Transitioning from Construction to Survey-Ready Compliance - Part 2

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The management plans, policies and procedures for renovations or expansions on an existing campus should reflect the impacts of the project on the existing facility. These impacts can include changes to facilities and areas, changes to infrastructure equipment and systems, new operational and infrastructure-related processes, and department locations or relocations.

Risk assessments may be required for safety, security, fire, and where the facility intends to permit patient smoking. Additional risk assessments may be done for input to the Emergency Operations Plan (EOP) and hazard vulnerability analysis (HVA), as well as hazardous chemicals, hazardous energy sources (including radiation, lasers, batteries), hazardous medications, hazardous gases and vapors, and radioactive materials. Other types of risk assessments apply to Life Safety Code™ deficiencies and Interim Life Safety Measure (ILSM) documentation, preconstruction risk assessments (PRA), and infection control risk assessments (ICRA).

Some of these risk assessments might be used to establish written inventories in the following areas as subsets based upon risk:

- Hazardous materials and waste
- Medical equipment (evaluation prior to initial use)
- Operating components of utility systems (evaluation of new component types prior to initial use)

Many of the systems and equipment, including life safety building features or components, must be commissioned and/or tested prior to initial use. It is not practical to list all of these item types here. Presumably project record documentation that includes all of the information required by the AHJ would be acceptable as long as it is available during survey.

The Project Record Documentation can be helpful in providing the complete list of components for ongoing testing provided that it is available early enough to be useful. The following systems and components require ongoing testing, and there would have to be policies, procedures, schedules, requirements, and forms that detail this testing:

- Fire safety equipment, fire safety building features, fire alarm, fire protection and sprinklers, fire extinguishers and extinguishing systems
- Smoke and fire dampers, air handling unit shutdown, elevator recall, etc.
- Door operation, exit door and corridor door resistance
- Medical equipment on the inventory
- Operating components of utility systems on the inventory
- Emergency power, medical gas, and vacuum systems and equipment
- Pathogenic biological agents in cooling towers, hot water and cold water systems
- Temporary systems required for ILSM

Project testing and certification reports would have to be on file and easily (Continued on page 2)
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accessible during unannounced surveys. Types of project-related testing and certification reports could include, but are not limited to, the following:

- Contractor documentation and commissioning (Cx) agent documentation
- Documentation of typical AHJ inspections and approvals: Local, State, NRC, DOT, FAA, etc.
- Helipads and separator tank, elevators, fuel tanks, pressure vessels, fire protection water systems, lightning protection systems
- Building automation or building management system
- Low voltage systems, both medical and otherwise

Part 3 will be in the January/February 2010 Compliance News issue.


CMS Categorical Waiver for Damper Testing Cycle

By Dean Samet, CHSP - DSamet@ssr-inc.com

On October 30, 2009, the Centers for Medicare & Medicaid Services (CMS) issued a “categorical waiver” whereby hospitals may apply the 2007 NFPA 80 and NFPA 105 six-year testing interval for fire and smoke dampers in heating and ventilating systems in hospitals without special application to CMS. This action brings CMS in line with The Joint Commission and other state agencies and authorities having jurisdiction (AHJs) across the country.

The CMS Survey and Certification Group October 30, 2009 memorandum states: “After due consideration of State survey agency findings and conclusions of the National Fire Protection Association (NFPA), we are issuing a categorical waiver pursuant to 42 CFR 482.41(b)(2) to permit a testing interval of six years rather than four years for the maintenance testing of fire and smoke dampers in hospital heating and ventilating systems, so long as the hospital’s testing system conforms to the requirements under 2007 edition of NFPA 80: Standard for Fire Doors and Other Opening Protective and the 2007 edition of NFPA 105: Standard for the Installation of Smoke Door Assemblies. The six-year testing interval shall commence on the date of the last documented damper test.

“While the 1999 edition of NFPA 80: Standard for the Installation of Air-Conditioning and Ventilating Systems specified a four-year testing cycle, the NFPA more recently determined that an increase to a six-year interval did not lower the fire protection of hospitals but could instead lower the incidence of infections that may be spread when the ventilation system was shut down and restarted at shorter time intervals. There is also some indication of cost savings to institutions when maintaining these dampers on a longer time interval.

