Inaccessible dampers bring with them long-term ILSMs
Consider consequences of untested dampers

It’s well known that The Joint Commission grants leeway to hospitals when it comes to operational testing of smoke and fire dampers that are inaccessible because of building features or other physical limitations.

But what you might not know is that if you choose not to test inaccessible dampers, you may need to carry out long-term interim life safety measures (ILSM) to offset any risks.

Here’s why: Joint Commission standard EC.02.03.05 requires hospitals to test dampers one year after installation and every six years thereafter. The purpose of the test is to verify that a damper fully closes, thus helping to protect occupants should fire occur or smoke appear in an area. (The six-year provision only applies to hospital buildings which provide inpatient services. Otherwise, damper testing is every four years.) However, The Joint Commission (formerly JCAHO) has stated numerous times that hard-to-reach dampers don’t need to be tested (see the June 2007 Joint Commission Perspectives). As future renovations or remodeling occur, facilities that have the opportunity to reconfigure out-of-the-way dampers must do so, the accreditor has indicated.

Entering dampers on PFIs

As a trade-off, The Joint Commission requires facilities to list all inaccessible dampers on a plan for improvement (PFI) under the electronic Statement of Conditions (e-SOC). When the commission transitioned to the e-SOC from its paper predecessor, it indicated that facilities should check off a six-year completion date on the electronic PFI for inaccessible dampers.

If that completion date approaches and the dampers remain inaccessible because no renovations have taken place, facilities need to submit an extension request for the PFI item.

Evaluating ILSM options

By definition, items listed on a PFI are life safety deficiencies, and as such, facilities must evaluate the deficiencies for ILSMs, says Elizabeth Zhani, spokesperson for The Joint Commission.

LS.01.02.01 requires facilities to have a written ILSM policy, and that standard cross-references LS.01.01.01, which sets provisions for PFIs.

“For example, if a fire damper was inaccessible in a rated barrier that protected oncology patients, then The Joint Commission would expect [at least one] ILSM to
Inaccessible dampers  < continued from p. 1

be in place related to the lack of building compartmentation,” Zhani says.

(See “What ILSMs can help balance damper deficiencies?” on p. 3 for a further look at your ILSM options.)

Any damper-related ILSM could be in place for six years in line with the PFI completion date, she says.

However, facilities should be careful about taking that route without thinking through the consequences, says Joshua W. Elvove, PE, CSP, FSFPE, fire protection engineer in Aurora, CO, and former life safety specialist for The Joint Commission.

“If you choose not to address the [inaccessible] damper as The Joint Commission permits you to, your ILSM is in perpetuity,” Elvove says. “That’s scary.”

Ramifications of inaccessible dampers

Elvove isn’t sure that a six-year ILSM truly meets the intent of an interim precaution. Beyond that debate, though, “there may be some impetus for you to make that damper accessible,” he says.

Consider the following four points:

➤ The Joint Commission’s relaxation of the six-year damper testing frequency only applies to operational tests for these hard-to-reach items, based on the 2007 editions of NFPA 80, Fire Doors and Other Protective, and NFPA 105, Installation of Smoke Door Assemblies and Other Protective. There are other tests related to dampers that aren’t affected by The Joint Commission’s move. For example, a smoke detector that ties into a smoke damper still needs to be tested annually under Chapter 7 of the 1999 edition of NFPA 72, National Fire Alarm Code, Elvove says.

➤ Dampers are important life safety features that, when working properly, limit the passage of heat, flames, and smoke from one side of a smoke or fire barrier to another. If a damper is inaccessible, “you have to assume the worst case: that it won’t close [during a fire],” Elvove says. “You need to think about this risk.” By comparison, a shut down sprinkler line would never be left inoperable for six years, and Elvove says dampers are an equally important fire protection feature.

Questions? Comments? Ideas?

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Along the same line, consider your property insurance company’s viewpoint, says Craig Rutledge, owner of Life Safety Services, a damper inspection and repair company in Louisville, KY. If an inaccessible damper is inoperable, but you don’t know it because you haven’t tested the equipment, what will an insurance carrier say if a fire occurs?

