

AD HOC HEALTHCARE COMMITTEE MEETING #5
KTAG REPORT & NOTES FROM AHC # 5
WORK GROUPS: FIRE/FIRE SAFETY; GENERAL; EGRESS
12/08/2011

Notes from the meeting are indicated in red.

Proposals are submitted for the following K-tags. Some K-tags changes are still under development.

Status Update K-tag WG 12/8/2011				
Proposal Number	Topic	Study Group Assignment	Status	Code development group
K12	Building construction type	General	New table in Chapter 11 - Drafted.	Group B – IFC
K23	Number of smoke compartments	General	Drafted. Combined K23, K24 and K26. Reason statement may need work.	Group B - IFC
K24	Smoke compartment size	General	See K23.	Group B- IFC
K25	Minimum smoke barrier rating	General	Chapter 11 - Drafted. Combined with K104. Reason statement needs review.	Group B- IFC
K26	Smoke compartment size for evacuation	General	See K23	Group B-IFC
K27	Smoke barrier door rating	General	Chapter 11 - Drafted combined with K28.	Group B-IFC
K28	Smoke barrier door width	General	Chapter 11 - Drafted. Combined with K27.	Group B-IFC
K40	Door width	MOE	IFC 1104.7 – Drafted and combined with K41	Group B - IFC
K41	Door to corridor	MOE	IFC 1104.7 – drafted and combined with K40	Group B - IFC
K44	Horizontal exits	MOE	IBC 3404.7/IEBC 403.7/IEBC 805.10 (New) - drafted	Group A – IBC/IEBC Group B - IEBC
K45	Illumination	MOE	4 changes – IBC 1006, 1024.1 & 1024.5	Group A - IBC
K47	Exit signs	MOE	IBC 1011.6.3 - drafted	Group A - IBC
K66	Smoking regulations	Fire	310.3 – drafted	Group B - IFC
K67	Heating Appliances	General	IFGC 303.3.1 - Drafted and combined with K68	Group A – IFGC, IBC Group B – IFC
K68	Combustion air	General	Drafted and combined with K67.	Group A – IFGC, IBC

				Group B – IFC
K76	Medical Gas Ventilation	Fire	5306.2.1 - drafted	Group B - IFC
K104	Smoke dampers	General	Drafted combined with K25.	Group B-IFC
K106	Generator	MOE	IBC 407.11 - drafted	Group A - IBC
K142	Hyperbaric chambers	General	407.9 and IFC Chapter 11 Complete.	Group A and B – IBC and IFC
K145	Emergency power	MOE	No change – K106	
K146	Alternate power	MOE	No change – K106	
K147	reference for electrical equipment	MOE	IFC 605.12 - drafted	Group B - IFC
K161	Existing elevators	Fire	IFC 1103.3 -drafted	Group B - IFC

FIRE/FIRE SAFETY WORK GROUP REPORT

PART II – K-TAG CODE CHANGE DRAFTS

Introduction: The following code change proposal drafts are organized numerically by K-tag issues as assigned to the FSWG. To help focus on the more pressing code change deadline for Group A code changes, note that these proposals for K-tags K66, K76 and K161 are all IFC code changes to be heard in code Group B. Note that K-tag K71, also a Group B code change, is still being developed.

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K-tag K66 Smoking Regulations

CODE GROUP B – IFC COMMITTEE

Fxx-12/13 **310.3.1 (New)**

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

310.3 “No Smoking” signs. The *fire code official* is authorized to order the posting of “No Smoking” signs in a conspicuous location in each structure or location in which smoking is prohibited. The content, lettering, size, color and location of required “No Smoking” signs shall be approved.

310.3.1 Group I-2 hospitals. In Group I-2 hospital occupancies where smoking is prohibited, “No Smoking “ signs are not required in interior locations of the facility if the signs are displayed at all major entrances into the facility.

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: <http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

This proposal will provide correlation with NFPA 101, Section 19.7.4.2 which contains an exception for healthcare occupancies that allows for a facility to not install secondary “No Smoking Signs” throughout a facility if primary signs are prominently displayed at all major entrances. This exception is not currently included in the IFC. Since healthcare facilities already prohibit smoking, where signs are posted at the entrances it is redundant and unnecessary to also require the signs to be posted throughout a facility that does not permit smoking, has a staff trained to monitor and policies in place to quickly stop or prevent the action.

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K-tag K76 Medical Gas Ventilation

CODE GROUP B – IFC COMMITTEE

Fxx-12/13

5306.2.1

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

5306.2.1 One-hour exterior rooms. A 1- hour exterior room shall be a room or enclosure separated from the remainder of the building by fire barriers constructed in accordance with Section 707 of the *International Building Code* or horizontal assemblies constructed in accordance with Section 711 of the *International Building Code*, or both, with a fire- resistance rating of not less than 1- hour. Openings between the room or enclosure and interior spaces shall be self-closing smoke- and draft-control assemblies having a fire protection rating of not less than 1hour. Rooms shall have at least one exterior wall that is provided with at least two non-closable louvered vents. Each vent shall have a minimum free opening area of 24 square inches (155 cm²) for each 1,000 cubic feet (28 m³) at normal temperature and pressure (NTP) of gas stored in the room

and shall not be less than ~~36 72~~ square inches (~~0.023 m²~~ 0.046 m²) in aggregate free opening area. One vent shall be within 6 inches (152 mm) of the floor and one shall be within 6 inches (152 mm) of the ceiling. Rooms shall be provided with at least one automatic sprinkler to provide container cooling in case of fire.

