# TSIG NEWS

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## ISSUE 40

### Inside this issue:




**We welcome all our readers and friends to stop by and visit our team of expert consultants at our booth at the 52nd ASHE Annual Conference & Technical Exhibition in Boston on July 12-15, 2015**

**Booth # 1217**

## TJC Has Left the Building – Now What?

**By Jerry Stewart**

Your hospital just completed its tri-annual Joint Commission survey and you've gone through your ten day clarification period with success. The hospital has received the final TJC survey report and you're working on the required ESC.

The pressure is starting to lift and people are taking vacations, life is getting back to the normal high stress of operating your hospital. You have a great weekend and you come in Monday morning and ----BAM! CMS is in the main lobby for a validation survey.

So what could possibly go wrong? You just had a successful TJC survey and your books are still in order. Your phones are ringing as you head down to the opening conference with text messages asking where you are and all, while going through your CMS mental checklist. You start to panic, have we properly prepared the CMS waiver adoption documentation to present in the opening conference with the surveyors? Can I remember which CMS waivers we adopted and have we met all of the NFPA 101 *Life Safety Code* (2000 & 2012 edition) requirements to successfully adopt the waivers?

Next you walk into the opening conference carrying what you hope are the most up to date and accurate life safety drawings (not the LSC deficiency drawings from the SOC) that you used during the TJC survey. There sit two state agency (SA) fire safety inspectors with the task of ensuring the hospital is in full compliance with the CoPs, especially the NFPA 101 *Life Safety Code* (2000) and the Physical Environment.

As we all know, CMS expects the facility to be in compliance at all times with the applicable sections of the NFPA 101 *Life Safety Code* (2000). The fire safety inspectors will usually have time to thoroughly inspect your facility from top to bottom based on the life safety drawings you provided. The inspectors will determine if the hospital is in compliance with the adopted CMS waiver requirements.

You start the building tour and you quickly realize the fire safety inspectors are tracing all smoke barriers, fire barriers, review designated suites, review all identified hazard rooms, exit routes, horizontal exits, exit passageways. You realize how critical it is to keep the facility life safety drawings up to date and accurate. Which we all know can be a difficult task with constant renovation or construction projects occurring.

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After building tours are complete and hopefully with **No** or very few K-Tags, you start the document review. The fire safety inspector(s) review the fire alarm system and sprinkler system testing and inspection documentation and ask which codes were used to inspect and test the systems. We think to ourselves that we passed EC.02.03.05 with flying colors, so what could the fire safety inspector(s) be asking for that is different from TJC? CMS expects compliance with the mandatory references listed in Chapter 2 of the NFPA 101 *Life Safety Code* (2000).

The fire safety inspectors can and will review the hospital testing and inspection documentation for compliance with listed mandatory NFPA codes and appropriate versions such as NFPA 72 (1999), NFPA 25 (1998) , NFPA 99 (1999) NFPA 90A (1999), NFPA 10 (1998), etc. If your inspection/ testing vendor is utilizing a different year than what is listed in the mandatory references (Chapter 2) of NFPA 101 *Life Safety Code* (2000) and not allowed by a CMS categorical waiver, you may be at risk for non-compliance and a K-Tag(s).

So what does all of this mean? The hospital must understand which reference NFPA codes apply (including appropriate year) and ensure vendors are following the appropriate codes when completing testing and inspection activities. The hospital must ensure documentation, provided by the vendor(s) or if completed by in house staff, is correct and complete.

Hospital life safety drawings must be up to date! Remember the fire safety inspectors can spend as much time as required to review the NFPA 101, *Life Safety Code* (2000) compliance in your facility. If the hospital has elected to use any of the CMS categorical waivers you must be able to explain how the hospital meets all waiver requirements and where the waivers are applicable.

So the bottom line, you never know when CMS will show up for a validation survey. Are you ready?

## Insuring Quality in Safety

### By: Ken Gregory

If I went all the way back to my romex pulling electrician days (and that's a LONG time ago) I'd bet a couple bucks that you couldn't open a wall and find a piece wire twisted are crooked in a wall. Or later in my career that every conduit bend was right on the money or it hit the scrap pile. Did that make the electricity go faster, of course not. But every night when I propped my feet up in my recliner, I had no problem relaxing knowing that I didn't just do my job, but did it the best of my knowledge at that time in my career. I couldn't even begin to tell you how many hospitals I have been through, or presentations I've done in the last few years, but one of the things I try to strive to every one is to do everything you do trying to do it better than the last time! I still use that same philosophy. Every day I learn something new to help me provide better service to you all.

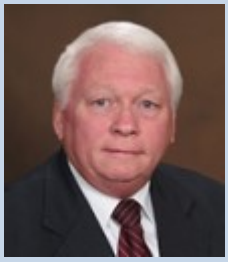
In my hospital days I nearly gave one of my hospital CEO's a heart attack one time by understanding and excepting that we can always improve a process. A good portion of our management team were sitting around the table during an accreditation survey getting ready to go on the building tour portion of the survey. The surveyor asked me point blank "Do you have any penetrations in your smoke and fire barriers we might find?" I replied, without stuttering, "Yes, it is certainly possible." (This is were the CEO fell out of his chair). But then I quickly followed with "My reasoning for that response is that I have 2.5 million square feet of hospital full of smoke and fire walls. To think I would not have a penetration would be beyond unrealistic, but we have an ongoing process of constantly preventing, identifying, and repairing them. What I will promise is that you won't find a pattern or lack of process" The surveyor understood and agreed, although my CEO might still have palpitations occasionally!