The Joint Commission allowed the six-year tests starting in January 2008; thus, no hospital has made it to the brink of a six-year PFI completion date for an inaccessible damper. As stated earlier, The Joint Commission had indicated that facilities will need to request a PFI extension if the dampers remain inaccessible after six years. However, there is no guarantee that the commission’s Standards Interpretation Group will approve such extensions.

Further, if facilities have inaccessible dampers, they need to ensure that the dampers don’t compromise airflow and pressurization by measuring these factors on both sides of the dampers, Zhani says.

If there is a restriction in flow or pressurization, the damper may be partially closed instead of being fully open. Such a situation might indicate a failed damper, which would require a more immediate resolution, she says. Don’t forget to document any resolutions you make, as such paperwork is an important aspect for surveyors to review.

**Making dampers accessible**

It may benefit facilities managers to question whether inaccessible dampers are truly unreachable, Rutledge says. In his experience, many such dampers can in fact be accessed with a little extra effort.

For example, dynamic fire dampers that slam shut with a spring may need two sets of hands to reset them once they’ve been tested. If a facility only has one access door to the damper, there may be an urge to label that damper as inaccessible because it can’t be easily reset.

In that case, Rutledge recommends either:

- Replacing the existing access door with a larger one to enable two sets of hands to reach the damper or to allow one person to achieve more leverage
- Installing a second access door on the other side of the damper so that a pair of workers can simultaneously reach the equipment

**What ILSMs can help balance damper deficiencies?**

If an inaccessible smoke or fire damper is listed on a plan for improvement, The Joint Commission wants you to consider whether any interim life safety measures (ILSM) are appropriate.

Given that mandate, the following ILSMs under LS.02.01.01 might be useful to offset any deficiencies caused by a damper that can’t be tested because it’s inaccessible:

- Inspect exits in affected areas each day
- Provide temporary but equivalent fire alarm and detection systems for use when a fire alarm system is impaired (in this case, if an inaccessible damper ties into an alarm system)
- Inspect and test any temporary systems each month
- Provide additional firefighting equipment
- Provide additional training on the use of firefighting equipment to staff members who work in affected areas
- Increase surveillance of areas in question, giving special attention to construction areas and storage
- Enforce storage and housekeeping practices to reduce combustible material in affected areas
- Conduct an extra fire drill each quarter
- Educate staff members about the risks associated with inaccessible dampers
- Train workers to compensate for impaired fire protection features

Remember, you don’t need to actually carry out any ILSMs for a given deficiency. The Joint Commission requires you to evaluate the need for ILSMs and base your decisions on that evaluation. If the evaluation indicates that ILSMs are necessary, at that point you would need to implement them or risk scrutiny from a surveyor.
Physician offices should seek business occupancy status
However, the Life Safety Code isn’t clear on how to classify these settings

Larger, accredited healthcare facilities have their fire safety requirements spelled out, but it’s not quite as clear-cut for physician offices and similar-sized facilities.

In smaller settings, life safety can easily be buried at the bottom of the to-do list, in part because safety matters sometimes fall to administrative assistants rather than facility professionals.

Additionally, physician offices are sometimes unsure whether to follow the Life Safety Code® (LSC), OSHA standards, or other regulations set forth by a local fire marshal.

A vague occupancy choice
Try looking up “physician office” in the LSC. You won’t find the term in the official language.

Chances are a physician office falls under a business occupancy rather than a healthcare occupancy. Although there are discernable differences with each occupancy type, the main difference for the purposes of this article is that a business occupancy usually has patients who can get out on their own, whereas a healthcare occupancy houses inpatients who have overnight sleeping accommodations or are physically incapable of moving themselves.

But this explanation isn’t easily laid out in the LSC to the uninitiated, says Brad Keyes, CHSP, a safety consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

“You have to come to that conclusion by deduction,” says Keyes, who is the contributing technical editor for Healthcare Life Safety Compliance. “In other words, it doesn’t fall in any other category, and it makes sense to put it in business. That’s kind of the catch-all.”

Although an annex note in the LSC mentions physician’s offices as possible business occupancies, annex notes are explanatory only and not part of the official code language.

Fortunately, being classified as a business occupancy means the standards will be a little less stringent for physician offices because they typically don’t have occupants who can’t get out on their own.

“If a fire were to occur in a doctor’s office, they could say, ‘Okay, everybody please exit the building,’ and for the most part, everybody could unless there are extenuating circumstances,” says Keyes.