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: <http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

The purpose of this proposal is to update Section 5306.2.1 on Medical Gas Systems to clarify and address the differences with the language in NFPA 99-2012, Section 9.3.7.5.2 with which hospitals are required to comply.

This proposed revision requires the vents to be of the non-closable type which is not currently required in the IFC, and of a larger size. It further defines the louver opening as “aggregate free opening” as required which is not currently specified in the IFC.

NFPA 99 is the more restrictive and sets the design of the louver to be specifically fixed where the IFC language may result is a “closable” louver which is not the intent of this code section. It also provides clarification on the sizing of the louver as it relates to the amount of gas being stored in the room where the IFC currently does not.

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K-tag K161 Existing Elevators

CODE GROUP B – IFC COMMITTEE

Fxx-12/13

1103.3; 1103.3.1 (New)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

1103.3 Existing elevators. Existing elevators, escalators, dumbwaiters and moving walks shall comply with the requirements of Sections 1103. 3.1 and 1103.3.2.

1103.3.1 Elevators, escalators, dumbwaiters and moving walks. Existing elevators, escalators, dumbwaiters and moving walks in **ambulatory care facilities** and Group I-2 hospitals shall comply with ASME A17.3.

1103.3.2 Elevator emergency operation. Existing elevators with a travel distance of 25 feet (7620 mm) or more above or below the main floor or other level of a building and intended to serve the needs of emergency personnel for fire-fighting or rescue purposes shall be provided with emergency operation in accordance with ASME A17.3.

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: <http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

The healthcare industry has historically been required to comply with regulations set forth by accreditation and certification agencies, such as The Joint Commission. Because the ICC family of codes does not currently have an existing elevator standard, ASME A17.3 *Safety Code for Existing Elevators and Escalators* is proposed for compliance of existing elevators in Group I-2 and ambulatory care facility occupancies. ASME A17.3 has been referenced by guidelines adopted by The Joint Commission for over a decade and this code change will provide correlation of the IFC with the mandated healthcare industry standard.

Adding a reference to ASME A17.3 will require that existing elevators, escalators, dumbwaiters and moving walks and their related operating equipment in ambulatory care facilities and Group I-2 hospitals comply with a minimum level of safety. Because the occupants of these types of facilities are often incapable of self-preservation, it will also provide important features essential for occupant safety including escalator and moving walk emergency stop buttons and automatic skirt obstruction stop feature and, for power dumbwaiters, hoistway door locking to keep doors closed except for the floor where the car is being loaded or unloaded. A new Section 1103.3 is included editorially to conform to established code style for multiple requirement sections.

Note:

- What is involved in a general reference to ASME A17.3?
- Should this be mandatory for ambulatory care?
- Should this be mandatory for any height building?

GENERAL WORK GROUP REPORT

PART II – K-TAG CODE CHANGE DRAFTS

Introduction: The following code change proposal drafts are organized numerically by K-tag issues as assigned to the GWG. To help focus on the more pressing code change deadline for Group A code changes the K-Tags are labeled accordingly.

K-tag - K12

Building construction type

Fxx-12/13

Table 11xx.x (New)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

CODE GROUP B – IFC COMMITTEE

**Fire code chapter 11?
Need charging paragraph**

K12	CONSTRUCTION TYPE LIMITATIONS FOR HOSPITALS, Group I-2 HEALTHCARE FACILITIES & AMBULATORY HEALTHCARE FACILITIES					
	TOTAL NUMBER OF STORIES OF BUILDING					
	Construction Type	Sprinklered* (see note)	Total Number of Stories of Building			
			1	2	3	≥ 4
	IA	Yes	P	P	P	P
		No	P	P	P	P
	IB	Yes	P	P	P	P
		No	P	P	P	P
	IIA	Yes	P	P	P	NP
		No	P	NP	NP	NP
	IIB	Yes	P	P	NP	NP
		No	NP	NP	NP	NP
	IIIA	Yes	P	P	NP	NP
		No	P	NP	NP	NP
	IIIB	Yes	P	NP	NP	NP
		No	NP	NP	NP	NP
	IV	Yes	P	P	NP	NP
		No	NP	NP	NP	NP
	VA	Yes	P	P	NP	NP
		No	NP	NP	NP	NP
	VB	Yes	P	NP	NP	NP

	No	NP	NP	NP	NP
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note a "No, indicates the building is not sprinklered throughout; but is sprinklered in conformance with IFC, level of I-2 and to level of discharge, sprinklered"

note b "Yes, indicates that the building is sprinklered throughout"

REASON: This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the [American Society for Healthcare Engineering](#), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at:

<http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

The Adhoc Committee on Healthcare is proposing this retroactive limitation requirement the (I-2 Institutional occupancy)(Healthcare facilities) retroactive allowable height based upon construction type because this is a **gaping** oversight for compliance requirements for nearly every healthcare facility and hospital.

