

# ASHE

American Society for Healthcare Engineering  
of the American Hospital Association

## Minutes - Healthcare Interpretations Task Force

Date: September 10, 1998

### Attending Representatives:

Robert Solomon, Chairman, National Fire Protection Association  
Dean Samet, Joint Commission on Accreditation of Healthcare Organizations  
James Merrill, Health Care Finance Administration  
Tom Gardner, American Health Care Association  
Phil Jose, Department of Veterans Affairs  
Kenneth Faulstich, Department of Veterans Affairs  
Douglas Erickson, American Society for Healthcare Engineering  
George Mills, American Society for Healthcare Engineering

### Members Absent:

Walter Smittle, Fire Marshal Association of North America

From: Douglas S. Erickson, Recording Secretary

Subject: Minutes of the September 10, 1998 Meeting of the Healthcare Interpretations  
Task Force

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### Call to Order:

The meeting was called to order by Chairman Mr. Robert Solomon at 9:20 a.m.

### Approval of Minutes:

The minutes of the February 19, 1998 meeting were approved.

### Meeting Agenda:

Mr. Solomon requested approval to follow the tentative agenda he sent out last week. The Healthcare Interpretations Task Force approved the agenda.

Discussion and Action:

1. Mr. Solomon reviewed the process for the meeting and the voting procedures approved by the Multi-Organizational Task Force. He reminded the HITF that only the JCAHO, VA, HCFA, and FMANA are able to vote on the motions presented and it take a  $\frac{3}{4}$  approval for a motion to become an official position of the task force. With the absence of the FMANA representative, the vote at this meeting will need to be unanimous in order to be forwarded for publication.
2. HCFA has not appointed an official representative, however, for this meeting Jim Merrill will represent the organization.
3. Mr. Solomon asked about the methods of communications the committee membership are going to use to publicize the results of this meeting. He reminded each organization that the final memo on the interpretations task force has been approved with a 30 day deadline for distributing the meetings approved outcomes. The HITF was concerned about how the health care constituents would know who we are and what makes the interpretations official. **Mr. Solomon volunteered to put together an introductory paragraph or two on the purpose, mission and membership of the task force.**

**Included with each publication of the approved interpretations will be this set of introductory paragraphs so the field understands who has issued the interpretation.**

4. Mr. Jose asked about the length of time the official interpretations are valid for once they have been published. The task force agreed that the interpretations will be locked to a specific edition of a standard and will be valid until that code or standard is changed, or forever if no code change is requested.
5. It was re-emphasized that all requests for interpretation need to come from one of the seven task force organizations.
6. All requests for interpretation should be submitted to Mr. Solomon at least 10 days in advance of the meeting. New business will always be accepted at the HITF meetings and issues can be introduced at that time, however, it is the desire of the membership to have advanced warning of the material being submitted. Mr. Jose suggested that all communication be handled through email and the task force membership agreed that this is the most efficient method of communication. Mr. Solomon is looking into having a button on the NFPA web page that would permit this task force to communicate through their web page.
7. The subject material to be reviewed by the task force should be generically presented so we are not reacting to a specific field condition. Organizations are urged to modify requests that are specific in nature so they can be answered in a general fashion. The task force is to make interpretations on those standards approved by the MOTF and should avoid providing

guidance on standards compliance. Requests for interpretations on the AIA Guidelines, ASHRAE, and OSHA standards will not be considered unless there is a conflict and a need to send a recommendation forward to an organization to resolve the conflict.

8. A concern surfaced about how we keep a hospital or consulting firm from gaming the system by modifying one of the HITF's interpretations. It was decided that each of the interpretations will be sequentially numbered, and identify a specific code, section and edition.

