or access medical record information

Maternal Child Health Unit

- In a Code Adam, what does the rest of the hospital do?
- Have you ever caught the perpetrator during a Code Adam drill?
- How long does it take for alarm to go off once the newborn's band breaches the security point?
- Any improvements made as a result of Code Adam drill?
- Looked in storage room
- What areas does generator supply ER power?
- Sprinkled?
- Any penetrations?
- How are outside companies handled?
- Is PM system automated?

Main Floor

- Smoke barriers
- Fire barriers
- Are door sweeps/asragals UL listed (in between doors)?
- How many fire extinguishers in building?
- Are dampers tested every 4 years?
- Interviewed admitting staff, what happens when alarm goes off?
- How do you know who's on-call from Plant Operations?

Recent Survey Experience

Nutrition Services/Cafeteria Kitchen

- Asked chef, how do you handle a fire?
- Looked in storeroom.
- Looked at entrance where supplies are delivered.
- Wanted hood cleaning sheets.
- Looked for ice build-up in walk-in freezer.
- Are supplies labeled, dated and rotated?

Generator Room/Downstairs

- Requested generator testing records.
- What is turnover time when one generator stops and the 2nd generator starts?
- Requested Battery Testing Records (for batteries operated on patient care units).
- How are oil levels monitored? How much fuel available in case of a disaster?
- O2 tanks secured inside? O2 tanks outside secured and on a cement pad?
- Saw a mercury spill kit on the wall and wanted to know how much mercury we had.
- X-ray storage, looked for 18" clearance from ceiling.

Data Use Session

- How did we improve the QI initiative?
- How is data collected for critical test reporting? (wanted to see it) Time frame. What happens if the provider doesn't respond after the 1st call?

What has the hospital done to improve patient fall rate? (q 12 hour shifts, low beds, bed exit alarms)

EOC Session

- 7 plans available at session, and questions, as below.
- Surveyors requested hazard vulnerability study be brought to EOC session
- What is role of safety officer?
- What problems were identified during safety surveys?
- What is smoking policy?
- How are security incidents identified?
- Hazardous waste: What is in red bag waste? How is radiation waste handled?
- Medical Equipment: Describe system.
- Any contracted services like CT? How are PM's handled for contracted services? (PM dates in notebook for staff to monitor).
- How many pieces of equipment at hospital?
- How are recalls handled? Walk through the process by giving recall example.
- What is most recent problem in fire safety?
- What have you changed recently in training/education in fire safety?
- Describe ER preparedness plans.
- Does Infection Control get involved with interim life safety measures?
- Hazard Vulnerability: What vulnerabilities have been identified?
- Who determines whether to activate the ER preparedness plan?
- How do you handle staffing?
- Is homecare involved in hospital's ER preparedness plan?
- Is there a priority system? (for seeing patients in blizzard)
- How many drills per year?
- Does homecare participate in drills?
- What coordination goes on with hospice, homecare and off-site facilities (clinics)?
- How often is hazard vulnerability plan reviewed?

Recent Survey Experience #1 (continued)

- Who does it?
- Is a risk assessment of hospital performed? (environmental factors) –Surveyors suggested that it can be done by outside company & then rank priorities.
- What improvements have been made?
- Tell us about the occupational health program and how workers' comp injuries are handled.

Tour of Pharmacy

- How are meds signed out on off hours? Access to narcotics?
- What is done the next morning? (sign-out log is compared to orders)
- What IV solutions are mixed by nursing? (oxcitocin)
- Clean room, mobilized isolation unit certified every 6 months.

Recent Survey Experience #2

JCAHO walked into our facility Tuesday 1/23/07 for their unannounced 4 day. The official announcement was posted to their website the morning of the visit with surveyor photos and bio. There were 4 surveyors, the normal 3 (administrator, physician and nurse) plus a life safety specialist. The Life safety specialist is only on site for one day which was the first day in our case.

The life safety day was a 2 hr. document review session and a 4-5 hr. building tour. At 8:30 the surveyor met one on one with the EC chair and talked about the eSOC and handed us a list of documents he wanted to see at 12:00 which was supposed to be the document review session. The document review started promptly at 9:00 AM followed by the building tour, I have a copy of the list he handed us is available if anyone is interested.

A few bullets:

- Pay close attention to EC 5.50 ILSM measures. In their own words, “we’ve broadened our approach to 5.50 where ISLM need to be implemented for any known life safety code deficiency, not just during construction or renovations projects”. Summary: you need to do a risk assessment for any known LSC deficiency and act appropriately. The criteria in your P & P for implementing ILSM’s should mirror the 11 elements identified in 5.50 as well as having a risk assessment form. I strongly recommend you take a close look at this.
- Generator testing: He looked at our monthly generator testing reports to make sure we were testing our transfer switches and it is documented. Surveyors comment “a lot of people just write down the transfer time i.e. under 10 seconds which isn’t sufficient.”
- Building Tour: the new approach is “see it, write it”, no more “fix it before they leave and it goes away.”
- Day 2 was the E of C session, broken into 2 parts. The first was a form of document review where the surveyor asked each component chairperson a few questions.

