MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
MONTANA STATE SENATE

MARCH 7, 1983

The meeting of the Public Health, Welfare and Safety Committee was called to order by Chairman Tom Hager on Monday, March 7, 1983, at 1:00 P.M. in Room 410 of the State Capitol Building.

ROLL CALL: All members were present with the exception of Senator Jacobson, who was excused. Woody Wright, Staff Attorney, was also present.

Many visitors were also in attendance. See attachments.

CONSIDERATION OF HOUSE BILL 299: Representative Jan Brown, District No. 32, said she introduced HB 299 at the request of the Department of Health and Environmental Sciences. This bill amends the definition of long-term care facility by adding a new definition on page 5 for intermediate developmental disability care. There are only three facilities that would fall under this category in Montana. Intermediate care facility license standards are for older people who need nursing care. That is not appropriate for some, they need standards that are appropriate for the needs of the mentally retarded. Jacqueline McKnight, from the Department of Health and Environmental Sciences, is at the hearing to answer any questions.

There were no opponents.

Chairman Hager asked for questions from the committee.

Senator Himsl asked if somebody could explain what degree of basic care is under this developmental disability care.

Jacqueline McKnight, Department of Health and Environmental Sciences, said in the CFR key points of nursing care is if elderly or handicapped. Developmental disability care would provide psychological, social, physical therapy and occupational care for the patient. The three facilities in the state that are currently providing this care do provide these services for the mentally retarded.

Senator Himsl asked if there was an institution that handled acute developmental disabilities.

Jacqueline McKnight said no, all are at the intermediate.

Senator Hager asked Representative Brown why the language on page 6, lines 20 through 23, relating to hotels, motels and boarding homes, was struck.

Representative Brown said she believed it was just removed to clarify the language. She deferred the question to Mrs. McKnight.

Mrs. McKnight said the amendments were attached by SRS so there would be no confusion as to what facilities this would apply to. The exclusion of that language is concurred with by the Department of Health. We never meant those group homes to be covered.

Representative Brown told Senator Hager that she had not asked anyone to carry this bill on the Senate floor if it was concurred in.

Senator Hager said he would handle that.

CONSIDERATION OF HOUSE BILL 322: Representative Metcalf, District #31, presented this bill to the committee. Under current law local governments may establish an emergency ambulance service and may levy 1 mill in order to pay for this service. HB 322 expands that so that local governments can provide an emergency medical service program. They would use the same 1 mill levy to pay for that. Drew Dawson, from the Department of Health and Environmental Sciences, is here today and will explain the need for the bill.

Drew Dawson, Chief of Emergency Medical Service Bureau, Department of Health, gave testimony in support of this bill. A copy of his testimony is attached as Exhibit 1.

Wilma Vinten, REMTA, a member of the Meagher County Volunteer Ambulance Crew, rose in support of this bill. A copy of her testimony is attached as Exhibit 2.

Bill Leary, President, Montana Hospital Association, said that they did not speak in the House Committee relative to this bill. We had some concerns with the bill but they have been addressed in the amendments on page 2. We are satisfied with this bill and would urge concurrence of HB 322.

There were no opponents.

Chairman Hager asked for questions from the committee.

Senator Marbut referred to page 2, line 13 "if the governing body receives a petition" and asked what the point was.

Mr. Dawson said there are two ways you can do it, without a petition and with a petition. The bill basically says if they receive a petition they have to make a decision within 6 months whether or not to oppose an EMS system. The way that it is now worded it has been interpreted as requiring a petition if they want to establish an EMS and this would allow the county commissioners flexibility.

Senator Marbut asked if it was necessary to have that as you are now establishing the right of the governing body to establish an EMS.

Mr. Dawson said yes, it is, because sometimes the local governing body may not recognize the need to establish this and the people can go before the governing body with a petition. Granted they could go before a regular meeting but this is an additional way to demand action.

Senator Marbut referred to line 3 on page 2 "hospital emergency rooms" and stated this is a significant service in the medical profession. With this bill the local governing body may in fact operate a hospital emergency room.

Mr. Dawson said the hospital emergency room is an over all part of the EMS system. It is important to establish a two-way radio communication system and important to do other things in the hospital emergency room in support of the over all system. With this in the bill the county commissioners can fund a two-way radio communication system. The strict interpretation of the law now would prevent them from doing that.

Senator Himsl said what it really does it requires the governing body to come up with a decision within 6 months.

Senator Norman asked how many counties are using the 1 mill ambulance now.

Mr. Dawson said a total of 18 counties are using some portion of the 1 mill levy. Eight or nine counties are using the full 1 mill levy. With this bill the law would be more flexible towards its use.

Senator Norman said flexibility in order for what.

Mr. Dawson said for the purpose of the EMS instead of just ambulance service.

Senator Norman asked if in the 18 counties they used the petition signed by 15% of the electors registered to vote.

