

HEALTHCARE INTERPRETATION TASK FORCE

19 NOVEMBER 2003

**Reno Hilton
Reno, NV**

MINUTES

1. The meeting was called to order at 10:10 AM.
2. Members and guests present were:

MEMBER

Ken Faulstich
Phil Hogue*
Tom Jaeger
Dean Samet
Robert Solomon
Dale Woodin

REPRESENTING

VA (Alternate)
DOD
Gage-Babcock – AHCA
JCAHO
NFPA
ASHE

GUESTS

Chad Beebe (Guest)
Josh Elvove
George Johnston (Guest)
Susan McLaughlin (Guest)
Tom Schipper (Guest)
Dick Strub

REPRESENTING

Washington St. DOH
VA
LLUMC
ASHE
Kaiser Permanente, ASHE
AHCA

3. The agenda was reviewed and it was noted that VA had one item to include under new business concerning smoke barriers and AHCA had a question on the website.
4. The minutes of the 20 May 2003 meeting were approved as submitted.
5. Review of Questions. Two subjects were submitted in advance for consideration.
 - A. AHCA – Door Locking Arrangements. A series of 8 questions were submitted relating to locking permissions in NFPA 101 for both new and existing healthcare occupancies. The background for this submission centered on items such as elopement/escape of occupants. The members agreed with the need to clarify the application of the door locking rules. After discussion, one revision was made to

Q.7, and responses were developed for all 8 questions. Due to a lack of an AHJ majority at the meeting, it was agreed to letter ballot the HITF (Editors Note: During the letter ballot, Mr. Bush raised a concern that interpretation of the proposed responses may still not be clear. AHCA asked that the issue be revisited by the HITF). See Enclosure A for the questions and Mr. Bushes' written ballot remarks.

B. ASHE – Emergency Generators. This item is trying to clarify the option of using batteries as a source for Type I EES. The provisions that govern this are not clear based on the language in NFPA 99. NFPA 101 and NFPA 110 requirements need to be reviewed further to determine if they are in conflict with NFPA 99. It was noted that an FI request on NFPA 99:4.4.1.2 may be made.

6. Discussion Items: Members had submitted several subjects in advance for information and update purposes. Subjects addressed were:

A. Nursing Home Fires. In light of the February and September 2003 multiple fatality nursing home fires, the group exchanged some basic update information. Changes for the 2006 edition of NFPA 101 have been submitted that would require retroactive automatic sprinkler protection. AHCA and NFPA issued statements calling for retroactive protection of all existing nursing home facilities.

B. Storage of “E” Medical Gas Cylinders. The number of cylinders that are situated outside of dedicated storage rooms has been based on different interpretations. The 2002 edition of NFPA 99 appears to provide some practical guidance on this issue. The HITF agrees that the provisions of the 2002 edition of NFPA 99 provides the proper guidance to address this subject. CMS is encouraged to utilize this criteria for storage of cylinders outside of the dedicated storage rooms.

C. CMS Participation with HITF. HITF members are concerned with the lack of participation by CMS both at the HITF meetings and in terms of applying the HITF interpretations. CMS participation is important. AHA and AHCA are working to set up a meeting with key CMS personnel to cover this subject.

D. Alcohol Hand Gel Solution. A TIA on this subject is currently being processed to NFPA 101. The one day meeting on this subject in September provided reliable information – all members were encouraged by the progress in this area. (Editors note: The initial TIA on this subject did not achieve the $\frac{3}{4}$ vote needed. Revised language was agreed to in February 2004, subsequently balloted, and then issued by the NFPA Standards Council on 15 April 2004).

7. New Business,

- A. Mr. Elvove brought up an issue concerning the extent of the smoke barrier/compartment requirements of NFPA 101 relating to new and existing healthcare occupancies. Two configurations were discussed – existing health care (with and without automatic sprinkler protection – new healthcare (with automatic sprinkler protection). Refer to Enclosure B for the configurations and questions.
- B. Mr. Jaeger asked if NFPA could keep the HITF Minutes separate from the HITF interpretations. Keeping them separate will help alleviate any confusion over what was actually voted on versus what was just discussed.

8. The next meeting will be held Tuesday afternoon, 25 May 2004 in Salt Lake City.

9. The meeting adjourned at 12:45 PM.

Minutes submitted by Robert Solomon, PE, NFPA

Encl: A. Locking Arrangements
B. Smoke Barrier Criteria

ENCLOSURE A
LOCKING ARRANGEMENTS

Memo

To: AHJ MEMBERS OF THE HITF
From: ROBERT SOLOMON
CC: HITF
Date: January 23, 2004
Re: FINAL RESULTS - LETTER BALLOT ON HITF REQUEST

The 22 January 2004 date for return of the HITF Letter Ballot has yielded the following results.

