

HEALTHCARE INTERPRETATIONS TASK FORCE INTERPRETATION

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Code: NFPA 101, 18-2.2.2.2 and 19-2.2.2.2; 2000 Edition

Background: Sections 18-2.2.2.2 and 19-2.2.2.2 of the 2000 Edition of the Life Safety Code (LSC) are being interpreted and enforced through Medicare & Medicaid Regulations and State enforcing authorities in a very inconsistent manner. It is clearly understood that some states have requirements that are more restrictive and different than Section 18-2.2.2.2 & 19-2.2.2.2 of the LSC, but the differing interpretations are occurring in states that have no requirements for locking of doors that are more restrictive than the LSC. The differing interpretations are also coming from the Federal level where to the best of our knowledge there are no requirements other than those contained in the LSC.

The Technical Committee on Health Care Occupancies in the 1988 edition of the LSC made major changes to the Code relative to the locking of doors in health care facilities. These changes were necessary to recognize how health care services were being provided in today's facilities and the need to lock doors to prevent the very real hazard of elopement by patients.

I personally submitted the proposal to expand the permissiveness to lock doors beyond psychiatric hospitals and certain areas in acute care hospitals. The substantiation for these changes was for the LSC to recognize the need to lock doors in nursing homes due to the significant increase in the population of Alzheimer and dementia patients. The Technical Committee wisely chose to expand the proposal and use the term "clinical needs of the patient" and not restrict locking to only psychiatric facilities. The Committee also wisely chose not to "laundry list" those illnesses that might require locking of doors and chose the words "clinical needs." It is my understanding that the Technical Committee did not restrict the types of locks that could be used, the number of locks in a means of egress unless time delay locks were used, or require a minimum number of patients whose clinical needs required locking before doors could be locked.

It is clear that many AHJs are not comfortable or are opposed to the permissiveness of the newer editions of the LSC relative to the locking of doors when the clinical needs of the patient requires locking to prevent elopement or escape. With the adoption of the 2000 LSC for Medicare / Medicaid, many AHJs are putting up roadblocks to try to prevent the locking of doors or to limit the number of doors that can be locked. Although not specifically a LSC issue, AHJs are even prohibiting the locking of doors using the requirement that a facility must maintain compliance with the requirements of the building code the facility was required to comply with when built, which did not permit the locking of doors. This borders on absurdity because

when these older facilities were built, they did not even house patients whose clinical needs required locking to prevent elopement. Even if they did house these types of patients, the facilities weren't heavily fined for elopement by the very same agencies that restrict or prohibit the locking of doors to prevent elopement.

Psychiatric hospitals, which have a lower staff/patient ratio than acute care hospitals and nursing homes, have key locked doors for more than 100 years. When the Technical Committee changed the requirements in the Code for the locking of doors in the 1988 Edition, there were no incidents brought to their attention that the key locking of doors in psychiatric hospitals had resulted in the injury or death of patients due to a fire or other emergency incident. It would be nice and neat if the only hazard a health care facility had to face was fire, but in the real world, this is not the case. Health care facilities must be given the tools to address such hazards as elopement, infection, etc.

Question 1: Is it the intent of the Code to require a minimum number of patients whose clinical needs require the locking of doors be housed in a healthcare facility in order to permit the doors to be locked?

Answer 1: NO

Question 2: Is it the intent of the Code that patients whose clinical needs require the locking of doors be housed in the same smoke compartment or on the same floor?

Answer 2: NO

Question 3: If the answer to Questions #2 is no, can the patients whose clinical needs require the locking of doors be distributed throughout the facility based on the health care program of the facility?

Answer 3: YES

Question 4: Is it the intent of the Code that the clinical needs of patients relative to the need to require doors to be locked be determined by the appropriate and qualified staff of the health care facility?

Answer 4: YES

Question 5: Is it the intent of the Code to restrict the type of locking device to time delay locks?

Answer 5: NO

Question 6: If the answer to Questions #5 is no, can key locks, cipher locks, magnetic locks and similar locks be used as long as they can readily be unlocked by staff present when the doors are locked?

Answer 6: YES

Question 7: Are locks, other than time delay locks, and locks used on doors for stairway re-entry, required to automatically unlock upon operation of the fire alarm system or power failure?

Answer 7: NO

Question 8: Are the number of locked doors in the means of egress limited other than for doors using time delay locks?

Answer 8: NO