



March 2005
Volume 3, Issue 2

*A Newsletter for Healthcare Executives and Facility Managers on Issues
Related to Accreditation and Regulatory Compliance*



Door locking arrangements shall be permitted . . . where clinical needs of the patients require special security measures . . .

SECURITY VS. FIRE SAFETY DOOR LOCKING ISSUES IN HEALTHCARE FACILITIES

Controlling access to and egress from security “sensitive areas” in accredited healthcare facilities is a requirement of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The “sensitive areas” are to be determined by each accredited organization. Locations to consider may include, but are not limited to, ERs, pharmacies, medication storage areas, newborn nurseries, dementia units, sub-acute care units, central stores, forensic units, and mechanical spaces.

The Joint Commission also requires compliance with the 2000 edition of the National Fire Protection Association’s NFPA 101 Life Safety Code®. The LSC is a code for safety to life from fire in buildings and structures and establishes minimum criteria for the design of means of egress for facilities so as to allow prompt escape of occupants from buildings and/or into safe areas within buildings during fire emergencies.

Herein lies the problem and challenge for security and safety professionals – securing or controlling access to and egress from security sensitive areas while continuously maintaining unrestricted means of egress for full instant use in those same or adjacent areas during fire emergencies per the Life Safety Code.

There are a number of LSC requirements and several code exceptions for doors in means of egress with regard to locking, latching and hardware. LSC Chapter 7, Means of Egress, contains the basic or fundamental requirements for all occupancies (see 7.2, 7.2.1.1.3, 7.2.1.5.1, 7.2.1.5.4, 7.2.1.6.1 and 7.2.1.6.2). Chapter 19, Existing Health Care Occupancies, contains the requirements for existing hospitals, nursing homes and limited care facilities (see 19, 19.1.1.1.5, 19.2.2.2.2, 19.2.2.2.4 and 19.2.2.2.5).

There is no easy way to ensure that your facility is in compliance with the requirements of the Life Safety Code while also attempting to control access to and egress from your designated sensitive areas, except by performing a thorough evaluation of your entire building. The initial step *(Continued on Page 3)*

INSIDE THIS ISSUE

Page **1** Door Locking Issues

Page **2** EC Advisory Bulletin

Page **3** OSHA Targets High Injury Rates

Page **4** Publications & Seminars



Lighting is controlled by patients, when appropriate.



JCAHO EC ADVISORY BULLETIN: ECAB #05-02

Don't rush to retrofit your patient room lighting controls in your acute care hospitals if previously approved by your state or other authority having jurisdiction (AHJ) prior to construction or any subsequent renovations. Why? Please read the following and perhaps save yourselves tens of thousands of dollars in attempts to comply with what appears to be a "retroactive" requirement.

Within the 2005 JCAHO Hospital Accreditation Standards manual there is a new Element of Performance, EP #6 in Standard EC.8.10, which states, "Lighting is controlled by patients, when appropriate."

The words, "when appropriate," are highly subjective, vague or nebulous and give us little direction on exactly what is required to fully meet the intent of this standard.

If one references the 2001 American Institute of Architects "Guidelines for Design and Construction of Hospital and Healthcare Facilities" Chapter 7, Paragraph 7.32.D3 Lighting, it states, "Patient rooms shall have general lighting and night lighting. A reading light shall be provided for each patient. Reading light controls shall be accessible to the patient(s) without the patient having to get out of bed. Incandescent and halogen light sources that produce heat shall be avoided to prevent burns to the patient and/or bed linen. The light source should be covered by a diffuser or lens. Flexible light arms, if used, shall be mechanically controlled to prevent the

lamp from contacting the bed linen. At least one night light fixture in each patient room shall be controlled at the room entrance. Lighting for coronary and intensive care bed areas shall permit staff observation of the patient while minimizing the glare."