There are many performance improvement programs out there and we have all been through many of them. But the one thing that is common in all is to constantly strive to improve your management, your processes, your outcomes, etc. I firmly believe that in order to achieve this it has to start with every single employee, reach to every vendor you use, and right to the board to be as effective as possible. I was presenting on ISO-9001 a couple of weeks ago and the one thing I hope I made clear is that what makes this "quality safety program" effective is the fact that it consistently strives to hold everybody accountable on every level, including outsourced components. For example if a department identifies a process change that can positively benefit the organization in any manner, be it cost savings, a safer environment, or better outcome for the people we serve, and leadership chooses not to support the improvement, they will be held accountable to have a really sound reason for that decision. An effective quality program isn't just looking at "revenue producing departments", as we called them in the old days, but embraces every aspect of the organization as apart of the organization's success. An efficient behind the scenes process/ program can be just as effective on a positive bottom line, and safety of a patient, as the newest CT machine for early detection of a deadly disease. It takes an "Organization", not any one department. An organization dedicated to always striving to improve themselves as a whole.

When evaluating your processes, programs, effectiveness and failures, be sure to look at all aspects. Do I have the right person doing it, or they a natural fit? Does my fire alarm vendor have the same level of quality, craftsmanship, and passion to do it right as you? Are we repairing with quality parts to reduce breakdowns? Whenever we have a system failure, does our evaluation of it include how we can prevent it in the future?

After every day of work go home feeling like you did your job the best you could that day, and sleep well my friends!!

For more information on quality in the workplace, or to find out where these programs are being taught by our staff, feel free to contact Ken Gregory at 615-598-2652 or gregoryk@tsigconsulting.com



## CMS- Humidity Categorical Waiver What's Different Now?

**By Ken McGraw**

Recently , many of our clients have asked whether CMS has rescinded the previously published categorical waiver allowing the reduction of humidity levels in anesthetizing locations.

There appears to be significant concern as to:

1. The specific requirements of this waiver
2. What has changed to make organizations question if the waiver is still allowed

Just a little history on the waiver first:

On April 19, 2013, The Centers for Medicare and Medicaid Services (CMS), published a statement (S&C: 13-25-LSC &ASC) issuing a categorical waiver LSC waiver permitting new and existing ventilation systems supplying hospital and critical access hospitals anesthetizing locations to operate with a relative humidity (RH) of 20%, instead of the previously required 35%. The maximum level was kept at 60%. This waiver would not be applicable if there were more stringent RH controls required by state or local laws and regulations, or where this reduction in RH would negatively affect ventilation system performance.

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This waiver was released by CMS in order to maintain consistence with the recent changes with the American Society for Heating, Refrigerating, and Air Conditioner Engineers (ASHRAE) Standard 170. The lowering of the RH levels was intended to provide adequate levels for patient health and safety while alleviating undue and unreasonable hardship on healthcare facilities.

Acceptance of this waiver does not require any specific applications however healthcare organizations are required to have written documentation that they have elected to use the waiver. This information and notification indicating adoption of this waiver is required to be immediately presented at the opening conference for any survey assessing Life Safety Code compliance.

Essentially the only requirements an organization must take includes:

1. Notification of acceptance of the waiver
2. Producing monitoring records/logs of relative humidity for anesthetizing locations and illustration of those processes for taking corrective action when measurements may fall outside of the desired parameters to ensure that appropriate levels are maintained.

Subsequent to the original issued statement, CMS has published an important update to the original Categorical Waiver. This document, S&C:15-27- Hospital, CAH, & ASC was issued on February 20, 2015, Potential Adverse Impact of Lower Relative Humidity (RH) in Operating Rooms (ORs). This document essentially stated that it has been noted that a humidity level of <30% may not be compatible with the instructions for use (IFUs) for some sterile supplies and electro-medical equipment used in operating rooms.

This statement was issued in conjunction with The Association for the Advancement of Medical Instrumentation (AAMI) and was a coordinated released on January 5, 2015 of a Joint Communication of how this lower humidity level in the OR may affect the performance of some sterile supplies and electro-medical equipment.

What exactly does this mean to our facilities?

1. The categorical waiver is still available and has not been rescinded
2. More effort on organizations that decide to accept this waiver as to the potential impact to the organization.

CMS does have an expectation for hospitals that choose to accept this waiver. CMS expects hospitals, CAHs, and ASC to follow the current information for use (IFUs) for any supplies and/or equipment that could be used in the ORs and that could be potentially affected by the acceptance of this waiver and the lower humidity levels. If an organization fails to adhere to the IFUs, it will be cited, even though the hospital has decided to use this categorical waiver. This would be cited under §482.41(c)(2) for hospitals, §485.623(b)(1), for CAHs, and §415.44(a)(1) for ASCs.

