

HEALTHCARE INTERPRETATIONS TASK FORCE
AGENDA
5 June 2007
Boston Convention & Exhibition Center
415 Summer Street, Room 103
Boston, MA
2:00 P.M. – 6:00 P.M.

1. Call to order 2:00 P.M.
2. Introduction of Members and Guests.
3. Review / Approval of December 2006 Minutes (See Enclosure A – page 3)
4. Review of Questions (See Enclosures B – page 14)
 - A. Items in the Corridor (See Enclosure B-1 – page 15)
 - B. Minimum Corridors Widths (See Enclosure B-2 – page 16)
 - C. Fire Drills (See Enclosure B-3 – page 17)
 - D. Alternative Method of Managing Maintenance-related Issues (See Addendum Enclosure B-4 – page 22)
5. New Business
 - A. By-laws Issues (See Enclosure C – page 20)
6. Old Business
7. Date / Location for Next Meeting
8. Adjournment (by 6:00 P.M.)

ENCLOSURE A

**MINUTES
HEALTHCARE INTERPRETATIONS TASK FORCE
DECEMBER 8, 2006**

**CMS Offices
7111 Security Blvd. Room B-310
Baltimore, MD
8:30 A.M. – 4:00 P.M.**

1. The meeting was called to order at 8:45 AM
2. Introduction of members and guests present was completed. Those in attendance included:

MEMBER

Joe Bermes*
Ken Bush*
Eugene Cable*
Philip Hoge*
Tomas Jaeger

David Klein (ALT)
Jim Merrill (ALT)
Hank Payne (ALT)
Robert Solomon
Dale Woodin

Mayer Zimmerman*

* Voting AHJ Member

REPRESENTING

Indian Health Services
International Fire Marshals Association
Veterans Affairs
DOD/US Army Corps of Engineers
Jaeger Associates/American Healthcare Association
Veterans Affairs
Centers for Medicare/Medicaid Services
Indian Health Services
National Fire Protection Association
American Society for Healthcare Engineering
Centers for Medicare/Medicaid Services

GUESTS

Pamela Baker

Lyn Bentley
Marilyn Dahl
Justin Givens
Antoinette Gray

Karen Jackson

REPRESENTING

American Association for Accreditation of Ambulatory Surgery Facilities
American Healthcare Association
Centers for Medicare/Medicaid Services
Centers for Medicare/Medicaid Services
American Association for Accreditation of Ambulatory Surgery Facilities
Centers for Medicare/Medicaid Services

Nancy McNabb
Jeff Pearcy

National Fire Protection Association
American Association for Accreditation of
Ambulatory Surgery Facilities

3. The minutes of the June 6, 2007 meeting (Orlando, FL) were approved as submitted.
4. Review of questions. Four questions and two discussion items were submitted as a part of the original agenda. Items reviewed included:

A. HITF: Door Gap Task Group Report. It was noted that an accompanying figure was separately distributed for the report. The draft report (8/14/06) was discussed. The task group looked at numerous scenarios and discussed lingering concerns. This item was prompted by implicit interpretation from some AHJs who defaulted to NFPA 80 allowances for 1/8 inch (max) gaps in all corridor doors. Even though NFPA 101 excludes NFPA 80 compliance with certain corridor doors, lack of a number resulted in the need to provide some guidance. The three questions in the TG report were accepted by the HITF AHJ voting members 4-1 and issued as shown (**Enclosure 1**).

EDITORS NOTE-A committee sponsored proposal for NFPA 101/NFPA 5000 was sponsored at the JAN 2007 committee meeting to get broader input on this issue)

B. AHCA: Smoking Restrictions in Nursing Homes. This subject concerns the extent to which the smoking regulations of NFPA 101 (18.7.4/19.7.4-2000 ed) extend to areas out side of and away from the primary nursing care facility. These areas could be a separate structure as well as simple concrete pads with or without an enclosure of some sort. There was agreement that patients/resident/staff who may use such areas requiem the same level of protection provided inside the main facility or building. The two questions in the request were accepted by the HITF AHJ voting members 4-1 and issued as shown (**Enclosure 2**).