The requirements identified in this Table for existing healthcare facility construction is absolutely necessary to be included in the I-Codes so that surveying and licensing requirements can be documented and provided for in the IFC. Without these limitations provided for in the IFC, to which the healthcare industry is required to comply and support, the implementation and use of the IFC as a compliance document could not be possible. While it is generally believed that most existing hospitals were constructed to comply with these minimum construction requirements, many were constructed using methods that were comprised of an "assembly" (i.e. minimum thickness concrete slab with a metal lath and plaster ceiling below) which provided the necessary fire rating. This section will allow all hospitals to be evaluated on an ongoing basis to verify the system/assembly used to obtain the required fire rating will be maintained or replaced with an equivalent system/assembly.

The existing allowance for the occupancies as stipulated in the proposed table, are less than that for new construction and do not increase the cost of construction and operations beyond what is currently mandated for healthcare facilities.

Ambulatory healthcare are required to be comply with based upon Federal Regulations, Licensing Requirements, state regulations and other approval/certification agencies.

Note:

- Reason – do not use ‘gaping over sight’
- The requirements are considerably more restrictive than Group B buildings (for ambulatory care). Consider separate table.
- Are ambulatory care facilities required to have a retroactive sprinkler system and/or separation? Look at IEBC instead of IFC Chapter 11 as possibility.
- Also addresses nursing homes

K-tags K23, K24, K26 - (See MOE K44)

K23 – Number of smoke compartments

K24 – Smoke compartment size (See also Proposal 2 from Topic 3)

K26- Smoke compartment size for evacuation

CODE GROUP B – IFC COMMITTEE

Fxx-12/13

(New) 11xx.1

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text to the IFC as follows:

(I-2 Hospitals)

11xx.1 Smoke barriers. *Smoke barriers shall be provided to subdivide every story used by persons receiving care, treatment or sleeping and to divide other stories with an occupant load of 50 or more persons, into no fewer than two smoke compartments. Such stories shall be divided into smoke compartments with an area of not more than 22,500 square feet (2092 m²) and the travel distance from any point in a smoke compartment to a smoke barrier door shall be not greater than 200 feet (60 960 mm). The smoke barrier shall be in accordance with Section 709. (IBC 407.5)*

Exception: *Smoke compartments in Group I-2 condition 1 shall be permitted to be 40,000 when the building is protected throughout with an automatic sprinkler system.*

11xx.1.1 Refuge area. *Refuge areas shall be provided within each smoke compartment. The size of the refuge area shall accommodate the occupants and care recipients from the adjoining smoke compartment. Where a smoke compartment is adjoined by two or more smoke compartments, the minimum area of the refuge area shall accommodate the largest occupant load of the adjoining compartments. The size of the refuge area shall provide the following:*

1. Not less than 30 net square feet (2.8 m²) for each care recipient confined to bed or litter.

2. Not less than 6 square feet (0.56 m²) for each ambulatory care recipient not confined to bed or litter and for other occupants.

Areas or spaces permitted to be included in the calculation of refuge area are corridors, sleeping areas, treatment rooms, lounge or dining areas and other low hazard areas.(IBC 407.5.1).

Note:

Trigger for existing, sleeping floors with more than 30 patients.

This is less than required for new construction, sleeping and non-sleeping floors.

Maybe not in IFC Chapter 11, but in IEBC

K-tags K25 and K104

K25 - Minimum smoke barrier rating

K104 – Smoke dampers

CODE GROUP B – IFC COMMITTEE

Fxx-12/13

11xx.1(New)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text to the IFC as follows:

11xx.1 Smoke barriers. Existing smoke barriers shall comply with Sections 11xx.1.1 and 11xx.1.2.

11XX.1.1 Smoke barriers and smoke partitions. Existing smoke barriers in Group I-2 occupancies hospitals shall be constructed to provide at least a ½ hour fire resistance rating and constructed in accordance with Chapter 7 of IBC. Smoke barriers shall be permitted to terminate at an atrium enclosure wall constructed in accordance with Section 404.6. Windows shall be protected by fire-rated glazing in accordance with the IBC ~~or by wired glass panels and steel frames.~~ A minimum of two separate compartments shall be provided on each floor with more than 30 patients. (perhaps link back to Chapter 7 of the IFC so that smoke barriers are not reduced to ½).

Exception: Previously approved wired glass vision panels shall be permitted to remain in place.

11xx.1.2 Smoke barrier penetrations. Previously approved smoke barrier penetrations without smoke dampers shall be permitted to remain. Smoke dampers shall be prohibited from being removed if part of the original approval.