Out of 6 eligible voting members 5 AHJ's agree with all 8 questions. See Ken Bush comments (Attached).

1 ballot was not returned – Mayer Zimmerman

Therefore this interpretation has passed and will be posted on the HITF web site.

LETTER BALLOT ON HITF REQUEST
NFPA 101, 2000 edition – Paragraphs 18.2.2.2.2 and 19.2.2.2.2
Kenneth E. Bush - IFMA
January 8, 2004

The paragraphs referenced in this interpretation request address only those locks installed on patient sleeping room doors, and not for other remaining doors in the means of egress. Locking hardware for those doors other than patient sleeping room doors is addressed by Paragraphs 18.2.2.2.4 and 19.2.2.2.4 of NFPA 101 which were not referenced as a part of this interpretation request. Several issues, particularly Question #6 dealing with specialized locking hardware such as magnetic locks, and Question #8 dealing with multiple doors are not usually associated with doors to patient sleeping rooms, and typically would apply to general egress patterns throughout the building. For the purposes of this correspondence, these responses are intended to address locking hardware installed on patient sleeping rooms only as stated in the original request for interpretation.

In response to the interpretation request, I am in agreement with all of the answers with the following comments:

1. For Question #1, it is understood that the facility houses the minimum number of patients to be classified as a Health Care Facility. Provided that such minimum number of patients is present to classify the overall building as a Health Care Occupancy, there is no minimum number of patients having special clinical needs in order to permit the installation of locking hardware on patient sleeping room doors.
2. For Question #6, there is no restriction on the type of lock to be installed provided that the lock can be readily unlocked by all staff, not just staff present in the area, when the doors are locked. This would include staff who may occupy an area for temporary or incidental duties such as maintenance, housekeeping, clerical or delivery purposes. In addition, staff who are not routinely present in an area where locks have been installed on patient sleeping doors, such as maintenance personnel who are a part of a facility-wide fire brigade or nursing or administrative personnel from various locations in the building, may have duties to respond to emergencies in such areas as outlined in the facility emergency plan. In those cases, these staff members may be responsible for patient evacuation or movement and require access to locked rooms in order to accommodate the provisions of the facility emergency plan. It should be noted that the current *Code* text does not specify or restrict that keys be issued to only staff who are present in areas where locks are installed.



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to: Robert Solomon - NFPA
from: Tom Jaeger – Gage-Babcock & associates, Inc.
subject: HITF request for interpretation section 18;2.2.2.2 & 19-2.2.2.2, **2000 Edition Life Safety Code**
date: November 10, 2003
cc: File

Section 18-2.2.2.2 and 19-2.2.2.2 of the 2000 Edition of the Life Safety Code (LSC) are being interpreted and enforced through Medicare & Medicaid Regulations and State enforcing authorities in a very inconsistent manner. It is clearly understood that some states have requirements that are more restrictive and different than Section 18-2.2.2.2 & 19-2.2.2.2 of the LSC, but the differing interpretations are occurring in states that have no requirements for locking of doors that are more restrictive than the LSC. The differing interpretations are also coming from the Federal level where to the best of my knowledge there are no requirements other than those contained in the LSC.

The Technical Committee on Health Care Occupancies in the 1988 edition of the LSC made major changes to the Code relative to the locking of doors in health care facilities. These changes were necessary to recognize how health care services were being provided in today's facilities and the need to lock doors to prevent the very real hazard of elopement by patients.

I personally submitted the proposal to expand the permissiveness to lock doors beyond psychiatric hospitals and certain areas in acute care hospitals. My substantiation for these changes was for the LSC to recognize the need to lock doors in nursing homes due to the significant increase in the population of Alzheimer and dementia patients. The Technical Committee wisely chose to expand my proposal and use the term "clinical needs of the patient" and not restrict locking to only psychiatric facilities. The Committee also wisely chose not to "laundry list" those illnesses that might require locking of doors and chose the words "clinical needs." It is my understanding that the Technical Committee did not restrict the types of locks that could be used, the number of locks in a means of egress unless time delay locks were used, or require a minimum number of patients whose clinical needs required locking before doors could be locked.

It is clear that many AHJs are not comfortable or are opposed to the permissiveness of the newer editions of the LSC relative to the locking of doors when the clinical needs of the patient requires locking to prevent elopement or escape. With the adoption of the 2000 LSC for Medicare / Medicaid, many AHJs are putting up roadblocks to try to prevent the locking of doors or to limit the number of doors that can be locked. Although not specifically a LSC issue, AHJs are even prohibiting the locking of doors using the requirement that a facility must maintain compliance with the requirements of the building code the facility was required

to comply with when built, which did not permit the locking of doors. This borders on absurdity because when these older facilities were built, they did not even house patients whose clinical needs required locking to prevent elopement. Even if they did house these types of patients, the facilities weren't heavily fined for elopement by the very same agencies that restrict or prohibit the locking of doors to prevent elopement.