What does this mean for healthcare wishing to accept this waiver?

Hospital wishing to utilize this waiver must realize that the most important aspect is to ensure patients are protected through the safe and effective use of equipment and products during surgical procedures. Additionally, hospitals have to be aware of the potential waste of resources for installation, energy and on- going maintenance that don't improve patient outcomes so that resources can be better utilized.

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It is important that healthcare facility leaders think about whether lower levels of humidity are desirable and appropriate for their facility based upon the potential impact on equipment and supplies being used. Before adopting the CMS Categorical Waiver and establishing the lower humidity levels (20%-60% RH), the healthcare organizations should conduct a detailed risk assessment to determine whether the potential impact to equipment and supplies may be compromised as a result of this change. This may best be evaluated by establishing a multi-disciplinary team of in-house resident experts from various departments such as Engineering, Infection Prevention, Operating Room, Risk Management, Clinical Engineering, Materials Management, Quality and Medical Staff.

Some questions that this team should consider assessing include:

1. What is the desired minimum humidity level and range in the OR and what is the actual level of humidity the HVAC system is able to achieve and maintain in varying weather conditions?
2. Have you assessed humidity level data over time to know whether, when, and for how long the humidity levels fall below 30% due to environmental conditions with all seasonal variations?
3. Have you determined what the IFUs say about humidity levels for each item in the existing inventory of supplies and equipment used in the OR?
4. What are the likely risks of using equipment that calls for a humidity level of 30% or higher (which may be prevalent with older electro-medical equipment?) What are the potential impacts on performance?
5. Request data from manufacturers documenting the variance of time that products can be out of range before their package integrity or performance are impacted. Learn and understand how integrity and performance are affected when supplies and equipment are stored and used out of range.
6. For any planned new supplies and equipment, what are the anticipated recommended humidity levels for storage and use?
7. Using all available information, have you done an overall assessment to determine whether the benefits of lowering the humidity level threshold below 30% override the potential risks?
8. If the decision is made to maintain humidity levels below 30%, consider moving supplies that call for humidity levels of 30% or higher to a humidity controlled closet.

As responsible Facility Directors, Infection Preventionist and Operating Room Managers it is critical that we are diligent in the assessment of maintaining an appropriate environment for surgical supplies and equipment. The proper temperatures, humidity levels, and pressures are critical and essential to providing a safe and effective environment for the patients that we serve.

# The G.O. Team's NFPA 101 Q & A

by **G**abriel Villegas, LEED AP and **O**lga Pankova, LEED AP

**Question: What are the requirements for dead-end corridors in Business occupancy?**

**Answer:** Dead-end corridors are limited to 20 ft in new business occupancy buildings that are not protected throughout by an approved, supervised automatic sprinkler system. If sprinklers are provided, the code allows the dead-end corridor pocket to be as long as 50 ft.

Existing business occupancies are permitted to have 50 ft dead-end corridor regardless of the presence of sprinklers.

*NFPA 101 2000 Edition Section 38/39.2.5.2*

**Question: We are looking for clarification in regards to the master fire alarm control panel location. What are the provisions as per the code?**

**Answer:** The code requires the location of the fire alarm control panel to comply with one of the following:

A protected area that is continuously occupied. Such an area would have 1-hr fire rated walls and ¾ hr fire-rated doors.
Provide a smoke detector. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted.
*NFPA 101 2000 Edition Section 9.6.4*
*NFPA 72 1999 Edition Section 1-5.6 and 3-8.41*

**Question: What are the requirements applicable to fire extinguisher in kitchen areas?**

**Answer:** A Class K-type fire extinguisher the most suitable to control fires inside kitchens areas. It is designed to form a thick layer over the grease to contain the fire until it is out. Also, these extinguishers must be located within 30 ft of the grease-producing cooking device.

In addition, a sign near the Class K-type extinguisher must clearly state that the fire suppression system protecting the cooking appliances should be activated first, followed by use of the portable Class K-type extinguisher.
This does not mean that ABC fire extinguishers can never be used in a kitchen; they can be use in areas that do not involve cooking.
*NFPA 101 2000 edition Section 18/19.3.5.6*
*NFPA 10 1998 Edition Section 2-3.2*

**Question: During a recent survey I was cited for a pass-thru window located in the pharmacy that was exceeding the minimum size required by the code. Can you please provide some clarification?**

**Answer:** It should be noted that these openings are permitted only in smoke compartments that do not contain sleeping patients.

Miscellaneous openings for new healthcare occupancies such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows shall be permitted to be installed in vision panels or doors without special protection, provided that

the aggregate area of openings per room does not exceed 80 sq. in. and the openings are installed at or below half the distance from the floor to the room ceiling. The only difference between new and existing healthcare is that for existing the opening cannot be more that 20 sq. in., unless the room or rooms are provided with a sprinkler system in which case the aggregate area can go up to 80 sq. in.

