Third Annual Award
Engineer of the Year Promotes NEHES Nationally

In 1981, Jack Gosselin was new to the healthcare industry and to rural, northern Vermont, where he had just joined North Country Hospital in Newport as Director of Facilities. Support came in the form of Jim Lawson, the late Director of Engineering at what is now Fletcher Allen Health Care and a NEHES board member.

"I really felt I was out there by myself up near the Canadian border when Jim called me, unsolicited, welcomed me to Vermont, and invited me to a board meeting in Nashua, NH," Jack said. "NEHES seemed to be one of the best ways I could stay current in my position."

Although a new job as Vice President of Facilities Management for HealthNet of New England eventually took him to Putnam, CT, Jack has remained involved in NEHES ever since he became a member. He’s proudest of the fact that he could help strengthen the Connecticut Healthcare Engineers’ Society as he did its Vermont counterpart, and that he has been able to accept several NEHES board positions along the way. Following ASHE regional realignments last year, Jack worked to start communication and interaction between chapters in New York and New England. His ASHE position, he said, allows him to promote NEHES’ interests to a national audience and bring better recognition for the Society.

Now in his second term as ASHE Region 1 Director, Jack is one of NEHES’ longest-serving volunteers and the third member his peers have named their Engineer of the Year. Previous winners were Mark Cappello, 1997, and Tom O’Sullivan, 1998. Nominees are judged on their service to the Society, the healthcare engineering profession, their institution, their state chapter, and to other engineers during the most recent calendar year.

"With great pleasure I’m able to announce someone as talented and worthy as Jack Gosselin being recognized with this award," said Mark, this year’s Nominations chair. "I’m happy that he is being recognized for his accomplishments and his involvement."

In Jack’s 14 years of service to NEHES, he has been both Vermont and Connecticut State Representatives, President, Treasurer, and Newsletter Editor.

In 1997, he was elected to his first one-year term as ASHE Region 1 Director. The position “certainly keeps you on the forefront of some of the national initiatives that govern what happens to our industry. As a board, we can direct the future of the premier healthcare engineering society in the world,” Jack said. ASHE membership now stands at about 6,000.

Jack’s future definitely includes continued involvement in NEHES. “It’s a commitment, but I get a lot of personal enjoyment out of it.”

He and his wife, Stephanie, and two sons, Ian and Alex, live in Pomfret Center, CT.

View Mercury Teleconference From One of 4 Sites

"Mercury Elimination and Pollution Prevention in the Healthcare Setting" will originate from New England Medical Center (Boston) on November 30 from 9 a.m. to 1 p.m. Other viewing sites are Dartmouth-Hitchcock Medical Center (Hanover, NH), Hartford (CT) Hospital, and the VA Medical Center (Togus, ME).

Speakers include Judy Shope, responsible for mercury recycling in Massachusetts; Bill Ravenisi, associated with Health Care Without Harm, a national watchdog organization; and Bill Pickard of Lightning Environmental, a waste and cost reduction firm.

Bob Loranger, ASHE President, NEHES President-elect, and NEMC Facilities Director, will present a closing talk.

Contact Steve Cutter, NEHES Education Chair, at (603) 650-7148 or Steven.D.Cutter@Hitchcock.org if you haven’t received a registration brochure.

Call these persons to obtain directions to the viewing sites of your choice: NEMC, Bob Loranger, (617) 636-5267; Hartford Hospital, Mark English, (860) 545-2661; Dartmouth, Steve Cutter; and VA, Bill Kulas, (207) 623-5720.

Certification Exam Coming in 2000 For Facilities Engineers

ASHE will offer both members and nonmembers the chance to earn certification for the title of Certified Healthcare Facilities Manager next year. ASHE is one of several AHA Personal Membership Groups which have decided to undertake the design of a Certification process.

When surveyed, 62% of the ASHE membership voted to have such a voluntary program, according to Mark Cappello, Director of Engineering, Southwestern Vermont Medical Center (Bennington). Mark and two other NEHES members, Steve Cutter and Ron Vachon, volunteered to serve on the ASHE-AHA Certification Steering Committee with ASHE members from all over the country because of their strong interest in education/career development.

Steve is the Director of Engineering, Dartmouth-Hitchcock Medical Center (Lebanon, NH), and Ron is the Director of Plant Operations, St. Andrews Hospital and Healthcare Center, Boothbay Harbor (ME).