C. AHCA: Nursing Home Staff and Fire Drills. This subject concerns the extent to which all staff must be available to participate in the 4 mandatory drill per year in accordance with NFPA 101 (18.7.1.2/19.7.1.2-2000 ed). The facility is to schedule and undergo four drills. The code recognizes that staff may be out sick, on vacation, on business related travel or working a different shift, thus there is no intent to do an accounting for each staff member. The first question in the request was accepted by the HITF AHJ voting members 5-0 and issued as shown (**Enclosure 3**).

D. CMS: Door Locking in Nurseries. This discussion was also related to the Door Locking Task Group report. This subject centers on the expanding definition of clinical needs for establishing a condition in which certain door can be locked. Locking of doors can take various forms now including door hardware equipped with a manual lock, key locking, key pads, badge swipe, wander guard and proximity technology. There was general agreement that the code has done an excellent job of addressing clinical needs. It is difficult to argue though that a security need (infant abduction threat for example) is a clinical need as intended by the NFPA committees.

Looking ahead, it was suggested that the HITF may want to consider a joint task group with the NFPA Technical Committee on Premises Security to determine what appropriate technologies may exist to best address the broader issues at hand. This would include adding requirements to, as an example NFPA 101:18.1.1.1.5, for:

- Features, systems and configurations for security needs.
- Incorporation of badge, keypad and proximity locking options.
- Procedures and protocols for lock down scenarios due to a hostile act (inside or in close proximity to the facility), civil unrest or quarantine scenarios.
- Selection of specific areas where the security provisions could apply such as newborn, neonatal and pediatric care areas.

A task group to look at lock down issues will determine what other issues would need to be considered. Task Group members are: Dale Woodin-Chair, Gene cable and Phil Hoge.

(EDITORS NOTE-A committee sponsored proposal for NFPA 101/NFPA 5000 was sponsored at the JAN 2007 committee meeting to get broader input on this issue)

E. NFPA: Emergency Power Supplies. NFPA was contacted by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) concerning an interpretation of NFPA 99, NFPA 101 and a CMS ruling concerning battery backup for certain medical equipment components. The use of battery back up power sources (NFPA 111) for certain types of continuous life support equipment (See definition in NFPA 99:3.3.37) in ambulatory surgical centers is allowed per NFPA 99 and NFPA 101. CMS (the AHJ in this case) has taken a position that the back up power source can only be provided by a generator (NFPA 110). The CMS position is consistent with 42CFR483.70(b)(2) that only makes reference to use of a generator.

CMS said they do have the ability to grant a waiver to the CFR citation and offered to work with AAAASF to resolve the concern. The HITF took no formal action on the subject.

5. New Business.

- A.** Dale Woodin provided an overview of some recent research that was conducted on the safe use of aerosol type (Level I) hand sanitizers. The research, conducted for Consumer Specialty Products Association was developed to determine the efficacy and use of these products in their healthcare environment. The information will be provided to committees at NFPA and ICC to consider for expanded use in healthcare facilities.
 - B.** Gene Cable provided an item concerning minimum corridors widths in suites. This item was voted to be held over until the next meeting.
 - C.** Gene Cable brought up an issue concerning sprinkler exemptions from certain small closets in hospitals and nursing homes. The HITF suggest that this issue has to be determined by the NFPA TC on Automatic Sprinklers and the TC on Healthcare Occupancies. There is simply no margin in NFPA 101 or NFPA 13 at present that would suggest that there is some minimum closet size that would not require sprinklers.
 - D.** Gene Cable brought up two by-law type issues. One concerns a name change for the HITF and one concerns a change in the vote margin needed to issue an interpretation. Both items will be held over until the next meeting.
- 6. Old Business.** A follow up to an NFPA 90A Formal Interpretation concerning a 50 CFM air infiltration limit was discussed. The background on the FI was discussed, but the main concern, is the 50 CFM an absolute maximum value still needs to be resolved.
- 7. Next Meeting.** The next meeting will be held during the 2007, WSCE in Boston. The tentative date was Tuesday, June 5, 2007 from 2:00-6:00 PM.
- 8. Adjournment.** The meeting adjourned at 2:45 PM.

ENCLOSURE 1
DOOR GAP TASK GROUP REPORT

HITF INTERPRETATION DECEMBER 2006 NO. 1

NFPA DOCUMENT NO: NFPA 101 2000 Edition

SUBJECT/BACKGROUND: Allowable gaps in certain corridor doors.