Psychiatric hospitals, which have a lower staff/patient ratio than acute care hospitals and nursing homes, have key locked doors for more than 100 years. When the Technical Committee changed the requirements in the Code for the locking of doors in the 1988 Edition, there were no incidents brought to their attention that the key locking of doors in psychiatric hospitals had resulted in the injury or death of patients due to a fire or other emergency incident. It would be nice and neat if the only hazard a health care facility had to face was fire, but in the real world, this is not the case. Health care facilities must be given the tools to address such hazards as elopement, infection, etc.

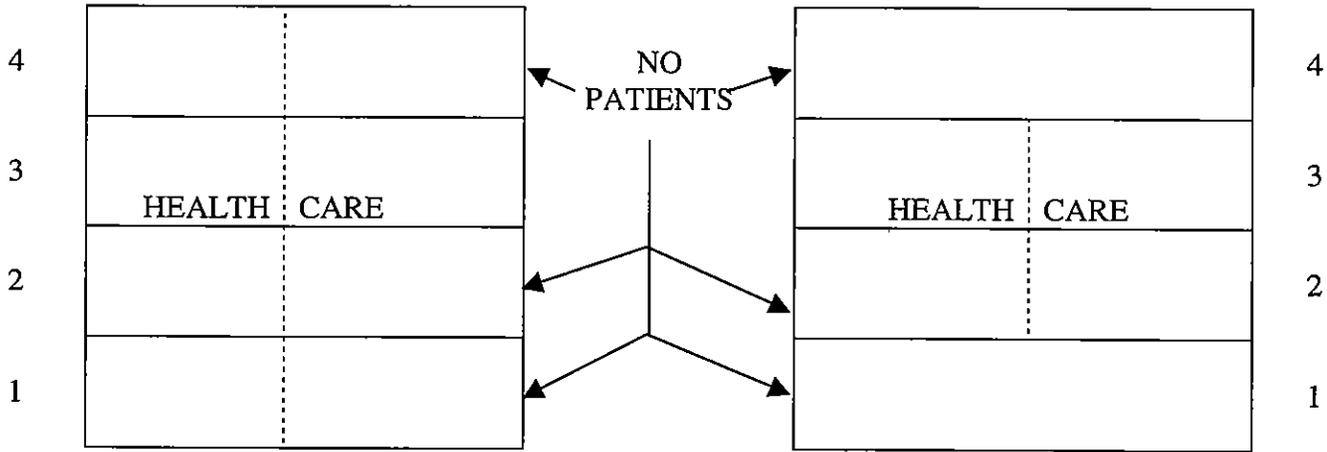
I am requesting the following interpretations of Sections 18-2.2.2.2 and 19-2.2.2.2 of the 2000 Life Safety Code:

1. Is it the intent of the Code to require a minimum number of patients whose clinical needs require the locking of doors be housed in a healthcare facility in order to permit the doors to be locked? **NO**
2. Is it the intent of the Code that patients whose clinical needs require the locking of doors be housed in the same smoke compartment or on the same floor? **NO**
3. If the answer to Questions #2 is no, can the patients whose clinical needs require the locking of doors be distributed throughout the facility based on the health care program of the facility? **YES**
4. Is it the intent of the Code that the clinical needs of patients relative to the need to require doors to be locked be determined by the appropriate and qualified staff of the health care facility? **YES**
5. Is it the intent of the Code to restrict the type of locking device to time delay locks? **NO**
6. If the answer to Questions #5 is no, can key locks, cipher locks, magnetic locks and similar locks be used as long as they can readily be unlocked by staff present when the doors are locked? **YES**
7. Are locks, other than time delay locks, and locks used on doors for stairway re-entry, required to automatically unlock upon operation of the fire alarm system or power failure? **NO**
8. Are the number of locked doors in the means of egress limited other than for doors using time delay locks? **NO**

ENCLOSURE B
SMOKE BARRIER CRITERIA

EXISTING (SEE 19.3.7.1)
(Smoke Barriers on all floors)

NEW (See 18..3.7.1)



CONFIGURATIONS

QUESTIONS

- 1) Floors 1, 2, 4 once classified as healthcare
- 2) Floors 1, 2,4 never classified as healthcare
- 3) Building protected with automatic sprinklers
- 4) Building not protected with automatic sprinklers

- 1) Can existing smoke barriers be removed on floors 1, 2 or 4?
- 2) Do automatic sprinklers have any impact on the removal decision?
- 3) Does removal of any smoke barrier diminish the level of safety to:
 - Less than that when originally constructed?
 - Less than that for new construction? (See Chapter 4)