**An official form needs to be developed which includes the above reference material and the necessary background for making the interpretation. Robert Solomon will be revising the initial document to include the items referenced.**

Interpretations:

1. **NFPA 101, 1985 - 1997 editions, Sections 12-2.5.2 – 12-2.5.8 and 13-2.5.2 – 13-2.5.8 Suites of Rooms.**

**ACTION:** The Healthcare Interpretations Task Force voted 3 to 0 to send this item forward to the NFPA for a formal interpretations by the Technical Committee on Health Care Occupancies.

**RESPONSE FROM NFPA:** The sleeping suite issue has opened a can of worms at the NFPA. We have checked back to 1981 code and it appears that constant, visual supervision was required across the board for any suite that had more than 8 beds regardless of what the suite was used for. I am having Mr. Harrington research the TCR/TCD info that revised these rules. I also spoke to Jim Lathrop at a seminar yesterday. Jims recollection was that the revisions to the suite rules were intended to be editorial, but it now clearly looks like a major change. So, this cannot likely be evaluated with an interpretation, but rather, it may necessitate a TIA.

Also, the other issue that came up here is: Does the sleeping suite that was described by Phil actually sound like a ward? Is the ward concept still used? What is the difference between a ward and a suite?

2. **NFPA 101: 7-7.5 & 7-6.1.4, JCAHO: EC.2.12a(2), NFPA 25: 9-2.7, NFPA 72: 7-3.2**

**QUESTION:** There needs to be a resolution for the conflict between the testing frequency requirements between NFPA 25 and 72 for water flow alarm testing.

**ACTION:** The Healthcare Interpretations Task Force voted 3 to 0 to table this issue until Mr. Solomon has an opportunity to review this issue with the appropriate NFPA staff. He will report back to the next task force meeting and at that time the task force may issue an

interpretation if NFPA has not resolved the issue.

**BACKGROUND:** There is a conflict in the NFPA standards on the frequency of testing water flow devices. The HITF is of the opinion that the NFPA needs to resolve this conflict and should look at the compelling documentation to retain the semi-annual frequency for all water flow devices which are part of an electrically supervised fire alarm system. This would follow the criteria specified in NFPA 72. For those water flow devices which are mechanical or only sound a local signal and not monitored the NFPA 25 frequency of quarterly might be required.

### 3. INTERPRETATION #98-1

#### **NFPA 101, 1985 Edition –**

**QUESTION:** Was it the intent of the Life Safety Code prior to the 1988 Edition to permit doors in the means of egress of health care facilities to be locked where the clinical needs of the patients required specialized security, provided staff can unlock the doors at all times?

**ANSWER:** Locking of these doors is acceptable provided: The clinical needs of the patients require specialized security measures for their safety; and Staff can readily unlock such doors at all times.

**BACKGROUND/SUBSTANTIATION:** Prior to the 1988 edition of the *Life Safety Code*, the code only permitted doors in the required means of egress of a health care facility to be locked with time delay type locks or in mental health facilities with keys. The more recent editions of the code now refer to the clinical needs of the patient and do not limit key locking to just mental health facilities.

For example, today's nursing homes have Alzheimer's units or wings. Alzheimer's is not a mental health condition and was not identified prior to the mid 1980's other than through vague terminology such as "senility" or "dementia".

AHJ's using editions of the *Life Safety Code* prior to 1988 are not permitting nursing homes to lock Alzheimer's units other than with time delay locks (special locks) because they are not mental health facilities. Time delay locks are totally inadequate for Alzheimer's patients. Alzheimer's patients have no idea that their pressing on the panic bar is the cause for the alarm and the locks eventually open without staff interceding. The constant alarming only causes the staff to disconnect the systems.

**ACTION:** The Healthcare Interpretations Task Force voted 3 to 0 to pass this interpretation.

### 4. INTERPRETATION #98-2

#### **NFPA 101, 1985 - 1998 Edition, Section 12-3.6.3 and 13-3.6.3 Undercuts on Corridor**

## **Doors**

**QUESTION 1:** Is it the intent of 12-3.6.2.1 and 13-3.6.3.1 to require conformance with NFPA 80, *Fire Doors and Windows* for non-rated corridor doors?

