The New “Life Safety” Chapter—What It Applies to and How Organizations Can Comply with It

The Joint Commission requires health care organizations to comply with the Life Safety Code® to help ensure fire safety. In the Life Safety Code, the National Fire Protection Association (NFPA) specifies construction and operational conditions to minimize fire hazards and provide a safety system in case of fire. To help assess compliance with the Life Safety Code, The Joint Commission created the “Life Safety” (LS) chapter, which includes all the Joint Commission requirements regarding Life Safety Code compliance. The LS chapter applies to any organization or part of an organization that is considered a health care, ambulatory care, or residential occupancy.

* Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.

What Is an “Occupancy”?

The Life Safety Code, otherwise referred to as NFPA 101®, defines occupancy as “the purpose for which a building or portion thereof is used or intended to be used.” Following are brief descriptions of several different occupancy types recognized by the Joint Commission.

**Health Care Occupancy**

A health care occupancy is defined in NFPA 101 Section 3.3.134.7 as “an occupancy used for purposes of medical or other treatment or care of four or more persons where such occupants are mostly incapable of self-preservation due to age, physical or mental disability, or because of security measures not under the occupants’ control.” Although this definition does not address overnight sleeping accommodations, Chapters 18 and 19 on health care occupancies address health care occupancies with overnight sleeping accommodations. Incapable of self-preservation means that in the event of fire, a person is not able to leave the building on his or her own (even if it requires the use of a wheelchair). For the purposes of occupancy definition, the fact that a person is in a wheelchair does not make him or her incapable of self-preservation. Health care occupancies include “general hospitals, psychiatric hospitals, and specialty hospitals,” as well as “nursing and convalescent homes, skilled nursing facilities, intermediate care facilities, and infirmaries in homes for the aged.”

**Ambulatory Care Occupancy**

NFPA 101 Section 3.3.134.1 defines an ambulatory care occupancy as “a building or portion thereof used to provide services or treatment simultaneously to four or more patients that (1) provides, on an outpatient basis, treatment for patients that renders the patients incapable of taking action for self-preservation under emergency conditions without the assistance of others; or (2) provides, on an outpatient basis, anesthesia that renders the patients incapable of taking action for self-preservation under emergency conditions without the assistance of others.”
Several points deserve special discussion here. First, it is the intention of the *Life Safety Code* that for a facility to be classified as an ambulatory care occupancy, four or more individuals at any one time must be rendered incapable of self-preservation. Second, the word *rendered* in this context means that the individuals must be made incapable of self-preservation by the treatment provided at the facility. For example, in an outpatient surgery center, having four or more people under anesthesia and/or recovering from it at one time would result in a classification of ambulatory care occupancy. On the other hand, individuals who arrive in wheelchairs might be considered to be incapable of self-preservation independent of any treatment provided. Each organization must carefully evaluate the services and treatment it provides to determine whether the individuals served will be rendered incapable of self-preservation.

The *Life Safety Code* does not intend that individuals who arrive at the facility in a wheelchair be counted as incapable of self-preservation. However, later editions of the code clarify that facilities that provide emergency or urgent care for patients who, due to the nature of their injury or illness, are incapable of self-preservation are ambulatory care facilities. This clarification closes a loophole in the 2000 edition of the *Life Safety Code* regarding the definition of freestanding emergency centers.

In addition to organizations that render four or more patients incapable of self-preservation, the LS standards also apply to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients served.

**Residential Occupancy**

Two types of occupancies that are addressed by the *Life Safety Code* at first glance appear to have little to do with health care. The Joint Commission classifies both as residential occupancies. The *lodging and rooming house occupancy* is used for facilities that provide sleeping accommodations for 16 or fewer occupants who are capable of self-preservation, and the *hotel and dormitory occupancy* provides sleeping accommodations for 17 or more occupants who are capable of self-preservation. Both types of residential occupancies are often used for residential treatment facilities, which are frequently accredited as behavioral health care organizations.

**Business Occupancy**

Per NFPA 101 Section 3.3.134.3, a business occupancy is “used for account and record keeping or the transaction of business other than mercantile.” This is a very broad definition, but as it applies to health care, the definition refers to a facility where no one stays overnight and where three or fewer individuals are rendered incapable of self-preservation at any given time by virtue of their treatment.

The Joint Commission does not require freestanding business occupancies to comply with the *Life Safety Code*, and those occupancies therefore do not have to comply with the LS standards. However, such facilities must comply with an “Environment of Care” (EC) chapter requirement EC.02.03.01, EP 4, which states that such occupancies must maintain free and unobstructed access to all exits. “For freestanding business occupancies, surveyors will be looking at any and all exits to make sure they are not blocked,” says George Mills, M.B.A., F.A.S.H.E., C.E.M., C.H.F.M., senior engineer, Standards Interpretation Group, Joint Commission.
A freestanding business occupancy is a separate building that is not physically attached to a health care or ambulatory care occupancy. Or it is a building attached to one of these occupancies but separated from it by a two-hour fire-resistance-rated assembly (FRRA), as long as there is no required fire exit from the health care occupancy into the business occupancy. Note that there can be a door between these occupancies, as long as it is labeled “not an exit” on the health care side.