Meeting in Chicago, the Steering Committee worked with Applied Measurement Professionals Inc. to develop eligibility criteria, exam structure, and exam questions.

The final phase of the process is the creation of a Program Committee, which represents ASHE in a new AHA Certification Center. The six-member Program group will review test questions that have been written, make changes where needed, and assemble the exam documents. Members will also continue to review exam results, establish pass/fail criteria, and make changes when needed. Committee members will serve for two or three years and will not be allowed to sit for the exam until a specified period of time has lapsed following their committee commitment. Steve has been selected to participate on this committee.

Facilities engineers who want to take the exam will first complete an application. If the AHACC approves the application, using eligibility guidelines that take into account time spent in healthcare and facilities management, the engineer may take the exam at its introduction during the ASHE conference in Seattle July 10-14, 2000.
Member in the Spotlight

So. County Hospital Gets Space-Age Fuel Cell: Only 130 Installed Worldwide

Ken Soscia, founder and president of Alternate Energy Corporation in Cumberland, RI, visited South County that Ken seriously considered the fuel cell as a possible source of energy for his institution.

A detailed study of South County's energy needs and current systems, Ken secured hospital management's approval and applied for three grants totaling $75,000 from federal and state programs and Providence Gas. South County's share of the installation costs is $250,000. The hospital expects to save $60,000-$90,000 per year on electricity and an undetermined amount on natural gas.

"This fuel cell will generate 200 kilowatts of electrical power continuously and will meet two-thirds of our base electrical load," Ken said. "We will get the benefit of this unit running at 100 percent efficiency for 365 days a year. We will utilize the byproduct of the process for our domestic hot water."

In addition to the successful installation of the fuel cell, Ken's 100-bed, acute care community hospital just completed JCAHO and HCFA surveys with no Type 1 recommendations in the Environment of Care area. And, his peers in the Rhode Island Healthcare Engineers' Society have named Ken their Member in the Spotlight — in part because of his work on their educational programming. Ken has been Education chair for the past year, Education chair for the 1997 Fall Seminar, and more recently, Education co-chair with Dave Fontes for the next Spring Seminar.

"He's a very active member and participant in our local Society," said President Jim Gilmore, Director of Engineering at Newport Hospital. "I can count on him to cheerfully help me out if I need him. He has been very instrumental in our Society."

Ken joined South County 20 years ago after positions as office manager and estimator for two contractors. "It was kind of an accident," he said of his move to health care. "The position became available, and a number of people who knew me recommended me for the job. I was hired as the Administrative Engineer and two years ago promoted to Facilities Manager."

He and his wife and two daughters live in Narragansett.

President's Comments

Thanks to Vermont Engineers for a Very Well-Run Fall Conference

It is with great pleasure that I am able to submit this report to you on the occasion of the 1999 NEHES Fall Conference here in Burlington, VT. There is no way I can do justice to the Vermont Healthcare Engineers' Society in writing here the praises for their efforts in putting this conference together, but I will attempt it anyway.

Anyone who has had the experience of being responsible for or participating in the development of a fall conference knows the agony and the ecstasy of the process: the agony of worrying about the number of registrants, the educational program and speakers, the hotel accommodations, vendor support, spousal programs, and a thousand other small but crucial details, and the ecstasy of knowing you've done a good job and a great service to the profession when all is said and done. Well, VHES, on behalf of NEHES and the healthcare engineering profession in New England, thank you for a job well done! And who could ask for a better venue than northern Vermont the first week of October?

As you may or may not know, responsibility for the NEHES spring and fall programs rotates from chapter to chapter. The 1999 Spring Seminar, conducted by the Connecticut Healthcare Engineers' Society in Leominster, MA last March 30 was a rousing success. The 2000 Spring Seminar will also be held in Leominster next March, sponsored by the Rhode Island Healthcare Engineers' Society. And the 2000 Fall Conference, tentatively scheduled for the week of October 9-14, 2000 in Sturbridge, MA will be (tentatively) conducted by the four Massachusetts chapters.