*NFPA 101 2000 Edition Section 18/19.3.6.5*

**Question: What are the requirements for egress corridor illumination in Healthcare occupancy as per NFPA?**

**Answer:** The required illumination must be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.

The two areas where the issue commonly occurs are in a vestibule and in the exit discharge. If a single light fails, 0.2 foot-candles of illumination must still be provided. Therefore, an area of the building with just one light could present a problem. It is recommend evaluating the minimum levels of illumination in terms of both emergency and normal lighting with one light not functioning.

*NFPA 101 2000 Edition Section 7.8.1.4*

**Question: Are corridor doors in patient sleeping areas required to be positive latching? Is the closer enough to keep the door closed in case of emergency?**

**Answer:** There are differences between new and existing Healthcare occupancies when it comes to corridor door requirements in patient sleeping areas.

For new healthcare the code is very straight forward - corridor doors must be provided with positive latching hardware. Roller latches are prohibited. Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials are exempt.

When it comes to Existing Healthcare, the code requires a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lb/ft. is applied to the door. Roller latches are prohibited on corridor doors in buildings not fully protected by a sprinkler system. As in new healthcare, wet areas are exempt.

*NFPA 101 2000 Edition Section 18/19.3.6.3.2*

**Question: Are portable space-heating devices permitted in Healthcare occupancies?**

**Answer:** Portable space-heating devices shall be prohibited in all health care occupancies with one exception. on: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).

*NFPA 101 2000 Edition Section 18/19.7.8*

**Question: Is there any difference between New and Existing Business occupancies when it comes to travel distance to exit?**

**Answer:** Travel distance requirements to an exit for New and Existing Business occupancies are exactly the same. It should not exceed 200 ft in buildings that are not protected throughout by an approved,

supervised automatic sprinkler system. If sprinklers are provided, the code allows up to 300 ft.

*NFPA 101 2000 Edition Section 38/39.2.6*

## Requesting A Traditional Equivalency from TJC

**By Wayne Kestler**

There are many components to include in the completed document package needed for a request for traditional Life Safety Code equivalency with Joint Commission. The Joint Commission requires healthcare organizations to follow the submittal process exactly. Any applicable deviation can result in denial of the request and/or re-submission. Below is a step-by-step approach to submitting requests for Joint Commission's traditional Life Safety Code equivalency.

1. Begin by completely filling out the Joint Commission Equivalency Request Form which is available on the Joint Commission web site. Utilize the form as a cover page for your documented request package.

   Amongst other information, the form contains a dialog box to enter a synopsis of the equivalency request. This synopsis should be short and simple, no more than one paragraph. An example of such a synopsis is provided below:

   Please review and approve the enclosed request for Life Safety Code equivalency at ABC Hospital. The purpose of our request for equivalency is to have a surgical unit that is greater than 10,000 square feet equivalized as a non-sleeping suite.

   The form also contains another dialog box to enter proposed mitigation and/or deficiencies to be corrected. Again, these statements should be short and simple. Opportunities to fully elaborate are available later in the process. An example of what this language should look like is provided below:

   The hospital intends to use fire sprinklers throughout to mitigate Life Safety Code requirements limiting the size of non-sleeping suites to a maximum of 10,000 square feet.

2. Attach a copy of the hospital survey report where applicable. (This is only required if a deficiency was found during a Joint Commission survey event. It does not apply to self-identified deficiencies).

3. Complete a "detailed" traditional request for equivalency letter. This detailed request letter must be created on organization/company letterhead that includes all required supporting evidence:

   Begin by re-stating the synopsis of the equivalency request that was entered into the Joint Commission Equivalency Request Form.

   Next draft a paragraph that details any pertinent background information on the building and/or the deficiency. Examples of such background information include: (The number of floor levels of the building, era of construction and construction type, location of the deficiency area, the size of the unit (for suite classification), and level of fire sprinkler protection and smoke detection.

   Next draft an explanation of the deficiency that the equivalency is being requested for. Include the specific Life Safety Code reference from NFPA 101, and any other relevant NFPA standards. Also include the Joint Commission life safety chapter reference, where applicable.

   Then provide a written description of the alternative methods proposed to achieve an equivalent level of life safety. This "alternative proposal" is the most important component of the detailed request letter, so don't be afraid to elaborate fully. This is the

opportunity to propose a trade-off to offset a prescribed Life Safety Code requirement with alternative means or methods.

Examples of “alternative methods” include but are not limited to, being fully a sprinkled building or compartment, or providing additional sprinkler protection for a specific purpose. Additional smoke detection also bodes well. References from other NFPA standards that support the case for equivalency have also proven to be effective. Having more than two exit access doors is effective for oversized suite classification. Just about any additional fire safety or security provision is worth including in the alternative proposal.

Be sure to attach detailed drawings showing existing conditions and proposed solutions, where applicable. (Drawings are always required for suite classification) Also include photographs or other documented evidence of the placement of equipment.

If additional work is required to support the alternative proposal then create a PFI in the hospital’s e-SOC and provide the unique ID number. Indicate the total cost and describe the source, availability, and commitment of funds for such work. Lastly, provide a timetable of the work events from the present through completion.