Local authorities can help
Although the upside to being classified as a business occupancy is less demanding requirements, the downside is less guidance. Hospitals can look to The Joint Commission (formerly JCAHO) or Centers for Medicare & Medicaid Services (CMS), both of which have adopted the 2000 edition of the LSC for fire safety requirements. But many physician offices don’t fall under Joint Commission accreditation or seek Medicare reimbursement from CMS, creating the perception that there is nowhere to turn.

But that’s not true, says John Nolan, a senior consultant at Russell Phillips & Associates, LLC, in Fairport, NY. The first place a small medical facility should turn to is community regulators, Nolan says.

“Talk with your local authority, whether it is your fire prevention bureau in your fire department, your fire marshal, or in very rural areas, it may just be your local fire department,” says Nolan. “Look at what they feel is acceptable for that type of occupancy. They really need to look at the type of patient that is catered to and then any special needs that they may have.”

Walk-throughs are good icebreakers
Keyes agrees that a good first contact is the local fire authority, which is often the fire marshal. Call him or her up and schedule a walk-through of the physician office. “Fire marshals love this because it’s a proactive approach and they want people to be proactive,” Keyes says, adding that taking this advanced approach will often buy leeway with the fire marshal. If a problem comes
up, the fire marshal may be more willing to work with a physician office in correcting it and providing a reasonable time frame to do so.

Perhaps more importantly, getting local authorities involved establishes continuity within evacuation procedures, so if an incident does occur, the whole process runs smoothly.

“In healthcare, the more involvement you have with your local authority having jurisdiction, the more effective your procedures are going to be, because everyone is going to be on the same page,” says Nolan.

**Training for fire extinguishers**

If your local authority operates under the *LSC*, there are set requirements for fire procedures, says Nolan. Again, these procedures are a bit more lenient for a business occupancy.

“[The *LSC*] basically focuses on requirements for fire drills and requirements for extinguisher training,” says Nolan. “As far as extinguisher training, it basically states that designated employees of a business occupancy will be periodically trained, and that is typically a requirement on an annual basis for most authorities having jurisdiction.”

Fire drills for physician offices are usually conducted in conjunction with the local authorities as well, which means contacting them will point you in the right direction as far as specific drill requirements, he says.

**OSHA rules may figure in**

Once training begins for employees to use fire extinguishers, a physician office also treads under OSHA’s umbrella. This training can come in several forms, from a simple visual lesson or video to an actual hands-on application. However, you should not require employees to put out a fire, since doing so includes more rigorous training.

“If you are going to start saying you will respond with the intent to extinguish, you are creating what OSHA would consider a fire brigade, and when you hit that fire brigade [threshold], there are much more regulations on the type of training and the type of protective equipment they need to have,” Nolan says. “Most healthcare occupancies and most general industries don’t want to put the funds or the man-hours into that training.”

To mitigate that, many smaller facilities train employees to use fire extinguishers, but only to use them if they feel comfortable. OSHA notes that individuals should only use fire extinguishers to put out small fires—a general rule is to leave blazes bigger than a trash can to professional fire departments.

The main responsibility of physician office employees “should be to assist in the evacuation of the immediate area, contain the fire to the best of their ability based on the construction of the building, and then to formally evacuate as the fire procedure dictates,” Nolan says.

Under OSHA regulations, there is nothing wrong with simply evacuating the building without even touching a fire extinguisher, as long as that is part of your emergency action plan. For most small practices, the easiest and safest course of action is evacuation, according to the OSHA *Regulatory Manual for Healthcare*.

One final authority to consider is insurance carriers. Physician offices may deal with two insurance companies, one for the building and one for the physician practice. The carrier for the building is not necessarily concerned about patients or workers, but the office itself.

See a sample fire prevention plan for physician offices on p. 6.
Sample fire prevention plan form

[Your practice name]
Sample emergency action plan
Fire prevention plan

The office safety coordinator or designee will be responsible for monthly inspections of all areas under his or her direction to confirm that no combustibles accumulate to constitute a hazard. Inspections will determine whether exits are unblocked, aisles are clear, fire equipment is unobstructed, and storage is neat and tidy.