Another aspect of NEHES' educational efforts this year is the video teleconference on the elimination of mercury in healthcare facilities, scheduled for November 30 at four sites: Boston, MA, Togus, ME, Lebanon, NH, and Hartford, CT. The Board has high hopes for this effort to be the continuation of a value-added educational service not only for the membership, but also for other continued on page 3
Are Off-Hours Surveys Next?  
JCAHO Approves Major Changes to Its Random Unannounced Survey Policy

By Robert J. Thompson, PE  
NEHES/ JCAHO Liaison  
Fire Protection and Safety Engineer  
Dept. of Veterans Affairs  
Bedford, MA

The Board of Commissioners of the JCAHO approved significant changes to the Random Unannounced Survey Policy for accredited health care organizations at its July 30-31 meeting.

Effective January 1, 2000, JCAHO will:
- Discontinue 24- to 48-hour notices for its random unannounced surveys;
- Conduct these surveys anywhere from 9 to 30 months following the previous survey;
- No longer indicate the specific areas to be targeted.

The scope and focus of review during an unannounced survey will vary, based on information from the previous triennial survey, known sentinel events, and other relevant information regarding the organization's performance.

The Random Unannounced Survey Policy applies to all accredited organizations except laboratories. JCAHO has conducted unannounced surveys at randomly selected accredited organizations midway through their accreditation cycle with a 24-hour advance notice and list of standards to be reviewed prior to the survey.

Off-Hours Surveys?

JCAHO surveyors will conduct a pilot test between October, 1999 and March, 2000. For 10% of the facilities surveyed, the surveyors will include off-hour inspections during evening, night, and weekend periods to see if these should be incorporated into future surveys. Joint Commission survey activities, including most unannounced surveys, have been conducted during regular daytime hours.

Accreditation Under Review

In addition, the Accreditation with Commendation Policy is under review by the Accreditation Committee of the Board of Commissioners. Early this year, the Committee sought input from the public and accredited organizations. The responses tended to support recognition of exemplary performance, but also reflected tolerance for a change in the current approach to recognition. The Board of Commissioners is expected to review and act on the Committee's final recommendations in November.

Other accreditation process improvements discussed by the Board in July included development of a pre-survey information packet that will provide surveyors with specific information about the healthcare organization's performance and permit exploration of any performance issues during the survey.

Your Input Desired

Input on the improvements being considered can be provided by sending an e-mail to accreditationimprovement@jcaho.org. For information, contact Rick Croteau, (630) 792-3176, or rcroteau@jcaho.org.

Thanks to Vermont Engineers

continued from page 2

interested parties here in New England. We are anticipating having brochures on the teleconference available here this week, and we will be mailing them out to everyone shortly.

Congratulations to Jeff Thomas on his selection as the Maine Healthcare Engineers' Society's Engineer of the Year, and to Jack Gosselin on his selection as the NEHES Engineer of the Year! These are prestigious awards that recognize significant contributions and achievements on the part of the recipients, and are especially meaningful because they come from peers.

Mark English is the Director of Engineering at Hartford (CT) Hospital.

ASHE Update

Curt Hibbard is New ASHE President

Jack Gosselin, Vice President of Facilities Management at Day Kimball Hospital (Putnam, CT) and the ASHE Region 1 Director, reports that 68 New England and New York ASHE members were among the 1,000 attendees and 350 vendors at the 36th annual ASHE conference in Philadelphia in June. NEHES, CHES (Connecticut Healthcare Engineers' Society) and the Greater New York Hospital Engineers' Society received Levels of Affiliation awards. More than 25 Region 1 engineers discussed chapter-related issues at the annual regional breakfast held in conjunction with the Conference.

Curt Hibbard, an ASHE member from Idaho with whom Jack has served on the ASHE board for three years, was voted ASHE President-elect. "Curt is a hard worker with strong vision for the Society," Jack said.

Several NEHES members are working on an ASHE-AHA certification program (see related story elsewhere in this issue.)

Other noteworthy ASHE events include:
- October 24-30: National Healthcare Facilities and Engineering Week;

Jack chairs the ASHE Facilities Management Committee. This group is working on benchmarking initiatives, using a NEHES benchmarking survey compiled by Bob Loranger, ASHE President and NEHES President-elect.

Submitted by Jack Gosselin
Health Care Task Force Spells Out Answers to Code Questions

By Eugene A. Cable, PE
NEHES Liaison to NFPA
Regional Safety & Fire Protection Engineer
Dept. of Veterans Affairs
Albany, NY

The Health Care Interpretations Task Force has dealt with some long-standing issues.