Mr. Dawson said that would depend a lot on the various counties. The law is open to so many interpretations. Yes, in a lot of them they did petition to adopt.

Senator Norman asked if that was required before the 1 mill can be adopted.

Mr. Dawson said that is required before they can establish the ambulance service.

Senator Norman said right now the counties, by contract, or maybe some of them own their own vehicles, can operate or contract for the operation of an ambulance, which would include the ambulance personnel, the driver and medical personnel on board, but would the ambulance include the radio.

Mr. Dawson said the way the law reads now the county commissioners contract does include what was listed, excluding the radio communication.

Senator Norman asked what else would they need.

Mr. Dawson said training, communication and a whole variety of other things necessary at local levels.

Senator Norman said it would not just be for ambulance but would go to train personnel.

Mr. Dawson said it could be used for that. That would be at the discretion of the county commissioners.

Senator Hager asked Wilma Vinten on page 1, line 20, which says, "air or surface ambulance services," do you envision this bill as allowing your county to obtain an air ambulance service.

Ms. Vinten said the bigger counties have air ambulance service and we utilize those. But we need quick response units in our county. We utilize the air ambulance service a lot but we are not saying we want to get one for our county.

Senator Hager asked Mr. Dawson if he would care to answer this on how it would be addressed in the certificate of need process.

Mr. Dawson said he couldn't answer that with respect to certificate of need.

Senator Himsl asked Ms. Vinten if she envisioned that the county would support a quick response unit.

Ms. Vinten said in our county quick response would be out of our ambulance service, we would use the same volunteers. A quick response unit for us would enable one person to take the equipment to the victim to stabilize him until the ambulance gets there.

Senator Christiaens asked Mr. Dawson if he knew what the "not limited to" was leading to.

Mr. Dawson said the intention of that was because the emergency medical system includes so many areas and rather than specifically identify everything we felt it would be best to provide a broad definition of essentially everything.

Senator Marbut said what this bill says is that local governments will be authorized to establish emergency medical services, which will include hospital emergency rooms. He commented the county can get into the business of emergency medical service, which might include an air ambulance service, training, communication and a number of other things. He asked if the sponsor of the bill really knew what the bottom line could be. The only limiting factor is 1 mill.

Representative Metcalf said he would be amenable to an amendment that would say on page 2, line 5, "may establish, maintain or contract for".

Senator Hager asked Representative Metcalf in relation to the hospital room, if he envisioned them being in the hospital or free standing.

Mr. Dawson said the intention wasn't to deal with free standing hospital emergency rooms but they would use the existing hospital based emergency center. They only wanted to provide more flexibility for the county commissioners.

CONSIDERATION OF HOUSE BILL 361: Representative Phillips, District #43, presented this bill to the committee. He stated the problem is the Uniform Building Code has adopted the requirement that self-closing or automatic closing corridor doors to patient rooms must be installed. Consequently any new facilities would require these self-closing automatic doors which slam shut. There are several people here today that will testify that this is not a very good idea.

William E. Leary, President, Montana Hospital Association, gave testimony in support of this bill. A copy of his written testimony is attached as Exhibit 3.

Leo Krisl, hospital consultant working under contract for the Licensing and Certification Bureau, Department of Health and Environmental Sciences, rose in support of this bill. A copy of his testimony is attached as Exhibit 4.

Sharon Dieziger, representing the Montana Nurses' Association, gave testimony in support of this bill. A copy of her testimony is attached as Exhibit 5.

Will Long, Montana Association of Hospital Engineering, Lewistown, is a proponent of this bill and asked for a favorable report on the bill from the committee.

John Spence, Montana Deaconess Medical Center, Great Falls, very strongly supports this bill.

Gene Fenske, Chief Engineer, St. Peter's Community Hospital, supports this bill and would be willing to give the committee an illustration of the problems involved with these doors.

Bill McCampbell, Director, Plant Maintenance, St. Patrick Hospital, Missoula, supports this bill. With the testimony that has been presented he strongly urges the committee concur with the bill.

Chad Smith, Montana Hospital Association, said he believed the principal points in favor of this bill have been said. He has been involved in this bill since its research and drafting and if the committee has questions involving the language in the bill he would be pleased to answer them.

Rose Skoog, Montana Health Care Association, rose in support of this bill.

Jim Kembel, Building Codes Division, Department of Administration, gave testimony explaining why these requirements were in the Code. A copy of his testimony is attached as Exhibit 6.

There were no opponents.

Chairman Hager asked for questions from the committee.

Senator Norman said they have been in the Codes since 1973 but he has not seen these type of doors in any of the hospitals he has been in.

Mr. McCampbell said St. Patrick's new hospital being erected in Missoula is awaiting the outcome of this bill as to whether they will enforce the automatic door closures.

Mr. Fenske said the new ICU and CCU facilities at St. Peter's Community Hospital were considered major remodeling and they had to comply with the codes. They do have the self-closing doors on the new section.