The Joint Commission standards reference the 2001 AIA "Guidelines." EC.8.30, EP #1 requires the following, "When planning for the size, configuration, and equipping of the space of renovated, altered, or new construction, the hospital uses one of the following: applicable state rules and regulations; Guidelines for Design and Construction of Hospitals and Healthcare Facilities, 2001 edition, published by the American Institute of Architects; or standards or guidelines that provide design criteria."

Both the AIA Guidelines and JCAHO standard EC.8.30, EP #1 are meant to be applied to new construction or renovation works and are typically not meant to be applied retroactively to existing construction and equipment installations unless mandated by an authority having jurisdiction. Therefore, while perhaps a very good idea, this new JCAHO requirement, "Lighting is controlled by patients, when appropriate," would be a retroactive requirement.

According to John Fishbeck, Associate Director of the Joint Commission's Division of Standards and Survey Methods, EC.8.10, EP #6 "was mistakenly put in..." to the Hospital Accreditation Standards manual and is "supposed to be corrected in HAP Update #1" and removed!

For more information, please contact Dean Samet at DSamet@ssr-inc.com



OSHA REACHES OUT TO EMPLOYERS WITH HIGH INJURY/ILLNESS RATES

During March 2005, Jonathan Snare, the Acting Assistant Secretary of Labor for the Occupational Safety and Health Administration (OSHA), sent letters to approximately 14,000 workplaces across the country to alert them that their injury and illness rates are significantly higher than the national average. In the letter, Snare encourages those companies to take steps to improve their health and safety programs. The letter and list of sites receiving the letter may be found at OSHA's website, www.osha.gov (see 3/10/05 OSHA Trade Release). Included in the list of recipients are more than 1,500 hospitals, nursing homes and other healthcare facilities.

Those companies receiving such letters will be targeted for OSHA inspections. In a recent speech to the American Bar Association's Occupational Safety and Health Law Committee, Snare stated that OSHA "will begin inspecting several thousand sites with the highest (injury and illness) rates."

Table: Health and Safety Training Required by OSHA (applicable to healthcare facilities)

HEALTH AND SAFETY TRAINING TOPIC	FREQUENCY	POSSIBLE TRAINING RECIPIENTS
Personal Protective Equipment	Before new PPE is introduced	Non-administrative personnel
Respiratory Protection	Annually	Maintenance personnel, medical decontamination teams
Confined Space Entry	Before first task requiring respiratory protection	Nursing and medical personnel
Lockout/Tagout	Before new equipment or procedures are introduced	Maintenance personnel
Bloodborne Pathogens	Annually	Nursing, medical and laboratory personnel
Hazard Communication	Before new hazards are introduced	Non-administrative personnel
Chemical Hygiene	Before assignments involving new exposure situations	Laboratory personnel
Emergency Response	Annually	Emergency response teams
Hearing Conservation	Annually	Maintenance personnel
Asbestos	Annually	Maintenance and housekeeping personnel
Ethylene Oxide	Annually	Central sterile supply personnel
Fall Protection	Before new equipment or hazards are introduced	Maintenance personnel
Incipient Stage Fire Fighting	Annually	Fire brigade members
Fire Extinguishers	Annually	All employees

In his letter, Snare offered several resources for addressing workplace safety and health concerns, including OSHA's website and onsite *(Continued on Page 4)*

Security vs. Fire Safety Door Locking Issues in Healthcare Facilities *(Continued from page 1)*

is to define or list the facility's particular security sensitive areas. This is a very important task that should be performed with input from administration and the medical/clinical staff, as well as security, safety, engineering, facility management and materials management personnel. The next step is to review the appropriate chapters and sections of the LSC to determine if the current door locking installations meet the intent of the code. A very useful tool to assist in this evaluation is to utilize a set of architectural floor plans. The final task is to complete a building tour, listing where any changes have to be made.

The following are a few of the Life Safety Code door locking requirements and "exceptions" to consider:

LSC 19.2.2.2.4 Exception No.1: "Door locking arrangements shall be permitted in health care occupancies or portions of health care occupancies where the clinical needs of the patients [e.g., psychiatric, dementia, Alzheimer's, etc.] require special security measures for their safety, provided staff can readily unlock doors at all times." (See 19.1.1.1.5 and 19.2.2.2.5.)