The following questions apply to requirements in the 2000 Life Safety Code for corridor doors other than those in required enclosures of vertical openings, exits, or hazardous areas, and other than those in smoke barriers.

Question 1: Does the Life Safety Code limit the gap between the edge of a corridor door and the door frame to 1/8-inch?

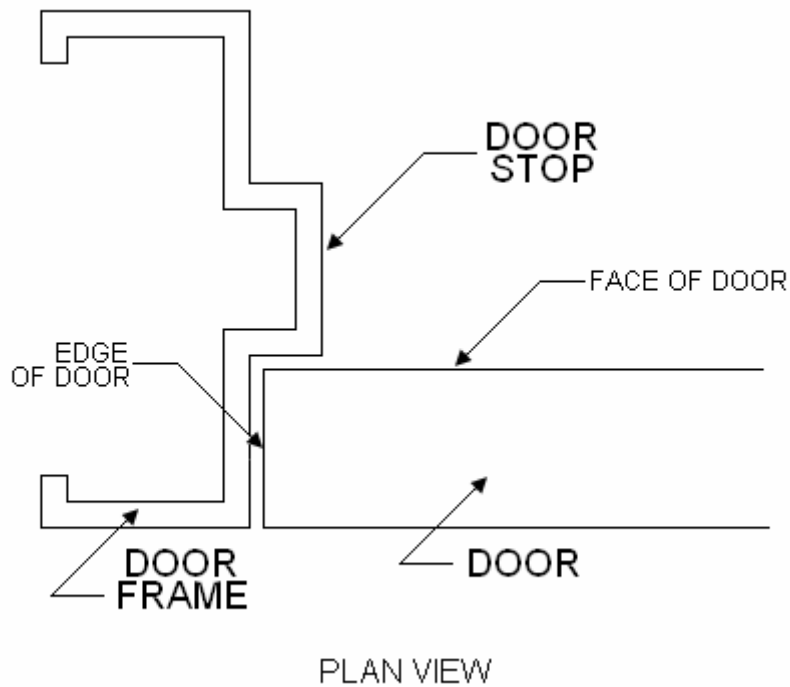
Answer: No. However, because the door stop functions as an astragal, the gap between the edge of a corridor door and the door frame shall not be greater than the depth of the door stop.

Question 2: Does the Life Safety Code limit the gap between the face of a corridor door and the door stop to 1/8-inch?

Answer: No. The Code does not specify a maximum gap dimension and specifically states that corridor doors are not required to comply with NFPA 80, Standard for Fire Doors and Fire Windows. The Code goes on to state that corridor doors should be relatively smoke tight. Due to the lack of specific dimensions for door gaps and the subjective language in the Code, the following guidance is deemed appropriate. In a smoke compartment that is not fully sprinklered, a gap not exceeding 1/4-inch between the face of a corridor door and the door stop should be permitted, provided that the door latch mechanism is functioning. In a smoke compartment that is fully sprinklered, a gap not exceeding 1/2-inch between the face of a corridor door and the door stop should be permitted, provided that the door latch mechanism is functioning. In a smoke compartment that is not fully sprinklered, to achieve a better fit the thickness of a 1 3/4-inch thick corridor door should be permitted to be reduced by removing not more than 1/4-inch from the face of the door. In a smoke compartment that is fully sprinklered, the Code does not impose construction requirements on a corridor door, provided that it resists the passage of smoke.

Question 3: Does the Life Safety Code limit the gap between the meeting edges of the leaves of a two-leaf corridor door to 1/8-inch?

Answer: No. The gap is permitted to exceed 1/8-inch provided that the meeting edges of the leaves are equipped with an astragal, a rabbet, or a bevel.



ENCLOSURE 2

SMOKING RESTRICTIONS IN NURSING HOMES

HITF INTERPRETATION DECEMBER 2006 NO. 2

NFPA DOCUMENT NO: NFPA 101 2000 Edition

SUBJECT/BACKGROUND: Smoking Policies.

Many nursing homes are establishing no smoking policies. This results in both staff and patients who want to smoke to smoke outside. Life safety surveyors are now requiring that the outside smoking areas comply with Sections 18 & 19.7.4 of the 2000 *Life Safety Code*. Specifically, the surveyors are requiring that the outside smoking areas be provided with noncombustible ashtrays of safe design and that metal containers with self closing covers be readily available to each outside smoking area.