Senator Christiaens said he believed the Deaconess Hospital has been built since 1973 but they do not have those type of doors.

Mr. Spence said the local authorities do not always enforce this. Our hospital was completely built since 1977 and we were not required to put these on.

Senator Himsl said supposing we pass this bill, what is it going to cost to get these self-closing doors removed.

Mr. Fenske said it is simply a matter of disconnecting electricity connections.

Senator Marbut referred to Section 50-60-301 "A municipal or county building code may include only codes adopted by the department" and questioned whether the bill should be amended.

Chad Smith said the House committee asked the same question and made the amendment on page 1, line 19, to take care of that. That was the intention of the committee in making the amendment to the bill, to address all building codes.

Senator Marbut asked if he was satisfied with that.

Mr. Smith said I think so. He believes subsection 1 on line 14, "health care facilities", should cover it.

Senator Marbut asked why they have the word "corridor" after "closing" in the title on line 7.

Mr. Smith said what the bill is addressing is the corridor door into the patient's room. What you are suggesting is to take that word out so it would read "automatic closing doors to patient rooms". He does not feel that wording is a problem and would suggest leaving it the way it is.

Senator Marbut referred to the wording at the bottom of page 1, "patient rooms does not apply to health care facilities as defined in 50-5-101." He asked if hospitals are defined separately from health care facilities.

Woody Wright referred to the code and showed Senator Marbut that they are defined separately.

Representative Phillips closed by stating this was a good hearing and he felt the testimony justified not requiring the self-closing doors. He urged that the committee concur with the bill. Senator Christiaens will carry the bill on the floor.

DISPOSITION OF HOUSE BILL 299: Senator Tom Hager asked Senator Norman if he could remember if this came out of the SJR 34 study.

Senator Norman was not sure.

Rose Skoog said this bill did not come out of the SJR 34 study. The Health Department is trying to define intermediate care for the developmental disability patient. This would provide one more level of long term care. They wanted to add one more definition. The SRS amendment was to clarify the facilities that would apply under this.

Senator Himsl asked if they wanted intermediate care to come under the long term care program.

Ms. Skoog said they want to have a separate definition so the Health Department can set up specific standards dealing with the DD patients as opposed to just intermediate care.

There were several questions from the committee members with regard to the SRS patient and reasons for the definition.

Ms. Skoog explained by stating what this is doing is putting a definition in the statute for the DD level and they will then define it by rules and any facility that meets that set of standards will be able to accept that kind of patient. If they do not meet the standards they will not be able to. This is simply putting into statute what is already being done. They are licensing ICF MR and authorizing rule making. What would be required if you take that patient. It is not a matter of adding additional nursing staff or changing your building codes. It is a matter of offering specialized staff or programs to deal with the MR or DD patient.

Chairman Hager closed the discussion on this bill.

CONSIDERATION OF HOUSE BILL 322: Chairman Hager appointed a subcommittee to look into this bill. The chairman of the committee will be Senator Marbut and the other two members are Senator Norman and Senator Hager.

DISPOSITION OF HOUSE BILL 361:

Senator Marbut made a motion that HB 361 be concurred in. The motion passed unanimously with the members present. Senator Christiaens will carry the bill.

ADJOURNMENT: There being no further business the meeting adjourned at 2:27 P.M.

Tom Hager
CHAIRMAN, TOM HAGER

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ROLL CALL

PUBLIC HEALTH, WELFARE, SAFETY COMMITTEE

48th LEGISLATIVE SESSION -- 1983 Date 3-7-83

NAME	PRESENT	ABSENT	EXCUSED
SENATOR TOM HAGER	✓		
SENATOR REED MARBUT	✓		
SENATOR MATT HIMSL	✓		
SENATOR STAN STEPHENS	✓		
SENATOR CHRIS CHRISTIAENS	✓		
SENATOR JUDY JACOBSON			✓
SENATOR BILL NORMAN	✓		

SENATE Public Health COMMITTEE

BILL ~~HB 361~~ VISITORS' REGISTER DATE 3-7-85

Please note bill no.

NAME	REPRESENTING	BILL #	SUPPORT (check one)	OPPOSE
William Leary	Montana Hospital Assn.	HB361	✓	
William Leary	Montana Hospital Assn	HB322	✓	
Sharon Dieziger	Montana Nurses Assoc.	HB361	✓	
[illegible]	Montana Deaconess Med Ctr	HB361	✓	
Bill [illegible]	Montana Association of Hosp. Engineering	HB361	✓	
Bill McCampbell	St Patrick Hospital	HB361	✓	
Leo Krist	Mt. St. Dept. of Health	HB361	✓	
Jacqueline McKnight	" " " "	HB361	✓	
Jim KEMBEL	Building Codes Division Dept. of Admin	HB 361	information	
[illegible]	St Peters ~~Hosp~~ Helena	HB361	✓	
Jacqueline McKnight	St Dept. of Health	HB299	✓	
Ellie Parker	"	HB299	✓	
Chad Smith	Mont Hosp Assn	HB361	✓	

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY

EXHIBIT 2

3-7-83

MONTANA EMERGENCY MEDICAL SERVICES ASSOCIATION

I'm Wilma Vinton, REMTA, a member of the Meagher County Volunteer Ambulance Crew, based in White Sulphur Springs, and a member of the Board of Directers of MEMSA, Montana Emergency Medical Services Assoc. the State association that represents Montana's emergency medical personnel.