Questions #98-1 through #98-7 are listed below. All of the questions are important to you, but I draw your attention to number 98-6, NFPA 101 section 13-3.2, hazardous areas door latching. We are all familiar with the scenario where inspectors from different agencies or even the same agency impose differing requirements based on their own interpretations. That is what the Authority Having Jurisdiction (AHJ) is all about and that is how Code should be applied, but it sometimes places an unfair burden on you, the facilities manager. When an interpretation is rendered, that means the four applicable AHJ’s — Fire Marshal’s Association, the Healthcare Financing Administration, the JCAHO, and the Department of Veterans Affairs — agree to the finding. Some questions have been removed from consideration due to no agreement or forwarded on to the appropriate NFPA Committee for formal interpretation.

The Task Force, which is sometimes called the Authority Having Jurisdiction Committee, is focused on health care issues. Questions for the Task Force must come from the members. You may submit questions through Doug Erickson or George Mills (ASHEx) or through Bob Thompson or myself.

98-1 NFPA 101, All editions prior to the 1988 edition. Background Information:
Prior to the 1988 edition of the Life Safety Code, the code only permitted doors in the required means of egress of a health-care facility to be locked with time-delay type locks or in mental health facilities with keys. The more recent editions of the code now refer to the clinical needs of the patient and do not limit key locking to just mental health facilities.

For example, today’s nursing homes have Alzheimer’s units or wings. Alzheimer’s is not a mental health condition and was not identified prior to the mid-1980s other than through vague terminology such as “senility” or “dementia.”

AHJ’s using editions of the Life Safety Code prior to 1988 are not permitting nursing homes to lock Alzheimer’s units other than with time delay locks (special locks) because they are not mental health facilities. Time-delay locks are totally inadequate for Alzheimer’s patients. Alzheimer’s patients have no idea that pressing on the panic bar will cause an alarm, or that the locks will eventually open without staff interceding. The constant alarming only causes the staff to disconnect the systems.

Question: Was it the intent of the Life Safety Code prior to the 1988 edition to permit doors in the means of egress of healthcare facilities to be locked where the clinical needs of the patients required specialized security, provided staff can unlock the doors at all times?

Answer: Yes. Locking of these doors is acceptable provided: The clinical needs of the patients require specialized security measures for their safety, and Staff can readily unlock such doors at all times.

NOTE: While this interpretation is rendered based upon the 1997 edition of the Life Safety Code, it should be noted that this interpretation is also applicable to the 1985, 1981, 1973 and 1967 editions of the code.

Question 1: Is it the intent of 12-3.6.2.1 and 13-3.6.3.1 to require conformance with NFPA 80, Fire Doors and Windows, for non-rated corridor doors?
Answer: No.

Question 2: Would a non-rated corridor door, provided with an average 1-inch undercut, be an acceptable arrangement?
Answer 2: Yes.

98-3 NFPA 101, 1997 Ed.

Question: Can the normal clinical staff in an area affected by a fire alarm impairment or a sprinkler system impairment be used to satisfy the requirements for a fire watch?
Answer: Yes. Clinical staff may fulfill this role provided, as determined by the authority having jurisdiction, there is an adequate staffing level to continuously patrol the affected area and that they have the means to make proper notification to other occupants in the event of a fire.

NOTE: While this interpretation is rendered based upon the 1997 edition of the Life Safety Code, it should be noted that this interpretation is also applicable to the 1994 Edition of the code.

Background Information:
This section of the Life Safety Code does not specifically address what percentage, if any, of fire drills must be announced or unannounced. This section expects fire drills to be held at both expected and unexpected times but does not specifically require more unannounced drills than announced fire drills.

Recently, JCAHO stated that at least 50 percent of the fire drills must be unannounced, although this requirement is not part of their EC standards. (See Healthcare Fire Protection Newsletter, October 1998, Volume 4, No. 10, page 11 as quoted by Jaret McIntyre, spokesperson for the JCAHO). This is their interpretation of section 1-7.5.

Question: Does Section 1-7.5 require that 50 percent or more of the fire drills conducted be of the unannounced type?
Answer: No. Each authority having jurisdiction may establish a percentage of unannounced drills as appropriate for the circumstances. For example, JCAHO has recently indicated that at least half of the fire exit drills should be conducted as unannounced drills. Regardless of this, no drill should ever jeopardize the welfare of the patient receiving care.