Question 1: Do the requirements of Sections 18 & 19.7.4 apply to designated smoking areas outside the building?

Answer: YES.

Question 2: If the answer to Question #1 is yes, is there a distance away from the building in which the requirements of Sections 18 & 19.7.4 would not apply?

Answer: NO.

ENCLOSURE 3
NURSING HOME STAFF AND FIRE DRILLS

HITF INTERPRETATION DECEMBER 2006 NO. 3

NFPA DOCUMENT NO: NFPA 101 2000 Edition

SUBJECT/BACKGROUND: Staff Drills.

Life safety surveyors are now requiring that every staff member of a nursing home participate in a minimum of 4 fire drills per year and provide written documentation to verify that each staff member has participated in 4 drills. Although this may sound like a simple and reasonable requirement, not all staff members are present when their shift has a drill. Staff members may be on vacation, sick, in training outside the facility, etc. It is not practical to conduct 2 to 3 drills per quarter per shift to insure that every staff member participates in 4 drills per year. The alternative is to have staff, which missed a drill on their shift, to participate in a drill on another shift. This would require paying overtime to these staff members. It is sometimes very difficult to get staff to come in during other shifts, particularly if they have second jobs or dependent children and I haven't even looked into the union issues it might create.

Question: Does the 2000 *Life Safety Code* require in Sections 18 & 19.7.1.2 that all staff members of a health care facility participate in 4 quarterly fire drills per year?

Answer: NO.

ENCLOSURE B
REVIEW OF QUESTIONS

MEMORANDUM

To: Robert Solomon, HITF Chair
From: George Mills, Sr. Engineer, The Joint Commission
Date: May 23, 2007
Subject: Items in the corridor

I would like to discuss computers on wheels (COWs) in corridors. Specifically:

1. How long should they be allowed to be in the corridor if they are inactive
 - a. Inactive would be the amount of time between staff accessing the computer
 1. i.e. 45 minutes since last accessed
2. Can COWs be stored in corridor alcoves that are <50 square feet in an unsprinklered compartment?
 - a. NOTE: These areas might have been originally designed as linen storage
 - b. If COWs can be stored in corridor alcoves, can they be charging?
3. Can COWs be stored in corridor alcoves that are <50 square feet in a sprinklered compartment?
 - a. NOTE: These areas might have been originally designed as linen storage
 - b. If COWs can be stored in corridor alcoves, can they be charging?
 - c. Should there be a limit to the total number of alcoves per smoke compartment?
4. Can COWs be stored in a dead end corridor in a unsprinklered compartment?
 - a. If COWs can be stored in dead end corridors, can they be charging?
5. Can COWs be stored in a dead end corridor in a sprinklered compartment?
 - a. If COWs can be stored in dead end corridors, can they be charging?
6. If COWs cannot be charged in the alcove or dead end corridor, where should they be charged?
7. Based on the above discussion, how would this affect the following devices:
 - a. Portable x-ray machines (i.e. C-arms)
 - b. EKG/EEG or other diagnostic equipment
 - c. Beds
 - d. Other equipment with electrical connections.

Interpretations Task Group Request Form

Name: Gene Cable

Address: PO box 8980, VA Albany NY 12208

Phone: (518) 626-5551

Document to be interpreted: NFPA 101 (2000) 19.2.5, 19.2.3.3 exception # 2

NFPA 101 (2006) 19.2.5.6, 19.2.3.4(4)

Edition: 2000 and 2006

Background Information (optional): Recently several surveyors have cited medical centers for not maintaining 6 and 8 feet corridor widths within suites, usually within emergency department suites.

The 2000 Code was quite clear on this issue where, under the corridor width requirements Section 19.2.3.3 had an exception stating “*Exception # 2 Exit access within a room or suite of rooms complying with the requirements of 19.2.5*”. We had the understanding that corridor width requirements do not apply within a suite. We would then default to Chapter 7 Section 7.3 and 7.3.4, which specifies a minimum width of 36 inches as the general rule and allows exceptions down to 28 inches. The 2006 Code has the same requirements.

Question 1: Within a space meeting the requirements for suite, can components of the means of egress including egress pathways to an exit, be reduced to a minimum of 36 inches clear width?

Question 2: Within a space meeting the requirements for suite, can components of the means of egress including egress pathways to an exit, be reduced to as little as 28 inches where the conditions of Section 7.3.4 are met?