I'm here in support of HB 322.

By changing the wording from "Ambulance" to "Emergency Medical Services Program", you will allow our local governments more flexibility in what the one(1) mil allowed can be used for.

There is more to Emergency Services than an ambulance. In White Sulphur we are hours, by ground ambulance, from the more sophisticated care of hospitals in Billings and Great Falls, but only minutes away by air ambulance. We service an area of 50 miles radius, but with the help of Quick Response Units and a good communications system, an accident victim can have life-saving care within minutes, no matter where the accident is.

Air ambulances, Quick Response Units, and Communications are all needed components of an EMS system. And the changes made by this House Bill will aid in pulling this system together.

The Meagher County Commissioners support this bill because thier goal is to set up and maintain a good EMS program but funds are needed to do this.

At the November Business Meeting of MEMSA, the House of Delegates voted to support the changes made by HB 322 because of the need of financial support to continue all the EMS System, not just ambulances.

If we can effectively maintain a good local EMS System, than we are well on our way to achieving and maintaining a good Statewide EMS System.

NAME: W. JAMES KEMBEL DATE: MARCH 7, 1985

ADDRESS: Building Codes Division, Dept. of Admin., State of Mont.

PHONE: 449-3933

REPRESENTING WHOM? Dept. of Admin.

APPEARING ON WHICH PROPOSAL: HB 361

DO YOU: SUPPORT? _____ AMEND? _____ OPPOSE? _____ Information

COMMENTS: See Attached Sheet

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: Leo Kriel DATE: 3/7/83

ADDRESS: 418 Raymond

PHONE: 442-7504

REPRESENTING WHOM? State Dept of Health

APPEARING ON WHICH PROPOSAL: HB 361

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENTS: See Attached

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: John Spence DATE: 3/7/03

ADDRESS: 1911 4th Ave No GT Falls

PHONE: 761-5721

REPRESENTING WHOM? Montana Deaconess Med Center

APPEARING ON WHICH PROPOSAL: HB 361

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENTS: _____

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: William Leary DATE: 3/7/93

ADDRESS: 1330 9th, Helena, Mt

PHONE: 442-1911

REPRESENTING WHOM? Montana Hospital Assn.

APPEARING ON WHICH PROPOSAL: HB 361

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENTS:

Written Statement submitted

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: Bill McCampbell DATE: 3-7-83

ADDRESS: 435 Rollins

PHONE: 549-4532

REPRESENTING WHOM? St. Patrick Hospital

APPEARING ON WHICH PROPOSAL: H.B. 361

DO YOU: SUPPORT? L AMEND? _____ OPPOSE? _____

COMMENTS: _____

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: Shaun Dierigen DATE: 3-7-83

ADDRESS: 3604 5th Ave So

PHONE: 453-1525

REPRESENTING WHOM? Mt. Nurses Association

APPEARING ON WHICH PROPOSAL: HB 361

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENTS:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: Will Long DATE: 3-7-83

ADDRESS: 814 8th ave NO Lewistown

PHONE: 538-7566

REPRESENTING WHOM? Montana Association of Hospital Engineering

APPEARING ON WHICH PROPOSAL: HB 361

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENTS: _____

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Exhibit 1
March 7, 1983

Testimony of
Drew E. Dawson, Chief
Emergency Medical Services Bureau
Department of Health & Environmental Sciences
To Senate Public Health Committee
In Support of House Bill 322

Mr. Chairman, Members of the Committee. Title 7 Chapter 4 currently provides that local governments may establish and maintain an ambulance service and that they may levy up to one (1) mill in support of an ambulance service. It further provides that, upon receipt of a petition; they may establish a joint ambulance service between the city and the county and share the costs proportionately.

There are several problems with the existing statute which reduce the flexibility of counties and cities. We must recognize that the original law was adopted in 1961 and then modified in 1967. No changes have occured since that time.

Technically, the only mechanism by which a city and county may establish a joint ambulance service is if they receive a 15% petition. This has been interpreted in a variety of ways by city and county attorneys including some who indicate that the petition must be received prior to adopting the one mill levy at either the city or county level.

House Bill 322 streamlines and clarifies the procedure. It gives cities and counties the option of establishing an individual or joint program without requiring a petition. It also allows for a petition to be initiated by the electors, and submitted to the governing body, with final action to be taken by the governing body. These proposed modifications will allow more flexibility and significantly clarify the process.