Oxygen
Remove oxygen tanks from the area of the fire. Shut off supplied oxygen lines only at the direction of the medical director or the nurse manager in the area of the fire. In case of fire, immediately seal off the area and call your county communications center. Simultaneously, only appropriately trained office personnel should contain the fire until the fire department arrives.

Sterilizers and other health services equipment
In the event of an emergency, only the medical director or his or her designee can order the shutdown of such equipment.

To help keep equipment failures to a minimum, award annual contracts to vendors for preventive maintenance and repairs. The vendor conducts annual inspections to maintain proper equipment performance.

Fire extinguishers
Assigned personnel are responsible for inspecting extinguishers each month and recording the inspection on the tag attached to each fire extinguisher. The inspection consists of the following elements:
- a. The condition of the extinguisher
- b. Confirmation that the extinguisher is full
- c. Confirmation that the pin is in place and hasn’t been tampered with

Sprinkler system
Maintenance personnel or an outside vendor should check the system on a semiannual basis.

Joint Commission notebook

New EP under LS.01.01.01 to be scored July 1

For those keeping track of such minutiae, The Joint Commission released the scoring category for a new element of performance (EP) under life safety standard LS.01.01.01.

LS.01.01.01 requires compliance with the 2000 Life Safety Code® and the Statement of Conditions. New EP 4 mandates that hospitals maintain records of inspections and approvals by local and state fire authorities.

This change, along with others in The Joint Commission’s Comprehensive Accreditation Manual for Hospitals, was precipitated by the commission’s reapplication for deeming status from the Centers for Medicare & Medicaid Services (CMS).

EP 4 is scored as a C category, meaning compliance will be judged on the number of times a facility does or doesn’t meet the provision.

The EP is also listed as an indirect impact requirement under the 2009 criticality model, and as such, indicates a failure might increase risks to patient safety over time. Indirect impact requirements are the lowest tier in the criticality system.

For years, The Joint Commission (formerly JCAHO) enjoyed automatic deemed status to survey hospitals on behalf of CMS, but CMS is now requiring the commission to reapply for this status. As a result, the accreditor updated some of its requirements to more closely align with CMS’ Conditions of Participation (CoP).

As of April 6, surveyors began reviewing the new EP, but noncompliance doesn’t affect accreditation decisions for facilities. However, beginning July 1, hospitals that don’t comply with the new EP will be scored against it.

Some facilities, such as those run by the U.S. Department of Veterans Affairs, aren’t subject to the CoP and thus may not need to comply with the new EP.

Surveyed hospital happy with life safety prep

Joint Commission surveyors visited Community Memorial Hospital (CMH) in Hicksville, OH, in January, ahead of an anticipated April arrival. Life safety compliance proved one of the strong points during the survey, says Jane Zachrich, RN, MSN, chief nursing officer at CMH.

Hospital officials are proud of the fact that the facility did not receive a citation for any life safety processes. “We were surprised by this because it is unusual not to be cited for something. One advantage might be because our facility is only two years old,” Zachrich says.

Being such a new facility, CMH invited an EC specialist from another facility to conduct an evaluation and offer a list of improvements, says Zachrich.

The EC specialist came in for a half day and suggested that CMH label fire doors and create a matrix to document work done. Another suggestion was to require contractors and vendors to submit their plans for hospital approval before work was performed and to check for unprotected barrier penetrations once the work was completed.

“This was the best thing that we could have done as a facility,” Zachrich says. “I think this put us way ahead of things.”

Illustration by David Harbaugh
Editor’s note: In the May Healthcare Life Safety Compliance, we examined data behind hospital fires. In the following story, we do the same for nursing homes, which traditionally have been more problematic settings for fire safety.

Here’s an interesting statistic: Although about half of all nursing home fires involved cooking activities gone awry, blazes that involve bedding materials or electrical wires are much more likely to result in deaths and injuries.

Those conclusions come from researchers at the NFPA, who amassed data on nursing home fires for the period from 2002 to 2005. Their report, U.S. Structure Fires in Nursing Homes, was published by the NFPA in September 2008.

In broad strokes, there are an estimated 2,810 fires in nursing homes annually, according to the report. These fires result in an average of 16 deaths and 130 civilian injuries each year.