Reason: This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of

building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the [American Society for Healthcare Engineering](http://www.iccsafe.org/cs/AHC/Pages/default.aspx), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: <http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

This section is added to address CMS K Tag 25 and CMS K Tag 104 on existing acceptable configuration of smoke barrier walls and smoke barriers that do not currently contain smoke dampers.

The intent of proposed section 11xx.1.1 is to bring noncompliant smoke barriers to at least ½ hour fire resistance rating. Previously approved smoke barriers are not intended to be reduced to ½. Chapter 7 of the IFC would require maintenance of approved construction. Proposed section 11xx.1.1 addresses hospitals that were originally approved without smoke dampers required. This provision would allow such situations to remain but would prohibit the removal of smoke dampers that were required.

The retroactive requirements are added to assist code officials and surveyors during the ongoing regular inspection of hospital facilities. These inspections are required by federal laws for certification and reimbursement. This requirement considers the minimum previously approved construction methods. This is consistent with the federal requirements that these facilities are currently held to.

Note:

- Current text does not allow for termination at a fire-resistant atrium wall.
- Look at how an atrium can be incorporated into a new hospital – future cycle.
- Number of patients is not directly related to care vs. sleeping rooms
- Number of patients should not related to smoke barrier construction

K-tags K27 and K28 (see also ongoing proposal from MOE for Chapter 11)

K27 Smoke barrier door rating

K28 –Smoke barrier door width

CODE GROUP B – IFC COMMITTEE

Fxx-12/13

11xx.1(New)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text as follows:

11xx.1 Smoke barrier doors. Existing smoke barrier doors in existing Group I-2 Occupancies shall comply with Sections 11xx.1.1 through 11xx.1.5

11xx.1.1 Smoke barrier door rating. Existing doors in smoke barriers in existing Group I-2 occupancies shall be in accordance with Section 716.5 of the IBC.

Exception:

1. Existing doors constructed of 1-3/4 inch thick solid bonded core wood
2. Non-rated protective plates shall be permitted in doors in smoke barriers
3. Vision panels of fire-rated glazing or wired glass panels and steel frames are permitted.

11xx.1.2 Door width. Existing doors in smoke barriers in existing Group I-2 occupancies shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors.

11xx.1.3 Horizontal doors. Horizontal sliding doors shall comply with NFPA 80.

11xx.1.4 Door closing. Doors shall be self-closing or automatic-closing in accordance with NFPA 80.

11xx.1.5 Door Swing. Existing swinging doors are not required to swing in the direction of the means of egress and positive latching is not required.

Reason: This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the [American Society for Healthcare Engineering](http://www.icsafe.org/cs/AHC/Pages/default.aspx), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: <http://www.icsafe.org/cs/AHC/Pages/default.aspx>

The proposal addresses doors in smoke barriers in existing Group I-2 occupancies. The intent is that if these provisions can not be met then compliance with the IBC is required.

This proposal address CMS K Tag 27 and 28 on existing acceptable configuration of smoke barrier walls.

Note:

- Don't want to reintroduce wired glass back into the code.
- Protective plates invalidates listing – or is it not better to protect the door so it is not damaged.

- Equivalent to listing or doors other than 1-3/4" should be permitted
- The door width is addressed better in general requirement in another change
- Put a positive spin on door swing requirement – not what you do not have to do.

K-tag K67 and K68

K67 Heating appliances K68 Combustion air

At AHC # 5, the committee spent a considerable amount of time reviewing and revising the original report relative to heating appliances.

Issues:

- Do not address all appliances
- Look for correct reference in IFGC – not general to 303.
- Cant submit changes to sections designated as ‘IFGS” – this is maintained by AGA
- Only direct vent fire places
- Stay away from ambulatory care this round
- Want to have this in Group I-1 and I-2 homes

The following text is a complete revision to the original report and includes revisions based on discussion between staff and the General WG following the meeting.

FGXX-12 303.3.1 (new);IMC 901.5 (new), 901.6 (new)

PART I - IFGC

IFGC 303.1 General. Appliances shall be located as required by this section, specific requirements elsewhere in this code and the conditions of the *equipment* and *appliance* listing.

IFGC 303.2 Hazardous locations. Appliances shall not be located in a *hazardous location* unless *listed* and *approved* for the specific installation.

IFGC 303.3 Prohibited locations. Appliances shall not be located in sleeping rooms, bathrooms, toilet rooms, storage closets or surgical rooms, or in a space that opens only into such rooms or spaces, except where the installation complies with one of the following:

1. The *appliance* is a direct-vent *appliance* installed in accordance with the conditions of the listing and the manufacturer’s instructions.