Part 2 was a 2 Hr. emergency management session where they picked a topic from our HVA and made us do a drill. The surveyor acted as facilitator and gave us a scenario, added a few twists during the process and then sat back and watched us do our thing. What she was looking for was too see if we were using the Incident Command System and if people knew their roles.

Reprinted with Permission From: *Bob Maniatis, CHSP*

If you would like to contribute an article for the benefit of the industry with your recent experience, we will print it in our next newsletter.

Did You Know?

Every **TSIG** client receives his own internet site called “Life Safety Center” wherein he/she has 24/7 access to all information prepared by **TSIG** including

BBI'S

PFI'S

BMP'S

BUILDING FEATURE DRAWINGS

DEFICIENCY DRAWINGS

LINKS TO:

DAMPER SURVEY (if available)

EC TRACKER (if subscribed to—see below)

PROFESSIONAL ORGANIZATION LINKS

TSIG NEWSLETTER

AND ANY INFORMATION RELATIVE TO LIFE SAFETY THAT YOU WISH TO INCLUDE.

AND THE BEST OF ALL — ITS FREE

And Did You Know?

OUR NEW ENVIRONMENT OF CARE TRACKER (ECT) SOFTWARE ALLOWS YOU TO SCHEDULE AND TRACK ALL REQUIRED JC, NFPA, POLICY, BMP AND LOCAL JURISDICTIONAL REQUIREMENTS. E-MAIL REMINDERS ARE AUTOMATICALLY SENT TO YOUR IN-HOUSE PERSONNEL OR VENDORS.

USE ECT FOR 60 DAYS WITHOUT OBLIGATION. IF YOU WISH TO CONTINUE TO USE IT, AS WE ARE SURE YOU WILL, THERE WILL BE A LOW MONTHLY HOSTING FEE. PLEASE CALL DAVID VINAS AT 212-420-8724 EXT. 238 FOR MORE INFORMATION.

Surviving JCAHO's New Life Safety Survey Process

TSIG Work Shop

June 8, 2007

Marriott Hartford Downtown

200 Columbus Blvd, Hartford CT

Speaker Profile



George Rivas, CHPS

George is recognized as one of the nation's leading experts in healthcare regulatory compliance, with a career that spans over twenty years in providing quality training and consultation for highly successful survey outcomes. George is the former Chief of the Fire Department for one of the largest VA Hospitals in the Country and has provided NFPA Life Safety Code ® training for hundreds of Hospitals nation-wide. He has also provided NFPA and JCAHO training for facility managers and safety officer for Military Hospitals all over the world.

Firm Profile

TSIG Consulting, Inc. is one of the largest firms performing JCAHO consulting services, training and education with clients nationwide. Our survey team of professionals are industry leaders in life safety code analysis, engineering, facilities management, and the JCAHO survey process.

TSIG Services include:

- SOC Preparation
- EC Continuous Readiness Program
- Mock Survey's
- eSOC services
- Fire Drills ILSM & PCRA Assessments
- Preparation of AutoCAD drawings

Register on Line @ <http://www.tsigconsulting.com>

Program Agenda

Program Key Components

- ◆ Historical overview of the Life Safety Code (LSC) survey process
- ◆ Who are the LSC surveyors?
- ◆ Defining the LSC Survey Process
- ◆ Document Review Session and Preparation
 - **Life Safety Records**
 - ⇒ Fire Drills
 - ⇒ Fire Plans
 - ⇒ Risk Assessments
 - ⇒ Testing Alarm Systems
 - ⇒ Testing Suppression Systems
 - ⇒ Fire Safety During Construction
 - **Utility Records**
 - ⇒ Generator Testing
 - ⇒ Changes for 2007
 - ⇒ Automatic Transfer Switch Testing
 - ⇒ Emergency Lighting Tests
 - ⇒ Medical Gas System Testing
 - **Interim Life Safety Measures (ILSM)**
 - **Preconstruction Risk Assessments**
 - **Common Problems**
 - **Useful Tools and Practices**
- ◆ Other Critical EC related Documents
- ◆ Maintaining the Statement of Conditions (SOC)
 - **Who performs the SOC**
 - **Keeping it a "living document"**
 - **Acceptable record keeping practices**
 - **Common Problems**
 - **Obtaining Equivalencies**
- ◆ Changes in the SOC for 2007
- ◆ Designing an effective Building Maintenance Program (BMP)