Background Information:
In many healthcare settings, charting areas for use by nurses are provided in corridors. These spaces are open to the corridor and are not enclosed. They are in addition to and often not visible from nursing stations. They range in size from a small desk in an alcove to large rooms and sometimes have several racks/shelves of paper records and/or x-ray film. Generally, they are not occupied at all times. Sections 

continued on page 5
Turn This Sheet Over for Fax-Back Survey!

By Eugene A. Cable, PE

This is a good example of legitimate debate among health care officials concerning proposed LSC language. Please state your opinion on whether (YES) or not (NO) the following proposed language should be accepted into the 2000 LSC. The questionnaire ON THE BACK OF THIS SHEET combines questions about Fall Conference attendance and LSC.

Proposed Section 13-3.5.2: All high-rise health care facilities shall be protected throughout by an approved, supervised, automatic sprinkler system installed in accordance with Section 7-7, within seven years of adoption of this Code Edition.

Exception: Buildings in which an equivalent engineered life safety system, prepared by a registered professional engineer who is experienced in fire and safety systems' analysis and design, is approved by the authority having jurisdiction.

Statement against adopting into code: by LSC Health Care Tech. Committee:
The building construction requirements applicable to health care occupancies located in the high-rise portions of a building help to assure structural integrity during a fire. Health care occupancies are required to have smoke compartmentation. Health care occupancies have trained staff available to help patients relocate or evacuate. The fire record in health care occupancies has been good; it does not substantiate the need for sprinklers to be installed retroactively in existing buildings.

Statement against: by Robert Loranger, President-elect, NEHES:
I am really concerned about those hospitals, usually smaller hospitals, that are hanging on by a thread, budget-wise. Any type of new regulation, new requirement, especially applied as a retrofit requirement, could push them over the edge. I certainly understand the benefits of sprinkler protection and support installing them whenever possible — but it should not be a forced requirement.

Statement for adopting into code: by Ken Isman, National Fire Sprinkler Association:
High-rise fires have the ability to overwhelm any fire department. Fire sprinklers offer the best, most cost-effective form of protecting the lives in the building. The Life Safety Code has, for many years, required sprinkler protection in existing hotels, motels, dormitories, apartments, and business occupancies. It is time to expand these requirements to all occupancies since the hazard has more to do with the buildings' size and arrangement, and the difficulty for the fire department to fight a fire in the building, than it does the actual use of the building.

Statement for adopting into code: by Eugene A. Cable, U.S. Department of Veterans Affairs:
The LSC currently requires retroactive sprinkler protection for most other high-rise occupancies even given the occupants are capable of self-preservation. Health care occupants ought to be provided the same level of reliable fire protection. Health care fire history demonstrates that fire can cause total or near total evacuation of facilities AND, more importantly, that smoke does spread vertically and horizontally. There are relatively few high-rise, non-protected facilities, so the historical perspective should be somewhat discredited in favor of considering the unacceptable of the high risks involved from a fire in a high-rise hospital. The exception would allow for alternative equivalent life safety protection to be certified by the professional engineer and approved by the authority having jurisdiction. The committee's statement against adopting this Proposal 101–487 exactly supports the exception originally submitted. If the building and staff situation meet the committee's statement, then the sprinkler retrofit would not be required. But, if an engineering analysis does not bear out building that these other health care features are equivalent to sprinkler protection, then the sprinkler retrofit is justified. I again submit to the committee that there are relatively few high-rise health care buildings that are not already sprinkler protected. Therefore, the impact would be small on the health care community overall. The seven-year period would give ample time to comply. From the engineer's perspective, full sprinkler protection allows maximum flexibility for clinical moves to new space, saves money by taking advantage of about 23 "trade-offs" and insurance premium savings, and would cause avoidance of the whole debate of sprinkler or not to sprinkler during renovation work.

(Don’t forget to turn this sheet over and fax back your opinion TODAY!)
IMPORTANT FAX-BACK SURVEY
NEHES Board Needs Your Input!

Please fax this survey back to Rick Malmstrom by November 16 at (617) 414-7054 (no cover needed). The annual Fall Conference is NEHES’ largest educational and networking event and offers tremendous opportunities for the Healthcare Engineer. Unfortunately, less than 40% of our membership typically attend the program. Your prompt response to this simple “fax-back” questionnaire will help the NEHES Board as it looks at Conference structure alternatives focused on increasing participation. **As an incentive, a $25 Home Depot gift certificate will be awarded to a lucky, randomly chosen, responder! (must respond by November 16)**

If you were unable to attend a recent NEHES Fall Conference, which of the following were applicable?