2. Vented room heaters, wall furnaces, vented decorative appliances, vented gas fireplaces, vented gas fireplace heaters and decorative appliances for installation in vented solid fuel-burning fireplaces are installed in rooms that meet the required volume criteria of Section 304.5.
3. A single wall-mounted unvented room heater is installed in a bathroom and such unvented room heater is equipped as specified in Section 621.6 and has an input rating not greater than 6,000 Btu/h (1.76 kW). The bathroom shall meet the required volume criteria of Section 304.5.
4. A single wall-mounted unvented room heater is installed in a bedroom and such unvented room heater is equipped as specified in Section 621.6 and has an input rating not greater than 10,000 Btu/h (2.93 kW). The bedroom shall meet the required volume criteria of Section 304.5.
5. The *appliance* is installed in a room or space that opens only into a bedroom or bathroom, and such room or space is used for no other purpose and is provided with a solid weather-stripped door equipped with an *approved* self-closing device. All *combustion air* shall be taken directly from the outdoors in accordance with Section 304.6.

IFGC 303.3.1 Fire places, appliances and decorative appliances in Group I-2. In addition to the requirements of Section 303.3, fuel gas-fired fireplaces and decorative appliances in Group I-2 Occupancies shall not be located in sleeping rooms, toilet rooms and bathrooms located in the patient sleeping or dwelling units, storage closets or surgical rooms. Fuel gas fired fireplaces and decorative appliances are permitted in other areas that open into such rooms or spaces only where the installation complies with all of the following:

- a. Combustion air is taken directly from the exterior,
- b. Flue gases are discharged directly to the exterior
- c. The combustion chamber is separated from the environmental air on the interior of the building.
- d. The appliances shall automatically shut down and stop fuel flow to the appliance upon any of the following events:
 - 4.1 when temperatures exceed the appliance listing,
 - 4.2 when there is failure to ignite
 - 4.3 upon activation of the fire alarm system
- e. Appliance controls are located in an approved restricted or locked location.
- f. A carbon monoxide detector shall be in accordance with IBC Section 908.7.

PART II - IMC

IMC 901.5 Fuel gas-fired Fireplaces and appliances in Group I-2. Fuel gas-fired fireplaces and decorative appliances located within smoke compartments containing patient sleeping rooms and surgical rooms in Group I-2 occupancies shall be installed in accordance with Section **303.3.1** of the IFGC.

IMC 901.6 Solid fuel-burning fire places and appliances in Group I-2. Solid fuel-burning fire places and decorative appliances shall not be located within smoke compartments containing patient sleeping rooms and surgical rooms in Group I-2 occupancies.

REASON: The AHC is proposing a revision to address oversights in the I-Codes of long-standing and operational requirements for hospitals and healthcare facilities that has not been specifically addressed. Beginning with a specific limitation within I-2 occupancies, language is being introduced to address the prohibition of fireplaces in these occupancies, other than those installed in accordance with the IFGC. The overview of these requirements for Group I-2 occupancies is that solid fuel burning fireplaces or appliances are not permitted in I-2 occupancies (hospitals/nursing homes); however, fuel gas fired decorative built fireplaces and gas-fired fireplace appliances are permissible under specific limitations and conditions.

The language proposed in the IFGC prescribes the limitations and conditions to provide the necessary safety and limitations of hazards found within the healthcare environments to the fire and ignition sources inherent to all fireplaces and gas-fired appliances. Combustion air is restricted from being drawn from a healthcare environment for more than the last decade. It is standard practice and operational procedure to control the ignition sources in these occupancies that can contain combustible, flammable (and sometimes even explosive) material. Fire risks need to be limited to the maximum extent feasible and specific requirements for these facilities are not currently or completely addressed in the I-Codes. The physical separation of the combustion chambers of fireplaces and gas-fired equipment is required to separate and provide a barrier between the ignition sources and the environmental air within healthcare occupancies. All combustion air is required to be taken directly from the exterior of the building with one exception that is already provided for in IFGC Section 303.3.

A new subsection addressing the requirements for combustion air of I-2 Occupancies has been added to IFGC Section 303.3 per Section 303.1.

Future submissions to proposals to the IFC have been drafted to clarify, restrict and limit this hazard in healthcare occupancies that will reference these requirements in the IBC, IMC AND IFGC and will also provide alternative means for compliance for existing facilities; given the hazard, the proposed IFC requirements will be 'retro-active'

requirements for healthcare occupancies (I-2); thus being proposed, however, these are not new requirements for these facilities but the coordination and provision of the construction and operational requirements for healthcare facilities.

COST IMPACT: No increase to the cost of construction for these facilities is associated with these code changes. Furthermore, given that all of the construction requirements will now be in the I-Codes, a potential reduction in costs for corrective actions and hazard mitigations could be reduced by stipulating these requirements in the I-Codes.

K-tag K142 Hyperbaric chambers

CODE GROUP A – IBC GENERAL COMMITTEE

Gxx-12/13 425 (New)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Revise IBC as follows:

SECTION 425 HYBERBARIC FACILITIES

407.9 425.1 Hyberbaric Facilities. Hyperbaric facilities in ~~Group I-2 occupancies~~ shall meet the requirements in Chapter 14 20 of NFPA 99.

CODE GROUP B – IFC COMMITTEE

Fxx-12/13 11xx.1 (New)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text to the IFC as follows:

SECTION 11XX HYBERBARIC FACILITIES

11XX.1 Hyperbaric facilities. Hyperbaric facilities ~~shall be in accordance with Section 425 of the IBC.~~ in Group I-2 occupancies shall meet the requirements in Chapter 14 of NFPA 99.