“Under this categorical waiver, a hospital that conforms to the above requirements will not need to apply in advance for a waiver nor will it need to wait until being cited for a deficiency in order to apply for a waiver. At the time of a CMS onsite life-safety code survey, the hospital must notify the survey team that it has elected to operate under this categorical waiver and is in conformance with the testing requirements of the above-cited 2007 NFPA edition. The survey team will note this attestation in its records and apply the 2007 testing cycle requirements in the course of its survey.”
CMS Clarifies LSC Application for Off-Site Buildings

By Dean Samet, CHSP - DSamet@ssr-inc.com

There are many instances when hospitals have off-site spaces or on-campus buildings physically separated or separated by rated construction where they provide ambulatory surgery or a variety of outpatient services. There are occasions when inpatients are transported to one of these buildings for services or treatment not available in the hospital. Does the occupancy designation change because some inpatients are being treated? What chapter(s) of the Life Safety Code® should be applied? In a July 30, 2008 e-mail to CMS regional personnel, the Centers for Medicare & Medicaid Services (CMS) Life Safety Code Specialist, James Merrill, P.E., provided the “Survey Process” criteria below that summarize the Life Safety Code® chapters to be applied to off-site buildings owned or leased by hospitals for outpatient department services, ambulatory surgical services, nursing homes, etc. This reconfirms and updates a Health Care Finance Administration (HCFA) directive written in March of 1993. This criteria may be used as a first step in determining appropriate LSC application for those instances when hospitals have off-site spaces or those separated by one-hour or two-hour construction between occupancies where they provide ambulatory surgical or other outpatient services.

Survey Process:

1. If inpatients receive treatment or services routinely, on a 24-hour basis (sleeping in the building), then Chapter 18/19 (Health Care Facilities) should be applied.
2. If outpatients (and/or inpatients, but the inpatients do not sleep in the building overnight) receive treatment or services in the outpatient building (a separate building), and if they are incapable or are rendered incapable, of self-preservation or receive general anesthesia, then Chapter 20/21 (Ambulatory Health Care) should be applied.
3. If outpatients receive treatment (and/or inpatients, but only on an occasional basis and they do not sleep in the building overnight), and if they are capable of self-preservation and do not receive general anesthesia, then Chapter 38/39 (Business Occupancies) should be applied.
4. If there is more than one occupancy in a building without a two-hour separation between occupancies, the most stringent occupancy chapter applies.

While the above-listed CMS survey process for occupancies outside of a healthcare occupancy is summarized, the nature of the medical services provided and to whom they are rendered must be considered as should the LSC definitions provided in the 2000 NFPA 101® Life Safety Code®.

Fireplaces in Hospitals

By Robert Trotter - RTrotter@ssr-inc.com

Prescriptive requirements for fireplaces in new and existing healthcare occupancies are found in the NFPA 101®, Life Safety Code®. Likewise the 2009 Hospital Accreditation Standards of The Joint Commission has three Elements of Performance in the Life Safety Chapter relative to fireplaces. They are:

- LS.02.01.50 EP 1. Fireplaces are not permitted in patient sleeping areas. Where allowed, fireplaces are separated from patient sleeping spaces by one-hour or more fire-rated construction.
- LS.02.01.50 EP 2. Fireplaces are equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650° F and constructed of heat-tempered glass or other approved material.
- LS.02.01.50 EP 3. The hearth of newly installed fireplaces is raised at least four inches above the floor.
Combustible Decorations

By Dean Samet, CHSP - DSamet@ssr-inc.com

It’s that time of the year again when there is a propensity to cover walls, doors and hang decorations from ceilings in celebration of the particular holiday season. Typically these decorations are not flame retardant; therefore they could contribute to the development or spread of a fire. Per Section 19.7.5.4 of the 2000 NFPA 101® Life Safety Code®, “Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present.”

It is a judgment call when determining if the hazard for fire development or spread is present; however, newer editions of the Life Safety Code do state that, “…consideration should be given to whether the building or area being evaluated is sprinklered.”

Policies and procedures (P&Ps) that prohibit and strictly limit the use of any combustible decorations should be in place and enforced. Send memos to each department, especially nursing units, and follow up with a safety/security personnel visit to discuss and answer questions regarding the P&Ps.

Just a reminder, fire safety is each and every staff member’s responsibility.

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PUBLICATIONS & SEMINARS

Publications

“Shock Resistant - Preventing arc-flash hazards in the hospital setting,” Health Facilities Management, October 2009

Speaking Engagements/Seminars in 2010

April 11-14, 2010 TAHFM Interlink 2010, Dallas, TX, “Hot TJC Topics for 2010”

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