The current statute provides that local governments may establish an ambulance service. Since the original enactment of this legislation in 1961, it has been well recognized that many other persons and agencies, in addition to ambulance services, impact on the care of the emergency patient. We now know that care rendered by the public, by law enforcement officers and by fire department personnel prior to the arrival of the ambulance service is critical to the patient's survival. We have Quick Response Units who provide care, but do not transport, and we recognize that the dispatch of emergency personnel and two way radio communications with the hospital Emergency Department are all important factors in whether the patient lives or dies. Training programs, at all levels, are essential elements.

Even though there are many important elements of an emergency medical services system, the current law only authorizes one of these components - the ambulance service. A strict interpretation of the law is unduly limiting and restrictive to those counties which wish to establish a comprehensive EMS system to improve emergency patient care.

House Bill 322 simply provides that cities and counties may establish an "emergency medical services program" rather than only an ambulance service, that they may use the one (1) mill levy for an EMS program and it provides a definition of an EMS program.

These changes in definition combined with the procedural changes are intended to make things just a little bit easier for local government and local EMS providers.

I would be happy to answer any questions you might have.

Thank you for your consideration.

DED:ke

EXHIBIT 2
3-7-83

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If we can effectively maintain a good local EMS System, than we are well on our way to achieving and maintaining a good Statewide EMS System.

Exhibit 3
March 7, 1983

Montana Hospital Association

(406) 442-1911 • P.O. BOX 5119 • HELENA, MONTANA 59604

STATEMENT OF WILLIAM E. LEARY, PRESIDENT, MONTANA HOSPITAL ASSOCIATION BEFORE THE SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE REGARDING WUPPORT FOR ADOPTION OF HOUSE BILL 361

In 1976 and 1977 the hospital industry became extremely concerned and vocal regarding the cost and operational impact of the National Fire Protection Association's publication the Life Safety Code, NFPA 101-1973, as adopted and utilized by state licensing agencies, HHS, JCAH and other local code enforcing agencies. Consequently, the American Hospital Association and other national and state hospital associations became active participants in the code-making process and sought elimination of excessive requirements, inclusion of equivalency alternatives for other essential requirements to allow flexibility in hospital design, and uniformity in the edition year of the code being used by various agencies. A fundamental concept that has been preserved in the Life Safety Code is the separation of the requirements into separate sections for new and existing construction, thereby lessening the retroactive impact of new code requirements. At this point in time, the JCAH, HHS and the Montana State Department of Health, the licensing agency authorities, are utilizing the Life Safety Code as the primary reference document to determine the adequacy of fire safety design of existing health care institutions.

However, city and state building authorities such as the Department of Administration, are also utilizing code documents developed by groups of building code officials, in our case, the Uniform Building Code. The Uniform Building Code is predominantly used in southwest, Rocky Mountain and western states as the primary design criteria document for new construction and major renovation.

The major problem which confronts the health care industry is that many of the Fire Safety concepts in the building codes are different and in conflict with those embodied in the Life Safety Code. This problem becomes even more complicated when we observe that local fire authorities and building officials may have to, by law, utilize the Uniform Building Code rather than the Life Safety Code as the criteria for determining adequate fire safety compliance in health care facilities.

The requirement for door closures onto all exit corridors is one such conflict between the codes which Montana hospitals are trying to rectify through the passage of House Bill 361.

National authorities have stated time and again that because of the uniqueness of a 24-hour business such as a hospital or nursing home, and due to the fact that hospitals and nursing homes are staffed on a 24-hour basis with personnel who are trained and consistently drilled on the method of evacuating patients in the event of a fire, these same authorities are more inclined to support the code requirements contained in the Life Safety Code for health care facilities rather than those in the Uniform Building Code or for that matter, the Standard Building Code or the Basic Building Code. One such authority is Jonas L. Moreheart, a nationally known fire protection engineer employed by the United States Department of Health and Human Services in Washington, D.C. and who currently serves as the principal fire protection advisor for the Medicare/Medicaid programs which affect some 25,000 hospitals and nursing homes throughout the nation.

I have attached for your review testimony given by Mr. Moreheart before the Baltimore County Board of Appeals in 1981, speaking specifically to the issue of self-closing devices on doors between patient bedrooms and central corridors and encourage you to take the time <u>now</u> to read his testimony, especially those portions which have been highlighted. You will find there have been tests conducted comparing the effect of a fire in a patient room with the door remaining open during the fire and another test when the door closed at 92 seconds after ignition. I believe the statement on page 4 points out most effectively that automatic door closing shortens the time available for rescue of endangered patients while leaving the door open to the corridor greatly enhances rescue time.

The statements on page 5 speak directly to response time by nursing personnel in detecting when smoke is in a room and again make credible statements as to the necessary adoption of House Bill 361.

Besides the cost inherent in installing automatic door closures in all of our health care facilities (approximately $400 per door) we wish your attention to be directed to true patient safety from fire within a health care facility.