Reason: This proposal is submitted by the ICC Ad Hoc Committee for Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the [American Society for Healthcare Engineering](http://www.icsafe.org/cs/AHC/Pages/default.aspx), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at:

<http://www.icsafe.org/cs/AHC/Pages/default.aspx>

This code change expands the scope of an existing requirement to include all of the occupancies that have hyperbaric chambers installed.

Hyperbaric chambers are used in multiple occupancy types, not just Group I-2. Most of the typical patients that use these devices are outpatients, and are typically housed in Group B occupancies. As the popularity of these devices increase, *these are showing up in residential settings as well*. This proposal would increase the scope of these requirements to anywhere a hyperbaric chamber is seen.

Note:

- Should address all occupancies for hyperbaric facilities, both new and retroactive.
- Not all of NFPA 99 Chapter 14 should be mandatory retroactive
- Add provisions to the IFC for operation and maintenance – perhaps working with the Fire Code Action Committee

MOE Study Group

K-TAG CODE CHANGE PROPOSALS

December 7, 2011

K40 – Door width – Jeff Bressette – see K41

K41 – Door to corridor – Jeff Bressette

CODE GROUP B – IFC COMMITTEE

Fxx-12/13

1104.7

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

IFC 1104.7 Size of doors. The minimum width of each door opening shall be sufficient for the *occupant load* thereof and shall provide a clear width of not less than 28 inches (711 mm). Where this section requires a minimum clear width of 28 inches (711 mm) and a door opening includes two door leaves without a mullion, one leaf shall provide a clear opening width of 28 inches (711 mm). ~~The maximum width of a swinging door leaf shall be 48 inches (1219 mm) nominal.~~ In Group I-2 and Ambulatory care facilities, doors serving as means of egress from patient treatment rooms or patient sleeping rooms shall provide a clear width of not less than 32 inches (813 mm). ~~Means of egress doors in an occupancy~~ In Group I-2, doors serving as means of egress and used for the movement of beds shall provide a clear width not less than 41.5 inches (1054 mm). ~~The maximum width of a swinging door leaf shall be 48 inches (1219 mm) nominal.~~ The height of doors shall not be less than 80 inches (2032 mm).

Exceptions:

1. The minimum and maximum width shall not apply to door openings that are not part of the required *means of egress* in occupancies in Groups R-2 and R-3.
2. Door openings to storage closets less than 10 square feet (0.93 m²) in area shall not be limited by the minimum width.
3. Width of door leaves in revolving doors that comply with Section 1008.1.4.1 shall not be limited.
4. Door openings within a *dwelling unit* shall not be less than 78 inches (1981 mm) in height.
5. Exterior door openings in *dwelling units*, other than the required *exit* door, shall not be less than 76 inches (1930 mm) in height.
6. *Exit access* doors serving a room not larger than 70 square feet (6.5 m²) shall be not less than 24 inches (610 mm) in door width.

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at:

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Doors in hospitals, nursing homes, and similar occupancies have historically required doors to be a minimum of 32-inches in clear width due to the nature of the occupants within the buildings. The BOCA Basic Building Code in 1975 and the Uniform Building Code prior to 1979 both started requiring doors providing a clear width of 32-inches. The Americans with Disabilities Act Accessible Guidelines (ADAAG) of 1994 and the 2010 ADA Standards for Accessible Design, along with the Unified Federal Accessibility Standards (UFAS) also require a minimum of 32-inches clear because of the width necessary to maneuver a wheelchair through a door opening. Adding Ambulatory Care Facilities to the rule does not add any additional restrictions further than the IBC for door sizing.

Note: Coordinate with general change

K44 – Horizontal exits – Ed Altizer – (See K23, K24 and K26)

CODE GROUP A – IBC General

Gxx-12/13

3404.7-3404.7.3 (New) [IEBC [B] 403.7-403.7.3(new)]

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text as follows:

IBC 3404.7 (IEBC [B] 403.7) Refuge areas. Where alterations affect the configuration of an area utilized as a refuge areas, the capacity of the refuge area shall not be reduced below that required in Section 3404.7.1 through 3404.7.3.

IBC 3404.7.1 (IEBC [B] 403.7.1) Smoke compartments. In Group I-2 and I-3 occupancies, the required capacity of the refuge areas for smoke compartments in accordance with Section 407.5.1 and 408.6 .2 shall be maintained.

IBC 3404.7.2 (IEBC [B] 403.7.2) Ambulatory care. In ambulatory care facilities required to be separated by Section 422.2, the required capacity of the refuge areas for smoke compartments in accordance with Section 422.4 shall be maintained.

IBC 3404.7.3 (IEBC [B] 403.7.3) Horizontal exits. The required capacity of the refuge area for horizontal exits in accordance with Section 1025.4 shall be maintained.