Next draft a statement indicating that the deficiency has been evaluated for the need to implement interim life safety measures in accordance with the criteria set forth in hospital policy. Indicate any measure(s) taken, if any. (This step is usually not necessary for suite classification).

A new requirement for all detailed request letters is written justification for why this issue poses an unreasonable hardship to the healthcare organization. All equivalency requests must now include an assessment of the hardship for which corrective actions may cause that, if completed, would not provide a significant benefit to patient care delivery. The hardship assessment should identify patient safety and/or financial impact.

Examples of unreasonable hardship might include but are not limited to the following:

- Installing fire proofing to structural I-beams which would cause impractical disruption and possible closure of an entire nursing unit.
- Since the surgical unit is too large to qualify as a suite, the hospital is subject to all the existing corridor requirements set forth in the 2000 edition of NFPA 101:19.3.6 as well as other corridor rule requirements set forth in NFPA 101: chapter 7. Thus, the hospital struggles with balancing the burden of compliance vs. having needed clinical equipment close by and accessible for clinical emergencies, (a patient safety hardship).
- Financial hardship would occur because existing fixed building features compromises life safety and the only corrective action would be result in significant construction costs.

Another new requirement for all detailed request letters is to provide a written assessment indicating that overall patient safety will not be diminished by the resulting equivalized conditions.

TJC has not specified any specific format for this assessment. And it is not required to be a separate document within the submittal. The request submitted must address the submitter having simply done an assessment of patient safety in relationship to the equivalency requested and that there is no negative impact to patient safety. Most submitters now include such language in the body of the executive summary/letter request.

My suggestion is that the healthcare organization document a simple risk assessment in relation to the proposed equivalency and provide a statement at the conclusion of the

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detailed request letter that states, “overall patient safety will not be diminished by the resulting equivalized conditions”. My experience has been that most equivalized conditions usually don’t diminish overall patient safety provided that detailed risk assessments are performed.

Sign the detailed request letter and include your contact information

4. The last requirement for submission is to have one of the following certifying in writing that to the best of their knowledge, the healthcare organization’s proposed alternative solution meets either the intent of the Life Safety Code or will provide an equivalent level of life safety.

    - A registered Architect; or
    - A licensed certified fire safety professional, (i.e., a fire protection engineer or professional engineer) or
    - A local authority having jurisdiction, (i.e., over enforcement of safety, fire marshal, or building official)

    This certification letter should be on the architect’s, engineer’s or AHJ’s official stationery and simply state something like that depicted below:

    We have reviewed and field verified the hospital’s ”Request for a Traditional Life Safety Code Equivalency’, dated __/__/__ in regard to the deficiency on the __ floor of the main Hospital building. We are familiar with the description provided, as well as the deficiency.

    To the best of our knowledge, it is our professional opinion that the hospital’s proposed Alternative Solution will provide an equivalent level of life safety to that intended by the Life Safety Code.

5. To submit a request for traditional Life Safety Code equivalency to Joint Commission, package up the following and submit via one of the two options listed below:

    - The Joint Commission Equivalency Request Form (Cover Letter);
    - A copy of the survey report (if applicable);
    - The detailed request for equivalency letter;
    - Any and all supporting drawings, photos or other documentation;
    - The certifying letter from an architect, fire protection engineer, PE or local AHJ;

**Option A:** Email Option (Maximum Size 10 MB): All applicable above documentation as an attachment submitted to Engineer@jointcommission.org. Reference the Health Care Organization (HCO) Identification Number after “Request for Traditional) Equivalency” is keyed into the subject line.

**Option B:** US Mail Option: All applicable above documentation in a pdf format on a NON-RETURNABLE, USB or CD sent receipt/return mail to:

The Joint Commission Department of Engineering
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
Re: Traditional Equivalency Request

The Joint Commission will send an email of receipt to the submitter email address listed in the JOINT COMMISSION EQUIVALENCY REQUEST FORM.

If you have any questions or need further guidance on submitting an equivalency request, please contact *TSIG Consulting Inc. at (212) 420-8724*

## Travel Distance In Healthcare

by **Larry Barlow**

More and more frequently I am finding travel distance issues in Healthcare buildings. It is a common mistake to think that you always have the 200 feet overall travel distance from any point in a fully sprinkled Healthcare building to get to an exit. By the 2000 edition of the Life Safety Code the 200 ft of travel distance has conditions. If you are surveyed under 2012 edition of the life safety code all of the following may not apply. It is understood that if you are surveyed under the 2012 edition of LSC you are not receiving Medicare/Medicaid funding because a Condition of Participation for M/M funding would be to meet requirements of the 2000 edition of LSC. If you are using another "Deeming" authority to meet the COPs for M/M then this applies to you.