In closing, I would remind you that there are approximately 7,000 hospitals in operation in the United States. The fire death experience in hospitals is far superior to any other occupancy in the U.S. I know of no life-taking fire in a Montana <u>hospital</u> over the past 25 years and while various studies conducted indicate

there are approximately 35 single death fires in hospitals per year in the United States, the statistics also point out the probability of dying as a result of a fire in a hospital is extremely low and significantly lower than any other occupancy.

Automatic door closures in health care facilities are not needed in spite of the requirement in the Uniform Building Code.

I urge your vote in concurrence with House Bill 361.

ATTACHMENT II

STATEMENT OF:

Jonas L. Morehart, P.E.
Fire Protection Engineer

BEFORE THE:

Baltimore County Board of Appeals
August 12, 1981

Case No.: CBA-81-102
Maryland Masonic Homes/Bonnie Blink

RE: Self-closing devices on doors between patient bedrooms and central corridor as required by 1978 BOCA, Sec. 610.4.1.

My name is Jonas L. Morehart and I am currently employed as a senior fire protection engineer for the U.S. Department of Health and Human Services in Washington, D.C. I have held this position since 1972 and currently serve as the principal fire protection advisor for the Medicare-Medicaid program which affects 25,000 hospitals and nursing homes throughout the nation. I am a member of the Committee on Safety to Life of the National Fire Protection Association and a Certified Professional Engineer in Virginia.

I appear here today in my professional capacity and not as an employee of the Federal Government. I am on annual leave and I am receiving no fees for my appearance here today. Only my travel expense from my home in Virginia will be reimbursed by the appellant. My supervisors at Health and Human Services are aware of this activity and have given their official approval. It is my feeling that there is no conflict of interest between the question at hand and any requirement of the Federal Government related to health care facilities. My views expressed here today are my own and do not represent any policy of the Federal Government.

My main interest in testifying is to inform this Board of Appeals concerning the potential danger to patients in a hospital or nursing home when a requirement for door closers on patient bedrooms is enforced as indicated in Section 610.4.1 of the BOCA Basic Building Code.

The original concept of life safety for any building was to evacuate the occupants in the event of a fire and all Codes specified stairways and fire escapes. Since some difficulty could be encountered in evacuating hospitals and nursing homes, the Codes specified fire resistive construction, but we all know that was not the complete answer. The next step in life safety in these patient occupied buildings was a requirement for a smoke barrier to divide the various floors into at least two areas and allow horizontal movement of patients, keeping stairways as a final resort. It is interesting to note that BOCA does not make this requirement.

With modern furnishings and contents capable of producing a fast burning and smoky fire, the next step was to protect the patient "in-place" by providing a fire barrier between the patient room and the corridor.

This requirement for fire resistive corridor walls and patient room doors theoretically worked in two directions. The walls and doors would keep fire effects (smoke, hot gasses, etc.) out of the patient bedroom, but if the fire started in a patient bedroom, the walls and doors would prevent any fire effects from reaching the corridor.

BOCA's approach in Section 610.4.1 considers only the concept of protecting the path of exitway access with the intent that the bedroom doors will be closed to confine a fire while the occupants will be able to use the corridor to reach an exit, such as a stairway. If for some reason smoke does reach the corridor, there is no requirement for a smoke barrier to provide horizontal movement and interim refuge.

BOCA's authors defend this basic compartmentation of the corridor by referring to the requirement for automatic sprinklers in section 1202.7. I am not advocating that automatic sprinklers in a patient room should be deleted from any Code, but by the time an automatic sprinkler head is activated, the patient in the room is beyond rescue by the nursing staff. If the patient room door happens to be closed during a fire in that room, the heat and toxic products from the fire build up so fast that the patient in that bed has no chance of survival.

In 1978, the Building Hardware Manufacturers Association sponsored a series of full scale tests at the I.T.T. Research Institute in Chicago. There were two almost identical tests, which upon analysis show the difference to be that in one test the room (simulated patient bedroom) door remained open during the fire and the second test had the door closed at (92 seconds) after ignition.

In the test with the door remaining open, the temperature at the ceiling reached 480 degrees F before activating the standard automatic sprinkler head. Smoke density at the three foot level was 0.029 OD per meter. (0.15 OD equals about 10% per foot obscuration. A smoke density of 0.5 OD per meter makes rescue even by fire department personnel very difficult.) Smoke density increased sharply after automactic sprinkler operation. Carbon Dioxide measurements were 600 parts per million after about five minutes. (5000 parts per million CO_2 is considered a relatively safe exposure.)

In the second test which had the room door closed after 92 seconds, the temperature at the ceiling peaked at about 570 degrees F but dropped a bit to about 400 degrees F and rose steadily until sprinkler operation at 750 degrees F. The smoke density at the three foot level increased significantly once the door was closed, something like fifteen times the level of the open door test. The most dramatic increase was the level of carbon dioxide, which went to 12,000 parts per million.