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at:

<http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

When a space is being altered the designer needs to check that an alteration does not conflict with the area being used as a refuge area from an adjacent compartment. There is a correlative change being proposed for IEBC Chapter 8.

CODE GROUP B - IEBC

EBxx-12/13

IEBC 805.10-805.10.3 (new)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text as follows:

IEBC 805.10 Refuge areas. Where alterations affect the configuration of an area utilized as a refuge areas, the capacity of the refuge area shall not be reduced below that required in Section 805.10.1 through 805.10.3.

IEBC 805.10.1 Smoke compartments. In Group I-2 and I-3 occupancies, the required capacity of the refuge areas for smoke compartments in accordance with Section 407.5.1 and 408.6 .2 of the International Building Code shall be maintained.

IEBC 805.10.2 Ambulatory care. In ambulatory care facilities required to be separated by Section 422.2 of the International Building Code, the required capacity of the refuge areas for smoke compartments in accordance with Section 422.4 of the International Building Code shall be maintained.

IEBC 805.10.3 Horizontal exits. The required capacity of the refuge area for horizontal exits in accordance with Section 1025.4 of the International Building Code shall be maintained.

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: <http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

When a space is being altered the designer needs to check that an alteration does not conflict with the area being used as a refuge area from an adjacent compartment. There is a correlative change proposed for IBC Chapter 34/IEBC Chapter 4.

Note: Coordinate with General proposal

K45 – Illumination – Tim Peglow
Split into 4 changes

K45 - Change 1
CODE GROUP A – IBC Means of Egress

Exx-12/13
1006.1.1 (New) [IFC [B] 1006.1.1(new)]

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text as follows:

1006.1.1 (IFC [B] 1006.1.1) Occupancy sensors. Occupancy sensors shall be permitted to activate the required illumination for the means of egress provided they meet all of the following conditions:

1. The occupancy sensors operate as fail safe devices when the occupancy sensor fails;
2. Where the occupancy sensor is activated by an occupant the area served is illuminated for a minimum duration of 15 minutes;
3. The occupancy sensor operates as a fail safe device in the event of a power supply failure to the emergency lighting system required by Section 1006.3.
4. The means of egress is not required to have illumination to charge luminous egress path markings in accordance with Section 1024.5

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: <http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

This change permits the use of occupancy sensors which has been allowed in some jurisdictions. It also help reduce energy as mandated by DOE.

Note: Possibly move 'fail safe' definition into IBC (already in IFC)

K45 - Change 2

CODE GROUP A – IBC Means of Egress

Exx-12/13

1006.2.1 (New), 1006.3.1 [IFC [B] 1006.2.1(new), 1006.3.1]

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text as follows:

1006.2.1 (IFC [B] 1006.2.1) Exit discharge. In Group I-2, at the exit discharge, exterior landings as required by Section 1008.1.6 for *exit discharge* doorways in buildings required to have two or more *exits*, failure of any single lighting unit shall not reduce the illumination level to less than 1 foot-candles (11 lux).

Revise as follows:

1006.3.1 (IFC [B] 1006.3.1) Illumination level under emergency power. Emergency lighting facilities shall be arranged to provide initial illumination that is at least an average of 1 foot-candle (11 lux) and a minimum at any point of 0.1 foot-candle (1 lux) measured along the path of egress at floor level. Illumination levels shall be permitted to

decline to 0.6 foot-candle (6 lux) average and a minimum at any point of 0.06 foot-candle (0.6 lux) at the end of the emergency lighting time duration. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. In Group I-2, failure of any single lighting unit shall not reduce the illumination level to less than 0.2 foot-candles (2.2 lux).

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at:

<http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

The intent of new Section 1006.2.1 is to assure that the failure of a single lighting unit will not comprise the minimum lighting levels needed to safely egress during exit discharge.

The revision in Section 1006.3.1 is to assure performance of the lighting system during an emergency. The requirement reates a level of redundancy needed to assure lighting levels.

The limitation to Group I-2 is due to the scope of the Adhoc Health committee. There are no reasons why this would not be a good change for a majority of occupancies.

K45 - Change 3 CODE GROUP A – IBC Means of Egress

Exx-12/13

1006.2, 1024.5 [IFC [B] 1006.2, 1024.5]

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

1006.2 (IFC [B] 1006.2) Illumination level. The *means of egress* illumination level shall not be less than 1 foot-candle (11 lux) at the walking surface. The *means of egress* illumination level shall not be less than 10 foot-candle (110 lux) at the walking surface where luminous egress path markings are required by Section 1024.1.

Exception: For auditoriums, theaters, concert or opera halls and similar assembly occupancies, the illumination at the walking surface is permitted to be reduced during performances to not less than 0.2 foot-candle (2.15 lux), provided that the required illumination is automatically restored upon activation of a premises' fire alarm system where such system is provided.

1024.5 (IFC [B] 1024.5) Illumination. Where *photoluminescent* exit path markings are installed they shall be provided with the minimum *means of egress* illumination required

by Section ~~4006~~ 1006.2 for at least 60 minutes prior to periods when the building is occupied.