**Travel Distance to an Exit:**

In order to use the full 200 feet of travel distance you would have to have a fully sprinkled BUILDING. A mistake that is frequently made is to think that a fully sprinkled building is the same as a fully sprinkled occupancy or even worse a fully sprinkled smoke compartment. An example of this would be to have an un-sprinkled Business or Industrial occupancy under or on top of a fully sprinkled Healthcare occupancy. The un-sprinkled space is still in the BUILDING so you cannot take the additional 50 feet of travel distance from the room door to an exit because the BUILDING is not fully sprinkled. In order to consider the other occupancy as a separate building it would have to be separated from the Healthcare occupancy by a vertically aligned 2 HR FRR (some exceptions apply) wall commonly referred to as a Party Wall, not just 2 HR FRR construction (2 HR FRR barrier). If you wonder if you have a Fire Wall (Party Wall) go to the roof and see if it extends above the roof. If it does not then it is a safe bet that you have 2 HR FRR construction only. Fire Walls go from dirt to sky.

By the 2000 edition of the LSC the overall travel distance is actually 3 measurements. The first part of the travel distance is from the room door (required as an exit access), to an exit. The maximum distance is 100 feet for un-sprinkled buildings. An additional 50 feet may be added if the building is fully sprinkled. This limits the travel distance from a room door (required as an exit access), to an exit to 100 feet in un-sprinkled buildings and 150 feet in fully sprinkled buildings. This is often overlooked and is where most mistakes are made. Room door to an exit can never exceed 150 feet.

The second part of the measurement is overall travel distance. Travel distance from any point in a room to an exit is limited to 150 feet in un-sprinkled buildings and 200 feet in fully sprinkled buildings. If you have a room in a fully sprinkled building where the travel distance in the room to the door of that room (required as an exit access), is 60 feet you would then be limited to 140 feet from the room door to an exit. You cannot exceed the overall travel distances "from any point in a room to an exit" limitations. For fully sprinkled buildings (200 feet), and non-sprinkled buildings (150 feet). I can travel as much as I want in the non-patient sleeping room but I cannot exceed the overall travel distance limit. (see image #1)

The third measurement applies to patient sleeping rooms and travel distance from any point in that room to the exit access door to that room. Travel distance within the patient sleeping room is limited to 50 feet. If you have a patient sleeping room in a fully sprinkled building and the travel distance in the room is 30 feet you would be limited to a overall travel distance of 180'. The same room in a non-sprinkled building would be limited to 130'. In both cases the limiting factor is the distance from the room door to an exit (150 feet and 100 feet respectively).

This is the mistake I see often. It is assumed, erroneously, that you have the full overall travel distance from any point in a patient sleeping room to an exit. You are not allowed to take travel distance not used in the patient sleeping room and add it to the travel distance from the room door to an exit. (see image #2)