1. ___ Could not take time away from work.
   What do you feel would be the ideal Conference length?
   ___ 4 days    ___ 3 days    ___ 2 days
   ___ 1 day

2. ___ Did not feel that the program had good value.
   Which parts of the program were not valuable enough to you?
   ___ Educational Programs   ___ Vendor exhibits
   ___ Social Functions

3. ___ Too far to travel.
4. ___ Costs too high.
   Which costs are too high?
   ___ Registration? (currently $195.00)
   ___ Travel/Accommodation costs?

5. OTHER:

Would you attend if part of the programming occurred on the weekend?    ___ Yes    ___ No
Would you favor holding the program at the same central location each year? ___ Yes    ___ No
Does your organization financially support programs like the NEHES Fall Conference? ___ Yes    ___ No

In addition to the Fall Conference questions, NEHES would like your opinion on the proposed 2000 NFPA Life Safety Code change (101 - Section 13-3.5.2) that is discussed ON THE BACK OF THIS SHEET.

Proposed Section 13-3.5.2 All high-rise health care facilities shall be protected throughout by an approved, supervised, automatic sprinkler system installed in accordance with Section 7-7, within seven years of adoption of this Code edition.

Your opinion:    ___ Yes, place proposal in Code.    ___ No, do not place in Code.
Is your health care building high-rise? ___ Yes    ___ No
Is your health care building full sprinkler protected? ___ Yes. If not, approx. % that is sprinklered ___ %

See Reverse Side for Code Change discussion! Fax This Back By November 16!
FAX BACK #: 1-617- 414-7054
Nurse Charting Areas, Positive Latching Requirements are Interpreted

(continued from page 4)

12/13-3.6.1 requires corridors to be separated from all other areas but allows several exceptions as such as nursing stations to be open to the corridor. The 1997 edition of the Life Safety Code Handbook states in the explanatory commentary that... "Areas used for charting and communications by doctors and nurses are permitted to be open to the corridor." Some AHJs are confused whether this statement in the LSC HB is universally applied.

**Question:** Is it acceptable to have charting areas that are not part of a nursing station open to a corridor in a healthcare occupancy in accordance with 12/13-3.6.1, Exception No. 3?

**Answer:** No. However, if such spaces can be protected using any of the options in: 101: 12-3.6.1, Exception No. 1, or 101: 13-3.6.1, Exception No. 1; or 101: 13-3.6.1, Exception No. 6, such spaces can be open to the corridor.

98-6 NFPA 101, 1997 Ed. Sec. 13-3.6.3.2

**Background Information:**

Some AHJs require that doors to hazardous areas off of a corridor in existing health-care occupations be provided with positive latching. Section 13-3.6.3.2 of the Life Safety Code requires doors to be provided with means suitable for keeping the door closed that are acceptable to the authority having jurisdiction. It does not state that latching is specifically required. The means used must be capable of keeping the door fully closed if a force of 5 lb is applied at the latch edge of the door. The appendix note to 13-3.6.3.2 states that a number of options exist for patient sleeping room doors such as... "Doors protecting openings to patient sleeping rooms or treatment rooms, or spaces having a similar combustible loading might be held closed using a closer exerting a minimum closing force of 5 lb at the door latch stile." Although the appendix note does not address doors to hazardous areas off corridors, some AHJs permit a self-closing device to serve as the means for keeping the door closed. For sprinkler protected hazardous areas in existing healthcare occupancies, Section 13-3.2.1 requires doors be equipped with self or automatic closers.

**Question:** Is positive latching required for corridor doors to hazardous areas that are sprinkler protected in existing health care occupancies?

**Answer:** No. Provided that a self closing or automatic closing device is installed on the door and that such device can meet the 5 pounds (force) criteria of 101: 13-3.6.3.2.

98-7 NFPA 101, 1997 Ed. Sec. 13-3.6.3.2

**Background Information:**

Section 5-10.1.4 requires that access to exits be marked by approved readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. It further states that sign placement shall be such that no point in the exit access corridor is more than 100 feet from the nearest sign, with an exception for existing buildings. Some AHJs interpret this to require two exit signs to be visible from any location in an exit access corridor, even in existing buildings.

**Question:** Must two exit signs always be visible from any location in an exit access corridor per Section 5-10.1.4?

**Answer:** No.

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**Don't Forget to Fill Out Your Fax-Back Survey By Nov. 16**

You could win a $25 gift certificate to Home Depot!