Signature: CABLE

Date: December 5, 2006

Healthcare Interpretations Task Force Request Form

(For June 2006 meeting)

Name: Gene Cable, Veterans Affairs

Address: PO box 8980, VA Albany NY 12208

Phone: (518) 626-5551. cell: (518) 641-8549

Document to be interpreted: NFPA 101 (2000) section 19.7.1.2
NFPA 101 (2006) section 19.7.1.4, 19.7.1.6, A19.7.1.4

Edition: 2000 and 2006

Background Information (optional): HITF addressed a very similar question in May 15, 2001 Disneyland Hotel from NFPA staff, "NFPA Request - Frequency of fire drills at SNF". It apparently concerned a State agency and drill requirements at a SNF attached to a hospital. The HITF did not make a formal interpretation and the minutes went on to say, "Unless the state regulatory agency made some determination with respect to licensing that the SNF and healthcare facility were one in the same, the drills must be completed independent of each other."

A new situation is emerging where fire alarm systems, with their amazing micro processing capabilities, are designed to limit where the alarm is sounded. These options are taken in coordination with the fire plan.

For example, a large 7-story healthcare facility is separated by 2-hour fire barriers into three buildings, Russell, Hamblet, and Stevens. Where buildings are attached and the option is taken to sound an alarm signal only in the Hamblet building, what effect would that have on the fire drill requirement? For the facility, did we just go from 12 drills per year to 36? The telephone operator still makes the Code Red announcement heard in all three buildings and selected staff respond from all three buildings according to the fire plan, to the fire area.

NFPA 101 A.19.7.1.4 states, "the purpose of a fire drill is to test and evaluate the efficiency, knowledge, and response of institutional personnel in implementing the facility fire emergency plan." . . . "Fire drills should be scheduled on a random basis to ensure the personnel in health care facilities are drilled not less than once in a 3-month period."

JCAHO EC.5.30 (2006) states, "The organization conducts fire drills regularly." EP 1. "Fire drills are conducted quarterly on all shifts in each building defined by the LSC as

the following: Ambulatory Health care occupancy, Health care occupancy, Residential occupancy." EP # 5 "Staff in all areas of every building where individuals are housed or treated participate in drills to the extent called for in the facility's fire plan." EP # 7 "The effectiveness of fire response training according to the fire plan is evaluated at least annually."

Specific example # 1: A health care facility consists of two buildings that abut each other but are separated by a 2-hour fire barrier. The fire plan calls for selected staff in building A to respond to the fire zone in building B. The fire alarm system activates only in Building B and a "Code Red" announcement is transmitted to both buildings according to the fire plan.

Are a total of 12 drills per year sufficient, randomly conducted among the two buildings? I believe YES.

Specific example # 2: Given the same situation as example # 1 except the fire plan does not call for staff in "Building A" to take action for an alarm in Building B, the fire plan does NOT call for staff response from one "building" to another. The phone operator "Code Red" announcement is still transmitted to both buildings. Does the drill in building B count as a fire drill only for building B? I believe YES. Now 24 drills are required for the facility? I believe YES.

Specific example # 3: Given a situation where a medical center is divided into several distinctly separated buildings, such as a mental health campus facility consisting of nine buildings connected by tunnels. The fire plan is specific to the building in alarm with the plan stating that available personnel from the neighboring two buildings respond to assist. The fire alarm system gives an automatic voice Code Red announcement throughout all nine buildings. Would 12 drills per year be sufficient for each group of three buildings? I believe YES. Campus wide would 36 drills per year meet the Code intent, 12 drills for each group of three? I believe YES.

QUESTION:

Is it the intent of the Code that twelve drills, once per quarter per shift, be conducted according to the extent of participation called for in the fire plan (~~committee deleted: rather than according to building designation?~~) (~~committee inserted: rather than based on building boundaries?~~)

Answer: YES

Signature: CABLE _____

Date: May 31, 2006

**ENCLOSURE C
BY-LAW ISSUES**

Memorandum

Department of Veterans Affairs

Date: December 6, 2006
From: Gene Cable, VA
Subj: Two Motions HITF Charter
To: HITF Voting Members

Motion 1:

To require a unanimous vote, 6 of 6, in order to issue a HITF interpretation.