This data, originally intended to justify the need to install automatic closers on patient room doors, seems to show that closing the door to the room of fire origin is effective in limiting the products of combustion in both the corridor and other patient rooms, but in turn causes life safety conditions in the room of origin to deteriorate very rapidly. Automatic closing shortens the time available for rescue of endangered patients, but leaving the door open to the corridor greatly enhances rescue time.

In a series of tests done earlier this year at the National Bureau of Standards, the results show conclusively that when the patient room door is closed, detection of smoke in the corridor is most difficult if not impossible. During twelve tests, the patient room door was closed during four of the tests. In the three fires classified as smoldering, a detector in the corridor failed to respond. In the test classified as low energy, the detector in the corridor took over 33 minutes to activate. In all the other tests with the patient room door open, the corridor smoke detector activated on the average of 54.4 seconds.

In spite of all the preceeding measures requiring fire resistance rated barriers, doors, and automatic sprinklers the entire system still depends upon the other patient room doors being closed at the proper time to prevent smoke from getting into these rooms where the patients will remain "in-place."

In a typical hospital or nursing home, none of the Codes requires a complete smoke detection system. (BOCA's automatic fire alarm system in Section 1216.3.1 is nullified by Section 1216.4 because of the requirement for automatic sprinklers.) The best smoke detector in the world is the human nose. It is capable of detecting only one to three parts per million while the best smoke detector doesn't activate for less than several hundred parts per million. It should be very clear that it is necessary that patient room doors be open if the nursing staff is to be able to make an early detection of a fire and effect a prompt rescue of endangered patients.

The door to a patient room is a vital means of communication. An open door not only allows a patient to see what's going on in the corridor and helps allay feelings of isolation, but permits the staff to keep eyes, ears, and nose on what's happening in the patient rooms. With bedroom doors partly open, the staff can observe the occupants during routine duties without having to stop and open doors.

The Life Safety Code, as currently written, depends upon the patient bedroom doors to be at least partly open. Open doors allow the staff to smell smoke or hear a scream for help. In many health care facilities, there are smoke detectors installed in the corridor. Open doors allow earlier warning by these detectors.

Now we have a slight dilemma. It is important that the doors be open until a fire begins and any endangered occupants rescued. Then it becomes urgent that the door be closed. The Life Safety Code depends upon the nursing staff to close the doors and rescue the patients in danger. BOCA makes the requirement for the door closers in Section 610.4.1. In practice, in those hospitals and nursing homes with closers on patient bedroom doors, the occupants usually wedge the door in an open position or disconnect the closer.

Proponents of automatic door closers probably agree with everything I've stated so far. Automatic closing of doors can be extremely dangerous for occupants in the room of fire origin. I have already shown how quickly the fatal combustion products can build up when the door is closed. An open door acts much like a safety relief valve and the corridor is a much larger volume which can absorb the lethal products of a fire and not sacrifice the fire room residents.

Let us imagine a facility with automatic closers on the patient room doors. Upon detection of smoke by smoke detectors, operation of the manual fire alarm system, or other means; all the patient room doors close. Now the nursing staff must begin opening doors again to look for endangered patients.

Logicially, the next step then is to install a smoke detector in each patient room and arrange the automatic door closer system so that all the patient room doors close upon detection except for the door to the room where the fire was detected. This allows the relief of combustion products, quick locating of the fire scene by the nursing staff, and the door does not hinder the staff while they make a rescue. Of course, this can get to be a very expensive system just to accomplish what any nursing staff should be able to do in a routine manner.

If automatic closers are installed they should only be of the type which allows the patient room door to operate as if it had no closer, otherwise as we have seen before, it would interfere with the day to day operation of the facility. I have with me a demonstration device to show any of the arrangements discussed here today. I would be happy to show you how it works and answer any questions.

House Bill 361

My name is Leo Krisl. I am a hospital consultant working under contract for the Licensing & Certification Bureau; Department of Health and Environmental Sciences. I am presenting the Department's view as well as my own and I speak in favor of this bill. I have spent more than 20 years reviewing plans and inspecting health facilities in 20 different states.

Self-closing doors are inherently a nuisance. Self-closing devices on patient bedroom doors would be intolerable. It is difficult to maneuver wheelchairs or walkers through such openings. Many patients in health facilities cannot even open such doors.

The first door-closers in hospitals were installed to isolate hazardous areas. After that they were installed to separate an exit stair. Next the facility was separated into smoke sections with openings in the walls protected by self-closing doors. Now there is a requirement that all doors opening into exit corridors be self-closing. I agree that the proper use of such doors can save lives unless persons are in the space where a fire originates.

Any safety system that interferes even slightly with the ease of operations in a facility will be circumvented by the staff. Seldom have I visited a facility which did not have at least one violation. Electrical and pneumatic hold-open devices and smoke detectors are unreliable enough to force shut-downs. These devices are now complicated enough that repairmen must be called. Repairmen are available only in a few cities in Montana. The number of breakdowns increases about twice as fast as the number of elements added to the system. One fire department disconnected the hospital alarm because of the many malfunctions.