**ANSWER 1:** NO.

**QUESTION 2:** Would a non-rated corridor door, provided with an average 1 inch undercut, be an acceptable arrangement?

**ANSWER 2:** YES

**BACKGROUND/SUBSTANTIATION:** After reviewing the original intent of this section along with recent fire modeling of a typical patient room or use area room door, the task force was of the opinion that an undercut of 1" would not jeopardize the safety of the room occupants or provide a substantial increase in the amount of combustion air for the fire. The main purpose for limiting the overall dimension of an undercut is keep the gap between the door and the floor from becoming the primary source of ventilation or exhaust for the room. The one inch dimension was not selected based on any scientific facts, but as a measurement which should resolve the majority of existing deficiencies cited. Surveyors and other authorities having jurisdiction must be aware that the real issue is not the height of the undercut, but whether this is a primary source of ventilation or exhaust air.

**Action:** The Healthcare Interpretations Task Force voted 3 to 0 to pass this interpretation.

## 5. **NFPA 220**

**Question:** Can fire resistive construction have exterior non bearing walls constructed of combustible materials?

This issue was discussed with no specific resolution from the HITF. Mr. Solomon will update the task force at it's next meeting on the direction the Technical Committee on Building Construction is going with this issue.

**ACTION:** No action by the Healthcare Interpretations Task Force as this is an NFPA issue.

## 6. **INTERPRETATION #98-3**

**NFPA 101, 1997 Edition.**

**QUESTION:** Can the normal clinical staff in an area affected by a fire alarm impairment or a sprinkler system impairment be used to satisfy the requirements for a fire watch?

**ANSWER:** YES. Clinical staff can fulfill this role provided that there is an adequate staffing level to continuously patrol the affected area and that they have the means to make proper notification to other occupants in the event of a fire.

**BACKGROUND/SUBSTANTIATION:** A fire watch is currently defined in the NFPA 101-1997 Life Safety Code, Appendix Section 7-7.5, which states:

A fire watch should at least involve some special action beyond normal staffing, such as assigning an additional security guard(s) to walk the affected areas. These individuals should be specially trained in fire prevention, in the use of fire extinguishers and occupant hose lines, in notifying the fire department, in sounding the building fire alarm, and in understanding the particular fire safety situation for public education purposes. Some authorities having jurisdiction require fire fighters to be assigned to the area, with direct radio communication to the fire department.

The Healthcare Interpretation Task Force identified only one specific criteria in the above, that the 'fire watch should at least involve some special action beyond normal staffing'. The rest of the appendix note is suggestive (i.e. the use of 'such as...'). Therefore, with the understanding that the above fire watch language is not specific to an occupancy, and that the typical healthcare staff person is familiar with appropriate fire safety and facility fire plan, the only aspect of this appendix being supported by the task force beyond this heightened awareness, is an organizations performance of a risk assessment to determine if it is necessary to implement 'special action beyond normal staffing' as suggested in the appendix.

**ACTION:** The Healthcare Interpretations Task Force voted 3 to 0 to pass this interpretation.

**7. NFPA 101, All Editions, Section 12-1.1.4.5 of the 1998 Edition Definition of Major Renovations, Alterations and Modernizations**

While the Healthcare Interpretations Task Force is sympathetic to the confusion and misapplication of this section of the code, a new definition does appear in Section 1-3.7 of the 1998 edition which should clear up some of the interpretation issues. **Mr. Solomon will also provide the task force with the language that HUD has adopted on renovations.**

Other Business:

1. The chairman requested Mr. Merrill to push HCFA for an official representative.
2. The name of the task force has been titled "Healthcare Interpretations Task Force" (HITF).
3. The next meeting will be on Tuesday, November 17, 1998 following the Multi-Organizational Task Force Meeting. It is assumed that this meeting will start at

approximately 3:00 p.m. and conclude at 6:00 p.m.

4. The meeting was adjourned at 4:10 p.m.