image #1

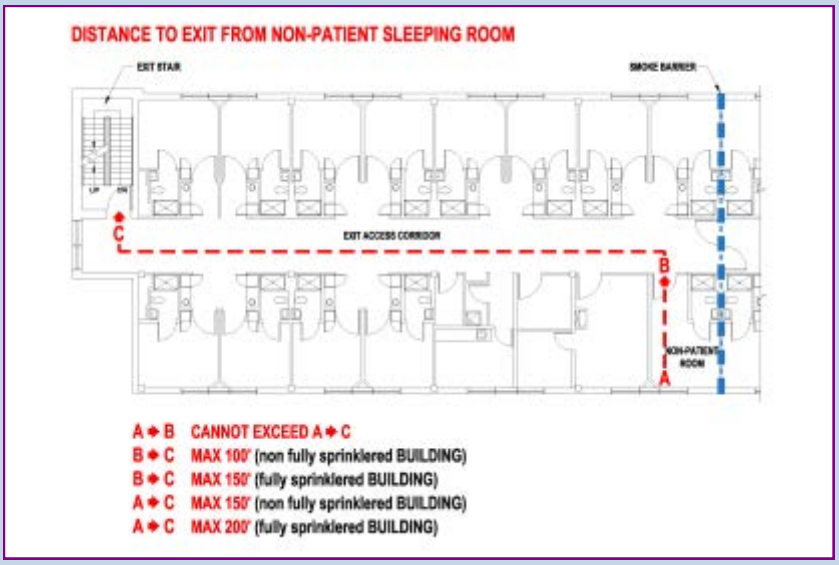



image #2

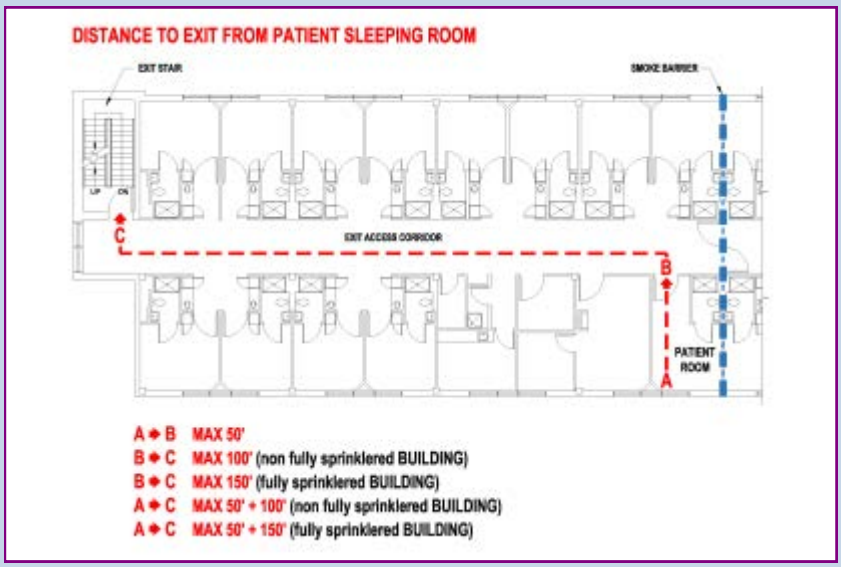
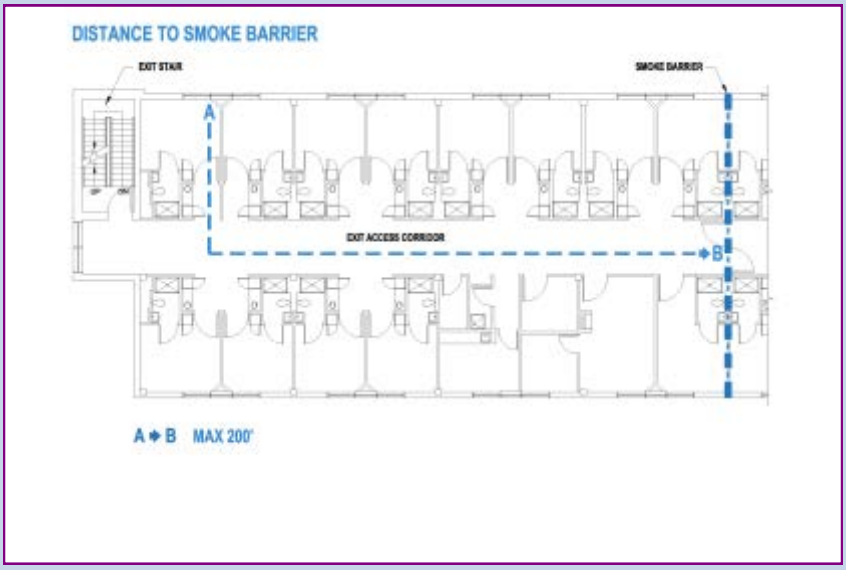



image #3



**Conclusion:**

If you do not have a fully sprinkled building and you have overall travel distances > 150 feet you definitely have an issue.

If you do not have a fully sprinkled building and you have overall travel distances from patient sleeping rooms approaching the 140 feet range you need to insure that you meeting the 100 feet limit from the room door.

If you have a fully sprinkled building and you have overall travel distance from patient sleeping rooms approaching 200 feet you need to insure that you are meeting the 150 feet limit from the room door to the exit.

Note: If you have suites you will be allowed to travel 100 feet within the suite but will still be held to the 150 feet overall travel distance limit to an exit for un-sprinkled buildings and 200 feet limit of overall travel to an exit in fully sprinkled buildings.

**Travel Distance in Smoke Compartments:**

Travel Distance to a Smoke Barrier is measured from the most remote point in the smoke compartment to a door in a smoke barrier. Because your patients can not normally be moved down a stair you cannot substitute a stair for a door in a smoke compartment. (see image #3)

Since the travel distance in a smoke compartment is limited to 200 feet to a door in a smoke barrier the barriers could be approximately 400 apart not every 200 feet. The limiting factors are travel distance to a door in a smoke barrier and sq ft limit of a smoke compartment which is 22,500.

One exception to this is based on the overall length and width of the smoke compartment. If neither is over 150 feet the travel distance to a door in a smoke barrier is unlimited.

**Conclusion:**

Review your drawings to make sure you do not have too many smoke barriers based on 200 between rather than 400 feet between.

Verify you are measuring from the most remote point to a door in a smoke barrier and not a door in a stair.

**Summary:**

The best way to determine if you have travel distance issues is have a good set of Life Safety Drawings developed that indicate overall travel distance to an exit and travel distance to a door in a smoke barrier. Once you have overall travel distances it is pretty easy to identify if you have room door to exit issues. It will also allow you to correctly evaluate quantity and quality of smoke compartments.

IF you have travel distance issues (greater than 100 feet from a room door in an un-sprinkled building or greater than 150 feet from a room door in a fully sprinkled building but are still within the overall travel distance allowance), you may want to create a PFI, with appropriate ILSM measures, and identify a completion date that allows for adoption of the 2012 edition of the LSC. The 2012 edition of the Life Safety Code eliminates the room door to exit limitations. In other words it is an overall travel distance approach. However the room travel limitation of 50 feet is still in effect for patient sleeping rooms. The 2012 edition of the Life Safety Code allows you to use the full travel distance (150 feet in partially or un-sprinkled buildings and 200 feet in fully sprinkled buildings).

Another option would be to request an equivalency based on a newer code. While either of these options would protect you from a Deeming Authority finding it will not protect you from a CMS finding. The only way to satisfy this issue with CMS would be to complete a Fire Safety Evaluation System (FSES) which is accepted by Deeming Authorities and CMS.