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: <http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

The change to Section 1006.2 is the light level needed to charge approved luminous markings. The change to 1024.5 is coordination with lighting levels required in 1006.2 and more specific pointer for this unique area.

K45 - Change 4 – Not going forward with this one CODE GROUP A – IBC Means of Egress

Exx-12/13

1024.1 [IFC [B] 1024.1]

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

SECTION 1024 LUMINOUS EGRESS PATH MARKINGS

1024.1 General. *Approved* luminous egress path markings delineating the exit path shall be provided in high-rise buildings of Group A, B, E, I, M, and R-1 occupancies in accordance with Sections 1024.1 through 1024.5.

Exception:

1. Luminous egress path markings shall not be required on the *level of exit discharge* in lobbies that serve as part of the exit path in accordance with Section 1027.1, Exception 1.
2. Luminous egress path markings shall not be required in Group I-2 occupancies where a defend-in-place method is utilized.

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of

the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: <http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

Photoluminescent exit path markings will not provide the needed illumination for extended periods of time to support defend in place strategies. Hospitals are required to have dual electric feeds which significantly increase the reliability of the electric service. Generators and electrical systems are installed and maintain per all applicable codes. The testing is validated by numerous inspecting agencies.

K47 – Exit signs –Jeff Bressette – Jonathan says not to do this

CODE GROUP A – IBC Means of Egress

Exx-12/13

1011.6.3 [IFC [B] 1011.6.3]

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Revise as follows:

1011.6.3 (IFC [B] 1011.6.3) Power source. *Exit* signs shall be illuminated at all times. To ensure continued illumination for a duration of not less than 90 minutes in case of primary power loss, the sign illumination means shall be connected to an emergency power system provided from storage batteries, unit equipment or an on-site generator. The installation of the emergency power system shall be in accordance with Chapter 27.

Exceptions:

1. *Approved exit* sign illumination means that provide continuous illumination independent of external power sources for a duration of not less than 90 minutes, in case of primary power loss, are not required to be connected to an emergency electrical system.
2. *Group I-2 hospital exit sign illumination shall not be permitted to be provided by unit equipment battery only.*

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at: <http://www.iccsafe.org/cs/AHC/Pages/default.aspx>

The IBC and IFC both have the same requirements. NFPA is less restrictive for UL listings of equipment. NFPA 70 is not referenced by IBC/IFC as does NFPA 99. IBC/IFC permit batteries.

Note: Jonathan Flannery to review.

K106 – Generator – Lennon Peake

K145 - Emergency Power

K146 – Alternate power

CODE GROUP A – IBC General

Gxx-12/13

407.11

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text as follows:

IBC 407.11 Electrical systems. In Group I-2 occupancies, the essential electrical power for electrical components, equipment and systems shall be designed and constructed in accordance with the provisions of **Chapter 27 and NFPA 99.**

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at:

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Currently emergency power systems are required to comply with NFPA 99 by the Center for Medicare/Medicaid Services (CMS) in order for a facility to receive federal reimbursement funds. Providing the code language requiring compliance with NFPA 99 will ensure the required power system is provided in Group I-2 occupancies. **While there is a reference to NFPA 99 in NFPA 70, there is no direct reference. This closes up a gap in the requirements. A reference to Chapter 27 will comprehensively address electrical systems including references to NFPA 70, 110 and 111.**

K147 – reference for electrical equipment – Lennon Peake

CODE GROUP B – IFC

Fxx-12/13

605.12 (new)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care

Add new text as follows:

IFC 605.12 Electrical systems maintenance. Electrical components, equipment and systems shall be maintained in compliance with the provisions of NFPA 70.

IFC 605.12.1 Group I-2 maintenance. Group I-2 electrical components, equipment systems shall also be maintained in accordance with the provisions of NFPA 99.

Reason: This proposal is submitted by the ICC Ad Hoc Committee on Healthcare (AHC). The AHC was established by the ICC Board of Directors to evaluate and assess contemporary code issues relating to hospitals and ambulatory healthcare facilities. The AHC is composed of building code officials, fire code officials, hospital facility engineers, and state healthcare enforcement representatives. The goals of the committee are to ensure that the ICC family of codes appropriately addresses the fire and life safety concerns of a highly specialized and rapidly evolving healthcare delivery system. This process is part of a joint effort between ICC and the American Society for Healthcare Engineering (ASHE), a subsidiary of the American Hospital Association, to eliminate duplication and conflicts in healthcare regulation. Since its inception in April, 2011, the AHC has held 5 open meetings and over 80 workgroup calls which included members of the AHC as well as any interested party to discuss and debate the proposed changes. All meeting materials and reports are posted on the AHC website at:

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Existing electrical systems are required to comply with NFPA 70 by the Center for Medicare/Medicaid Services (CMS) in order for a facility to receive federal reimbursement funds. Providing the code language for Group I-2 occupancies will ensure the required electrical systems are maintained per NFPA 70.

Note: Should the reference to NFPA 99 be for all group I and ambulatory care facilities?