Compare those numbers to hospitals, which only see an average of one death and 29 injuries annually, according to NFPA research. Although the NFPA doesn’t specify it, the gap in casualties between nursing homes and hospitals may have to do with hospitals generally having a higher degree of sprinkler protection.

Additionally, nursing home fires lead to an annual estimate of $6.6 million in direct property damage.

Trouble spots to monitor

Cooking equipment was involved in 54% of nursing home fires, with the majority of them stemming from confined cooking fires. A confined fire involves the contents of a pot, pan, or similar container without the flames extending beyond the pan.

The leading list of specified items or materials involved with ignition during nursing home fires includes the following:

- Confined cooking equipment
- Clothes dryers and washing machines
- Trash and rubbish receptacles
- Clothes dryer fires have long been a bane for nursing homes, as we’ve documented in this newsletter over the years. Such fires are occasionally associated with staff members or residents ignoring a simple precaution: ensuring that the lint traps are cleaned. (See the chart on p. 9 for more information about the top sources of nursing home fires.)

The NFPA makes an important point that may not be obvious in the statistics: Nursing home fires that originate in electrical wiring, cable insulation, mattresses, or bedding result in disproportionately more deaths and injuries.

It’s hard to draw a firm conclusion as to why deaths and injuries are more associated with these items, although some of the reason appears to be because such materials are common in resident bedrooms. According to the report, 92% of the annual fire deaths and 35% of injuries for 2002–2005 occurred in bedrooms.

Report skips a noteworthy fire

As mentioned earlier, the NFPA statistics cover a period from 2002 to 2005. In 2003, the two deadliest fires in U.S. healthcare facilities in at least the past decade occurred at a pair of nursing homes:

- On February 26, 2003, a resident at the former Greenwood Health Center in Hartford, CT, intentionally lit bedding material with a lighter, causing a large

A growing problem

Nursing home fires are on the rise, according to the latest NFPA statistics. From 2001 to 2005, there were at least 2,620 fires annually in nursing homes. Prior to 2001, that number hadn’t been reached since 1989, when there were 2,650 fires.

Source: U.S. Structure Fires in Nursing Homes, published by the NFPA.
fire that killed 16 residents. The suspect was never charged because of her diminished mental state. On September 25, 2003, a fire occurred at NHC Healthcare in Nashville, which killed 15 residents. Authorities were unable to determine an official cause.

The NFPA report’s statistics include the Hartford fire, but not the Nashville incident, which on the surface is a glaring omission. The Nashville blaze is only mentioned briefly in an appendix.

Sources of information are partly to blame for the absence of Nashville information. The NFPA pulls its statistics from surveys of fire departments and information from the National Fire Incident Reporting System (NFIRS), a voluntary program overseen by the U.S. Fire Administration.

“It appears that the Nashville fire you are referring to was not reported in NFIRS and, therefore, did not have the same effect on estimates as the Hartford fire, so it was not noted in the report,” says Jennifer Flynn, a research analyst at the NFPA and author of the nursing home report.

That said, the omission of the Nashville fire probably stops the death rate statistics in the report from being unrealistically inflated by a pair of abnormally catastrophic fires, says Marty Ahrens, manager of fire analysis services at the NFPA.

Also, although the Hartford and Nashville fires resulted in many deaths, from a cause point of view they are only two out of thousands of fires measured in the report, adds Ahrens. Opportunities to learn from nursing home fires aren’t skewed by the absence of the Nashville blaze.

Fires prompt federal action

Neither the Hartford nor the Nashville facility had full sprinkler protection, which gave a black eye to the industry and raised questions about the safety of nursing home residents, many of whom are physically or mentally incapable of evacuating themselves during a fire.

The backlash from the two fires eventually led to Centers for Medicare & Medicaid Services issuing a final rule in 2008 that mandates all nursing homes must have sprinkler protection by August 13, 2013. Nursing homes without sprinklers currently will need to retrofit this equipment. The regulation will cost nursing facilities about $846 million.

Newer editions of the Life Safety Code® also mandate all nursing homes have sprinklers.