We should issue, what could be a very powerful finding, only when we are 100%.

The Code is only as good as the AHJ applying it. An AHJ can be unreasonable on either end of the spectrum, too strict or too lenient, we together are striving to avoid the two extremes. And we often have to pick a somewhat arbitrary number or measure, when the Code doesn't.

I submit we need to be very careful, since we are deciding issues without full consensus of the NFPA Code making Technical Committee. We have had a similar concern when persons write or call NFPA staff to get an interpretation, we say that is one man's opinion. At least with HITF we have a 6 man's opinion.

It has always been awkward when one of the AHJs disagrees with the rest. Our "charter" states 3 of 4 voting members must vote for the finding. (NFPA Web Page – HITF) Of course now we have 6 AHJ members so we should address this voting question regardless. And we have a situation where the HITF interpretation is not binding to any one AHJ – which at least in part ruins the mission of HITF; which is "to provide consistent interpretations on national codes and standards referenced by CMS, JCAHO and state and territorial AHJs."

Requiring a unanimous vote strengthens the HITF findings.

The potential downside for asking a unanimous vote is that less interpretations may be issued. Any issue that can not be decided, 6 of 6, would then either be left unanswered or go to the appropriate Technical Committee for interpretation.

Motion 2:

To rename or re-establish the official name of this task force to AHJc, the Authority Having Jurisdiction Committee.

We can see at the NFPA Web page, HITF, that: *“this coalition, now known as The Authority Having Jurisdiction Committee, is comprised of representatives from:”*

We should at least discuss what is the official name of our group? And discuss the need for health care professionals and fire safety design professionals to readily recognize who we are and what we do. My experience, even within the VA, is that I have to constantly explain who and what is the HITF.

“AHJc” would be readily recognized whereas “HITF” seems unsuccessful and even a touch misleading since we do not officially interpret NFPA Code, only the Technical Committee can do that. We do agree on reasonable enforcement and application of Code. Further, this subtle name change could help defuse some of the objections I hear Technical Committee members expressing, concerning the very existence of this Task Force.

If anyone wishes to discuss this ahead of our December 8 meeting please feel free to call me at (518) 626-5551 or Cell (518) 641-8549, thank you.

Eugene A. Cable, P.E.
Safety and Fire Protection Engineer
(518) 626-5551

Memorandum

To: Robert Sololmon, Chair HITF
From: George Mills, Sr Engineer, The Joint Commission
Date: May 29, 2007
Subject: Alternative Method of Managing Maintenance-related Issues

In lieu of continuous compliance with the following items would an acceptable alternative method be an ongoing management process for identifying and resolving deficiencies? (See NFPA 101-2000, 1.5.2)

1. Fire resistance rated assemblies (FRRAs) that are 1-hour or 1 1/2-hr FRRAs (including occupancy separation doors, stair doors, horizontal exit doors, and hazardous area room doors) have properly functioning positive latching devices, self-closing or automatic closing devices, and gaps between meeting edges of door pairs is $\leq 1/8$ " with $\leq 3/4$ " undercuts.
2. Smoke barrier doors have properly functioning self-closing or automatic closing devices and are maintained to prevent the spread of smoke.
3. Corridor doors have properly functioning latching devices and are maintained to prevent the spread of smoke.
4. ≤ 1 hr FRR wall penetrations are properly sealed.
5. Smoke barrier wall and corridor wall penetrations are properly sealed.
6. Exit signs and means of egress illumination devices function properly.
7. All means of egress are maintained free from the accumulation of snow and ice and have ≥ 2 means of illumination.
8. Linen/trash chute inlet and outlet doors have properly functioning positive latching devices and self-closing or automatic closing devices.
9. Trash collection rooms are not used for any other purpose or storage.
10. Clear space extending ≥ 18 " below standard pendant sprinkler heads to top of storage is maintained, although perimeter room wall shelving may extend up to the ceiling when not located directly below any sprinkler head.
11. Portable space heating devices are prohibited in patient treatment and sleeping areas.
12. All combustible decorations are prohibited, unless flame retardant.
13. Furnishings, decorations, or other objects do not obstruct access, egress, or visibility of exits. Exit access and egress are kept clear and clutter-free.
14. Grease producing devices, including exhaust hoods, exhaust systems and grease removal devices are clean and maintained.