**Resolving Life Safety Code Deficiencies**

Once an organization has determined into which occupancy classification it falls and identified which standards apply to the organization, it is time to assess for LS standards compliance. This can be done through the Periodic Performance Review (PPR) process or another comprehensive review of the LS standards. As an assessment progresses, an organization may identify deficiencies in Life Safety Code compliance. Such deficiencies should be addressed immediately when possible. Otherwise, an organization can take one of the following three actions:

1. Use a management process or corrective maintenance program that documents the deficiency and actions to resolve the situation within 45 days.

2. Obtain a Life Safety Code equivalency approved by the Joint Commission. This could include a traditional equivalency—which requires input from a local fire official, an architect, or a fire protection engineer—or a fire safety evaluation system (FSES).

3. Create a Plan for Improvement (PFI) in the Statement of Conditions™ (SOC) form. “The option to use a corrective maintenance program to address a compliance issue is new,” says Mills. “In the past, whenever there was a Life Safety Code compliance issue, the Joint Commission required an organization to create a PFI or have an equivalency. With the option to use a corrective maintenance program, a PFI may not always be necessary. A corrective maintenance approach is viable so long as the problem can be resolved within 45 days and the organization documents the deficiency and corrective actions. Otherwise, an organization must create a PFI to address the issue.”

**Creating a Building Maintenance Program**

As a proactive approach to LS chapter compliance, an organization can choose to create a Building Maintenance Program (BMP)—an optional, planned way to appropriately and effectively manage certain features of fire protection in a health care facility. An effective BMP includes the following:

- Written strategies to manage the items covered in the program
- A documented schedule for the frequency of maintenance
- Processes for evaluating the effectiveness of the program

Although this type of program is not a requirement of the standards, the Joint Commission recommends creating a BMP as a best practice to help proactively address potential repair and maintenance issues and prevent compliance problems. It is important to note that although organizations are encouraged to use this type of program, doing so will no longer provide a scoring advantage for organizations during an on-site survey.
Not every aspect of *Life Safety Code* compliance can be managed in a BMP. However, organizations can proactively resolve certain types of deficiencies by using such a program, including those addressed by the following questions:

- Do 1 1/2-hour FRRA doors and 1-hour FRRA doors (including occupancy separation doors, stair doors, horizontal exit doors, and hazardous area room doors) have the following:
  - Properly functioning positive latching devices?
  - Properly functioning self-closing or automatic closing devices?
  - ≤ 1/8 in. gaps between meeting edges of door pairs?
  - < 3/4 in. undercuts?

- Do linen/trash chute inlet and outlet doors have properly functioning:
  - Positive-latching devices?
  - Self-closing or automatic closing devices?

- Are doors in smoke barriers:
  - Equipped with properly functioning self-closing or automatic closing devices?
  - Maintained to prevent the spread of smoke?

- Are corridor doors:
  - Equipped with properly functioning latching devices?
  - Maintained to prevent the spread of smoke?

- Are smoke barrier wall penetrations properly sealed?

- Are corridor wall penetrations properly sealed?

- Are means of egress illumination devices properly functioning?

- Are exit signs properly functioning?

- Are means of egress maintained to be free from the accumulation of ice and snow?

- Are the following grease-producing devices clean and maintained:
  - Exhaust hoods?
  - Exhaust duct system?
  - Grease removal devices?

Other topics to consider for the BMP include the following:

- Management of fire proofing
- Management of penetrations in fire barriers
- Linen/waste discharge rooms not used for storage
- Management of penetrations in floor assembly
- Means of egress locking
- Clear space ≥ 18 in. below standard pendant sprinkler heads to top
- Prohibition of portable space heaters in patient treatment and sleeping areas
- Prohibition of combustible decorations
- Obstruction of access, egress, or visibility of exits

Any items in a BMP that are found to be out of compliance must be promptly repaired, usually through a work order system. Note that a BMP does not apply to items that are lacking at a required location; rather, it applies to those that are not in good repair.
Documentation of these routine inspections and associated corrective maintenance is used to demonstrate the effectiveness of a BMP to a Joint Commission surveyor. For more information about a BMPs and other aspects of the LS standards, see the Joint Commission publication *The Life Safety Book: A Guide to Using The Joint Commission Life Safety Chapter and the Statement of Conditions™*.

### Life Safety Occupancy Key

#### Health Care Occupancy
- 4 or more individuals incapable of self-preservation
- Hospitals
  - General
  - Psychiatric
  - Specialty
- Long term care
  - Nursing and convalescent homes
  - Skilled nursing facilities
  - Intermediate care facilities

#### Ambulatory Care Occupancy
- Outpatient settings where 4 or more individuals at any one time are rendered incapable of self-preservation
- Ambulatory surgical centers seeking accreditation for Medicare/Medicaid certification

#### Residential Occupancy
- **Lodging and rooming house occupancy**
  - Provides sleeping accommodations for 16 or fewer individuals
  - No personal care services provided
  - No individual cooking facilities; with or without meals
- **Hotel and dormitory occupancy**
  - Provides sleeping accommodations for 17 or more individuals
  - Members of same family not in same room
  - No individual cooking facilities; with or without meals

#### Business Occupancy
- No one stays overnight, and 3 or fewer individuals are rendered incapable of self-preservation