The top sources of nursing home fires


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<tr>
<td>Cooking equipment</td>
<td>54%</td>
<td>41%</td>
</tr>
<tr>
<td>Clothes dryer or washer</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>Heating equipment</td>
<td>9%</td>
<td>9%</td>
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<tr>
<td>Trash or rubbish receptacles</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Electrical distribution and lighting equipment</td>
<td>3%</td>
<td>6%</td>
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<tr>
<td>Smoking materials</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Intentionally set</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>Other sources</td>
<td>13%</td>
<td>17%</td>
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Source: Based on material in U.S. Structure Fires in Nursing Homes (September 2008) and Facilities That Care for the Aged (March 2006), published by the NFPA.
discusses the requirements for fire drills, which apply to buildings with 500 or more occupants, or 100 occupants above or below the level of exit discharge.

Even if your building does not meet this occupant load requirement, you may have other fire drill requirements from another authority (e.g., The Joint Commission [formerly JCAHO] or your local fire marshal).

Section 39.7.1 refers to section 4.7, which discusses evacuation and relocation in detail. The purpose of conducting fire drills is to prepare and train your staff members for the proper response when an actual fire occurs. Therefore, the occupants in your freestanding medical office will need to evacuate from the building whenever the fire alarm activates and it is not a test of the alarm system.

It is better to get the people out safely and then determine what caused the alarm. Note that you are not required to evacuate patients during a fire drill. During a drill, staff members need to demonstrate they know and understand the procedures and pathway to evacuate the building and where the relocation rallying point is once they get outdoors. They can use simulated patients or staff members playing the roles of patients to demonstrate this knowledge during drills.

This concept of evacuating the building in the event of fire does not apply to all occupancies, however. Most notably for healthcare occupancies (e.g., hospitals or nursing homes) and detention or correctional occupancies, the LSC features language that requires staff members to be trained in the relocation of occupants to areas of refuge or smoke compartments.

Relocating? Taking a new job?

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had to test the locks on an annual basis. Is this true? If so, what are we supposed to be testing?

Although Chapters 18 and 19 in the LSC permit delayed egress locks in hospitals, section 7.2.1.6.1 explains how they need to be installed.

One of the aspects of operation for delayed egress locks is the requirement to be interfaced with the building fire alarm or automatic sprinkler system. The doors are required to unlock upon water flow, activation of a heat detector, or activation of no more than two smoke detectors. Note this does not necessarily include the activation of a manual pull station.

Although the LSC does not reference a specific requirement for testing delayed egress locks, NFPA 72, National Fire Alarm Code (1999 edition), has a requirement for testing interface equipment.

Table 7-2.2, paragraph 19 says interface equipment connections must be tested by operating or simulating the equipment being supervised. Signals that are required to be transmitted must be verified at the control panel.

Delayed egress locks are not necessarily supervised, but they do have an interface device (control relay) that unlocks the doors on a signal from the fire alarm control panel. NFPA 72 recommends the testing of interface equipment be conducted annually.

One could draw the conclusion that your delayed egress locks should be tested annually to ensure that the power controlling the locks actually drops out upon water flow, activation of a heat detector, or activation of no more than two smoke detectors.

**Hazardous areas in business occupancies**

Do hazardous areas in business occupancies require a self-closing door if the room is protected with automatic sprinklers? We had a surveyor cite us for not having a closure on the door to a storage room that is considered to be hazardous.

Existing business occupancies are required to follow Chapter 39 of the LSC, which states that hazardous areas (e.g., storage rooms) must follow section 8.4.

Section 8.4.1.1 offers the following three options to protect hazardous areas:

- Create a one-hour barrier around the room, which would include a fire-rated door that has positive latching and a self-closer
- Protect the area with sprinklers
- Use both options if the hazard is severe

You are only required to comply with one of the above. If your storage room is protected with automatic sprinklers, as yours is, then there is no requirement for a barrier or a door. If there is no requirement for a door, there is no requirement for a closing device on the door.

However, 8.4.1.2 requires new construction to provide smoke partitions when the hazardous area is protected by automatic sprinklers. Smoke partitions are required to have self-closing doors (see 8.2.4). If your storage room qualifies as a new occupancy or new construction in an existing occupancy, then the surveyor is correct: You need a closure on that door.

See the March Healthcare Life Safety Compliance for more information about hazardous areas, including how to judge whether an area constitutes a severe hazard.