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**NFPA Liaison Is Both Advocate and Informer**

By Eugene A. Cable, PE

Your NFPA Liaison is your advocate concerning NFPA Codes/Standards. Advocacy is a two-part function:

Information sharing — informing you of high impact changes and interpretations. New information; proposed Code changes, Code changes, and Code interpretations are reported to the NEHES Board for dissemination to local Chapters and highlights are published in this newsletter.


You can ask me to voice your position on active Code change proposals or to coach you in submitting/creating your own new Code change proposals. You can also call, e-mail, or fax any Code interpretation issues for submission to a formal interpretation process. This can involve related JCAHO standards as well.

My contact information is: phone, (518) 472-1006; fax, (518) 463-4984, or e-mail, Eugene.Cable@med.va.gov.

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**Certification Exam**

(continued from page 1)

Afterward, the test will likely be given as a computer-based exam at locations across the country.

Applicants will pay a fee (as yet undetermined) to take the exam. They will have the opportunity to purchase study materials, but won't be required to do so. The exam will be based on job experience and knowledge, and take approximately two hours to complete.

For further information, contact ASHE at (312) 422-3800. Call APM at (913) 541-0400 to request a CHFM Candidate Handbook.
Save This Date!

NEHES
Spring Seminar
March 28, 2000
SHERATON FOUR POINTS
LEOMINSTER, MA

Organizers:
Members of the Rhode Island Healthcare Engineer's Society

Welcome to NEHES!

James A. Bove, Director of Facilities, Good Samaritan Medical Center, 235 N. Pearl St., Brockton, MA 02301, (508) 427-3264.


Andrew S. Ferraguto, Vice President, Engineering/Environmental Services, Franciscan Children's Hospital, 30 Warren St., Brighton, MA 02135, (617) 779-1450.

Clem E. Gritsavage, Quality Improvement Practitioner, Department of Veterans Affairs, North Main St., White River Junction, VT 05009, (802) 295-9363, Clem.Gritsavage@Med.Va.Gov.

Fred Rohde, Team Leader, Engineering-Maintenance, at Rutland Regional Medical Center, 160 Allen St., Rutland, VT 05701, (802) 747-3660, FRohde@RRMC.org.

R. Brian Sallisky, Project Manager, Putnam Memorial Health Corporation, 100 Hospital Drive, Bennington, VT 05201, (802) 447-5505, RBS@phin.org.

Anand K. Seth, Director of Utilities and Engineering, Partners Healthcare Systems, 16 Blossom St., Boston, MA 02114, (617) 726-2424, aseth@partners.org.

Foundry Explosion Tests Hospital’s Disaster Plan

When the Jahn Foundry in Springfield, MA exploded early one February afternoon, Baystate Medical Center’s disaster plan was tested beyond what anyone could have predicted.

Hospital officials immediately activated the plan, complete with command center and jobs for everyone, as soon as they heard about the explosion. But some unforeseen events threatened to upset that plan.

First of all, friends and relatives of many workers, along with media representatives and clergy, began streaming into the hospital. No one knew exactly what had happened at the nearby plant, or the number and the identities of the injured. In addition, storms that day had grounded all helicopters that could have transported the injured to burn units elsewhere. Finally, Baystate was at high patient census when ambulances from the foundry began arriving.

By chance, Dennis Desmarais, Baystate’s Director of Engineering, was on vacation that day, but his well-trained department carried on without him. Several employees worked as runners, bringing supplies to the Emergency Room.

“Ten or 11 burn cases were triaged here,” Dennis said. “There was tremendous activity in the ER, and 100 doctors responded. Rooms had to be set up for the press and for the families. The biggest problem was identification of the injured, because they were so badly burned. It took quite a while to straighten it out.” Baystate personnel also had to move ICU patients temporarily into other parts of the 686-bed hospital to make room for the injured. The patients were then taken by ambulance to burn units elsewhere in Massachusetts and Connecticut.

“Our hospital did a fantastic job,” Dennis said. “We got a lot of praise on how patients were handled. Afterwards, we set up several meetings to critique all that was done.”

The foundry explosion wasn’t the first time Baystate’s disaster plan was activated in the 30 years Dennis has worked there. “We’ve activated for other disasters, usually weather-related, such as loss of power. Those impact me and my department more.”

Contributed by Dennis Demarais