## Being a Professional

**By Ode Keil**

Professions are groups identified with bodies of knowledge. Engineers, lawyers, nurses, physicians and others have established themselves as professions. They have formed national and international societies to establish standards of practice and codes of conduct to demonstrate to all their commitment to ideals of high quality, improving lives and high standards of behavior. These standards and codes obligations one assumes when taking on the role of professional.

Healthcare facilities management is a profession. The members have created local, state, national and international societies. Each has established standards, codes of conduct and ways to distinguish members who demonstrate professionalism through certification, contributions to the profession and other means. The societies have research and advocacy functions. The benefits and value of these is only realized with the individual members become accountable for living the standards and using the resources to better the organizations and individuals he or she serves.

As professionals healthcare facilities managers are being challenged to apply themselves to new problems. New problems cannot be solved with old knowledge. The first challenge of solving new problems is to understand change and how to be a change agent. Every profession is continuously reinventing itself as new knowledge, technologies and relationship emerge with the passage of time. Every reader has heard someone make statements about leadership being a lifetime learning experience. Professionals are leaders, learning is an obligation.

The second challenge of new problems is developing innovative roles, processes and tools. A popular phrase in use today is “disruptive technology”. It is used to describe a new tool that is so different and superior to all previous related technology that it immediately creates opportunities to develop new ways of doing things and to do new things not previously perceived as possible. The healthcare business is involved in a whirlwind of new possibilities because the number of disruptive events is at an all-time high. Facilities managers are clearly along for the ride as the industry works to redefine itself as the foundation for living healthy lives rather than the repair shop for injury and acute and chronic diseases and conditions. Telehealth, shifting from inpatient to outpatient services, managing the impact of the growing consumerism movement and other forces are reshaping the physical landscape of healthcare. Locations are changing, demands on buildings and infrastructure are changing and the velocity of change is propelling people forward in ways that require agile decision making and adaptability as core skills.

The third challenge of new problems is learning to manage collaboratively across different cultures, in the face of the business drivers above and to build new relationships in organizations to achieve common goals for the public good. The consolidation of healthcare will continue for years to come. Businesses will be brought together. The integration of cultures is an awkward and sometimes painful process. Being able to navigate this challenge is, in my view, the most difficult of all the challenges of being a professional and a change agent.

In the end, we will be professionals if we inspire people to learn, to have higher goals and bigger dreams and to become more.

## Revised AFS and PDA Accreditation Decision Process
**by Dean Samet, CHSP, CJCS**

Per the March 11, 2015 *Joint Commission Online* publication, effective immediately, the accreditation decision processes for organizations undergoing resurvey and renewing their accreditation has been revised. These revisions have been made to the Accreditation with Follow-up Survey (AFS) and Preliminary Denial of Accreditation (PDA) processes to streamline the post-survey process and expedite the resolution of requirements for improvement (RFIs). Purportedly these changes will reduce the time between an accreditation survey and the rendering of a final accreditation decision and help safeguard patient safety.

Accreditation Decision: **Accreditation with Follow-up Survey (AFS)**
– In the previous process, the Accreditation Committee of the Board of Commissioners made all follow-up actions.
– In the revised process, the Joint Commission's chief medical officer will make AFS decisions. (Exceptions may be presented to the accreditation for action). Organizations will receive notice of the AFS decision within 10 business days of the accreditation survey. A follow-up survey is to be conducted within approximately four months.

Accreditation Decision: **Preliminary Denial of Accreditation (PDA)**
Note: Revisions do not apply when the PDA recommendation is based on the following:
> An immediate threat to patient health or safety
> Individuals or organizations do not possess required licenses, registrations or certifications
> Falsified documents or misrepresented information are used to achieve or retain accreditation
> If an organization with a Contingent Accreditation decision has failed to clear noncompliant standards during the follow-up survey

– In the previous process, PDA decisions were made when an organization's patients were at risk for a serious, adverse outcome. Because subsequent improvements by the organization were not considered in the PDA decision-making process, there was little incentive for organizations in PDA status (and on track for Denial of Accreditation) to expedite the resolution of problems- potentially leaving patients at risk.

– In the revised process, all corrective evidence of standards compliance (ESCs) are due within 45 days of the organization being notified of the PDA recommendation. After the ESC is accepted, a follow-up survey is conducted to validate that the organization has implemented the improvements. If all the RFIs that resulted in the PDA are resolved, staff will recommend that the accreditation history reflect a "time limited" PDA decision. In addition, the current accreditation status will be upgraded to Accreditation with a Follow-up Survey. This includes a second follow-up survey. If the organization does not resolve all the RFIs that resulted in the PDA, staff will recommend that the organization receive a PDA decision and continue toward Denial of Accreditation.

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# TSIG News

## ISSUE 40

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### WHAT OUR CLIENTS SAY ABOUT TSIG:

Tom,

Thank you so much for all of your help with RiverCrest and Doctors Hospital. We truly appreciate everything you've done for us and we look forward to continuing to work with you.

Sincerely,

Christy Messer CEO Associate Corporate COO

NeuroPsychiatric Hospital & Research Institute