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Send us your questions

If you have a question about life safety compliance, fire codes and standards, or the EC, pass it along to us and we’ll include it in one of Healthcare Life Safety Compliance’s future “Questions & Answers” columns.

Send us your questions in writing by:

- Mail to Healthcare Life Safety Compliance, 200 Hoods Lane, P.O. Box 1168, Marblehead, MA 01945
- E-mail to swallask@hcpro.com (include “Q&A” in the subject line)
- Fax to 781/639-2982 (send your fax to the attention of Healthcare Life Safety Compliance)
Quick tip

Put lab fire blankets on an inspection schedule

Occasionally, we hear about the debate over whether laboratories should keep fire blankets handy.

On one hand, these blankets can help put out a fire on someone when properly used. On the flip side, improper techniques with a blanket can actually make matters worse for a victim by creating a chimney effect that sends smoke and toxic gas toward the person’s face.

The bottom line: If you have fire blankets in any labs, inspect them as you would any other piece of fire protection equipment.

No formal requirements for blankets

The College of American Pathologists, a prime accrediting group for U.S. hospital laboratories, doesn’t require fire blankets in laboratory settings, says lab safety expert Terry Jo Gile, MT(ASCP), MA Ed, owner of Safety Lady, LLC, in North Fort Myers, FL.

Additionally, most labs don’t require the presence of fire blankets, particularly in newly constructed sites. Existing labs with fire blankets can certainly keep them handy, although there is no mandate to do so, Gile says.

However, much like other fire protection equipment, if a lab has a fire blanket available, make sure it is in good condition and actually in any canister hung to the wall, Gile says.

“One time, I went into a lab and they had a canister on the wall, and I checked, and the canister was empty,” she says. “That would be a violation even though they aren’t required, because the presumption is that if there is a canister, then there is an expectation that the blanket is inside.”

Steps to take if you have lab blankets

For labs that have fire blankets in wall canisters, verify annually that the blanket:

➤ Rolls out of the canister easily
➤ Doesn’t have any holes in it

“I checked one once, and moths had eaten several holes in the wool blanket,” Gile says. “Another time, the blanket stuck in the housing.”

You can take the same approach if your operating rooms have fire blankets, but be sure to check with local authorities before removing blankets. Also, if your staff members are expected to use fire blankets in any area, set up refresher training for them. Perhaps blanket inspections and training could occur simultaneously for efficiency.

If you find consistent problems with fire blankets, consider adding this concern to your department surveillance rounds.
Quiz questions

1. (T) (F) Facilities must always implement interim life safety measures (ILSM) in response to inaccessible dampers that can’t be tested.

2. (T) (F) The Life Safety Code® (LSC) defines a physician office as a “business occupancy generally used for patient appointments with their physicians.”

3. (T) (F) About half of all nursing home fires involve problems with cooking activities.

4. (T) (F) Fire and smoke dampers must be tested every six years in hospitals.

5. (T) (F) Annex notes in the LSC are explanatory and not part of the official code language.

6. (T) (F) The College of American Pathologists generally requires fire blankets in laboratories it accredits.

7. (T) (F) Under OSHA regulations, there is nothing wrong with simply evacuating a physician office during a fire alarm.

8. (T) (F) The Centers for Medicare & Medicaid Services will only require nursing homes without hardwired smoke detection systems to install sprinklers by 2013.

9. (T) (F) The LSC requires semiannual testing for delayed egress locks.

10. (T) (F) Hazardous areas must have sprinkler protection and be enclosed by a one-hour barrier.

A supplement to Healthcare Life Safety Compliance
1. **False.** The Joint Commission wants facilities to consider ILSMs to offset inaccessible dampers, but there is not a mandate to actually implement ILSMs in such cases.

2. **False.** The *LSC* doesn’t mention the term “physician office” in its official sections.

3. **True**

4. **True**

5. **True**

6. **False.** The accreditor doesn’t require fire blankets in labs.

7. **True**

8. **False.** The agency will require all nursing homes, regardless of other fire protection features, to have sprinkler protection by 2013.

9. **False.** The *LSC* has no requirements for delayed egress lock testing, although NFPA 72, *National Fire Alarm Code*, has some related testing provisions.

10. **False.** Generally, hazardous areas can be protected by one or the other of these options. Only hazardous areas judged to be severe hazards must comply with both options.