Smoke evacuation systems are now coming into use. We have two of them and another under construction. Where this is available I do not see how the requirement for self-closing doors can even be justified. It would even be feasible to disconnect the smoke doors from the alarm system. On the other hand, even with all

the violations, we have had only isolated incidents. In three cases I know of, where the patient set themselves on fire, the position of the door, opened or closed, leading into the room was immaterial and the sprinkler head in the room did not save them.

I find it strange that the federal government, which has forced health facilities to spend millions for safety equipment, has no requirements for the doors covered by this Bill. The current Life Safety Code specifically states that 'door-closing devices are not required on doors in corridor wall openings other than those serving exits or required enclosures of hazardous areas'.

I would prefer to be in a facility protected with no more than a fire alarm where the administrator is safety conscious, than in one which is covered by every imaginable safety device and the staff pays no attention to safety practices.

For these reasons, I urge you to pass this Bill.

EXHIBIT 5
March 7, 1983

Montana Nurses' Association

2001 ELEVENTH AVENUE (406) 442-6710

P.O. BOX 5718 • HELENA, MONTANA 59604

I am Sharon Dieziger and I represent the Montana Nurses' Association. We wish to speak in favor of HB-361. Certainly in this day of escalating health care costs we all have a concern about regulations that increase those costs. However, our primary concern must be directed toward the safety and well being of patients in our health care facilities.

Certainly every hospital has defined disaster plans for the hazards of fire and evacuation of patients.

Because we are constantly aware of the potential hazards, the present porcedures practiced within our facilities for actual fires and drills include:

All nursing staff immediately respond to closing all doors in a nursing unit. This task is completed in a manner of seconds. As the doors are closed, nurses have the opportunity to account for the location of all patients and to offer an explanation and alleviate any patient's fears. This is certainly more acceptable for patient safety and does not expose our patients to the numerous hazards which would be created by the installation of automatic door closures. If doors automatically close without explanation, do you know what an ambulatory patient does? He trots right out into the hallway to see what is going on, and I would too.

To install automatic door closures, in which the door would remain closed would:

1. Block open auditory and visual communications to patients during fire drills.
2. Inhibit mobility for pediatric, debilitated, and handicapped patients. Patients dependent upon mobility aids, such as walkers, wheechairs, and

crutches would be unable to operate the door and could be injured if they were in the path of a closing door.

3. Create an immediate danger for a patient, if a fire was in the patient's room.
4. Prevent the nurse from hearing many of the audible alarms attached to equipment, which alerts the nurse to changes in the patient's condition, i.e., intravenous controllers, cardiac and apnea monitors.
5. Create an isolated atmosphere for persons already in a stressful situation.
6. Further jeopardize the mental status of confused or psychiatric patients.
7. Increase the need for additional staffing to provide the necessary monitoring.
8. In fact, inhibit evacuation in the event of a fire. It would take a minimum of 2 people to evacuate an ambulatory patient, one just to hold the door open so you could get out.
9. Block immediate access in a life-threatening situation, i.e., cardiac arrest.

Installation of door closures which would be activated by the fire alarm system would create the following problems even for a regularly scheduled fire drill:

1. Subject patients to possible injury, when entering or leaving the room, if the system were activated.
2. Create patient anxiety until a nurse could provide reassurance (which could have occured if the nurse had initially closed the door).
3. Delay accounting for the location of all patients.
4. Create an unnecessary hazard in patient care.

Our system has proven to be safe and managable. We urge you to support HB-361 and thank you for this opportunity to share our views.

Exhibit 6
Submitted by W. James Kembel
March 7, 1983

STATEMENT OF THE DEPARTMENT OF ADMINISTRATION

House Bill No. 361

The door closer requirement for health care facilities addressed by the bill has been in the Uniform Building Code since 1973 without change. The model code is enforced throughout the Western United States as now written.

We would suggest the following points be considered during your deliberations.

- Door closers create an area of refuge, for building occupants that are not capable of exiting on their own, until help can arrive.

- Door closers help to retain death causing smoke in the area of fire origin thus providing needed time to control the fire and safely evacuate building occupants.

- Door closers help to maintain the exit corridor with a relatively smoke free atmosphere so that rescue and medical personnel can safely remove occupants.

- The fire history in certain types of medical facilities was one of the major reasons for the current code requirements.

STANDING COMMITTEE REPORT

March 7, 19 83

MR. PRESIDENT

We, your committee on PUBLIC HEALTH, WELFARE AND SAFETY

having had under consideration HOUSE Bill No 361

PHILLIPS (CHRISTIAENS)

Respectfully report as follows: That HOUSE Bill No 361

BE CONCURRED IN

~~DO PASS~~

TOM HAGER, Chairman.

STATE PUB. CO.
Helena, Mont.