LSC 19.1.1.1.5: "It shall be recognized that, in buildings housing certain types of patients or having detention rooms or a security section, it might be necessary to lock doors and bar windows to confine and protect building inhabitants. In such instances, the AHJ shall make appropriate modifications to those sections of this Code that would otherwise require a means of egress to be kept unlocked."

LSC 19.2.2.2.5: "Doors located in the means of egress that are permitted to be locked under the provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by such a reliable means as the remote control of locks, by keying all locks to keys carried by staff at all times or by other reliable means available to staff at all times. Only one such locking device shall be permitted on each door."

LSC 19.2.2.2.4 Exception No.2: "Delayed egress locks complying with 7.2.1.6.1 *(Continued on Page 4)*

Security vs. Fire Safety Door Locking Issues in Healthcare Facilities (Continued from page 3)

shall be permitted, provided not more than one such device is located in any egress path.” Note: Building must be protected throughout with a fire detection system or fully sprinklered. Such doors must unlock upon activation of one of the following: the sprinkler system, any heat detector, not more than two smoke detectors, loss of power controlling the locks, or an irreversible process within 15 seconds (30 sec. w/ AHJ approval) of pushing the release device.

LSC 19.2.2.2.4 Exception No.3: “Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.” Note: Such doors must unlock upon activation of one of the following: loss of power controlling the sensors and/or locks, building fire alarm system, building sprinkler or fire detection system(s), if provided.

LSC 7.2.1.1.3: “For purposes of Section 7-2, a building shall be considered occupied at any time it is open for general occupancy, open to the public, or at any other time it is occupied by more than 10 persons.”

While it is imperative to control access to and egress from security “sensitive areas” in healthcare facilities, it is also essential to perform a thorough review of the 2000 NFPA 101 Life Safety Code® requirements when determining door locking, latching and hardware compliance. Failure to do one without the other could result in an unsafe or unsecured healthcare environment where safety and security literally go hand in hand.

*For more information, please contact
Dean Samet at DSamet@ssr-inc.com*

OSHA Reaches Out to Employers with High Injury/Illness Rates (Continued from page 3)

consultation program. One important first step that healthcare institutions should take is to verify that employees are receiving appropriate health and safety training. The table shown summarizes training topics and frequencies required by OSHA for healthcare



facilities. Health and safety training is recognized as a key component of any health and safety program and an effective tool for reducing workplace injuries and illnesses.

*For more information, please contact
Leo Old at LOld@ssr-inc.com*

SSR PUBLICATIONS & SEMINARS

Seminars in 2005

- Apr. 14 Association for Professionals in Infection Control, Columbus, OH, “Occupational Health Risks in a Hospital Environment”
- Apr. 19 Tennessee Society of Professional Engineers, Memphis, “Fire and Explosion Dynamics”
- Apr. 21 California Society for Healthcare Engineering, Newport Beach, “JCAHO EC Standards & Survey Update for 2005”
- Apr. 28 Oklahoma Association of Healthcare Engineers, Oklahoma City, “Life Safety Code Education”
- May 4-5 South Carolina Society of Healthcare Engineers, Myrtle Beach, “Life Safety Code”
- May 13 Florida Healthcare Engineering Association, Gainesville, “JCAHO EC Update for 2005/2006; What You Should Know and Prepare For”
- June 29 Texas Association of Healthcare Facilities Management, San Antonio, “Life Safety Compliance for Healthcare”
- July 28 AHA Leadership Summit, San Diego, “2005 JCAHO Update”
- Oct. 5 New England Healthcare Engineers Society, Burlington, VT, “EC/JCAHO 2005 Update”



2995 Sidco Drive
Nashville, Tennessee 37204

For additional information, contact:

DEAN SAMET, CHSP
800-545-6732
DSamet@ssr-inc.com
www.ssr-inc.com