

**AHC Meeting #7 July 12-13, 2012
General Work Group Report – Group A Codes**

FG3 – 12

303.3.1 (New); IMC: 901.5 (New), 901.6 (New)

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

THIS IS A 2 PART CODE CHANGE. BOTH PARTS WILL BE HEARD BY THE IFGC COMMITTEE AS 2 SEPARATE CODE CHANGES. SEE THE TENTATIVE HEARING ORDERS FOR THIS COMMITTEE.

PART I – IFGC

Add new text as follows:

303.3.1 Fireplaces and decorative appliances in Group I-2 occupancies. 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, storage closets, surgical rooms, toilet rooms and bathrooms located in the patient sleeping or dwelling units. 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:

1. Combustion air is taken directly from the outdoors.
2. Flue gases are discharged directly to the outdoors.
3. Appliance combustion chambers are separated from the environmental air on the interior of the building.
4. Appliances shall automatically shut down and stop fuel flow 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
5. Appliance controls are located in an approved restricted or locked location.
6. A carbon monoxide detector with a local alarm shall be provided and installed in accordance with Section 908.7 of the IBC.

PART II – IMC

Add new text as follows:

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.

901.6 Solid fuel-burning fire places and appliances in Group I-2. Solid fuel-burning fireplaces and appliances shall not be located in Group I-2 occupancies.

Exception: Solid fuel-burning fireplaces and appliances shall not be prohibited in Group I-2 nursing homes provided that they are not located in smoke compartments that contain patient sleeping rooms.

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 AHC is proposing a revision to address some of the oversights in the I-Codes of long-standing and operational requirements for hospitals and healthcare facilities that has not been specifically addressed. The requirements being proposed in this code change have been long-standing provisions of the construction and operational requirements for healthcare facilities.

Justification: 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.

The solid fuel burning fireplaces and appliances (decorative or heating) present open flames that cannot otherwise be controlled or extinguished like similar gas-fired appliances. The attention to and the tending of the open flames from solid fuel burning appliances require the opening any surrounding compartment while the flames and ignition sources are present; thereby, exposing the I-2 environment (within the patient smoke compartment) to the ignition sources. When gas-fired appliances are utilized, the ability to completely control the fuel source and all open flames and ignition sources is possible and does not require exposure to or tending of solid fuel burning materials. The AHC committee is recommending the restriction of solid-fuel burning fireplaces and appliances in the I-2 occupancy.

Future submissions to proposals to the IFC are being drafted to clarify, restrict and limit the ignition source hazards in healthcare occupancies that will reference these requirements being proposed in the IBC, IMC AND IFGC. The code sections that address the installation of fuel gas-fire fireplaces and appliances will also provide alternative means for compliance for existing facilities. Given the hazards present with these appliances in the I-2 Occupancies, the proposed IFC requirements will be 'retro-active' requirements for healthcare occupancies (I-2); please note, these are not new requirements for the I-2 Occupancy facilities but are needed in the I-Codes for coordination of the long-standing 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. This change is consistent with existing federal certification requirements.

FG3-12

PART I – INTERNATIONAL FUEL GAS CODE

Public Hearing:	Committee:	AS	AM	D
	Assembly:	ASF	AMF	DF

PART II – INTERNATIONAL MECHANICAL CODE

Public Hearing:	Committee:	AS	AM	D
	Assembly:	ASF	AMF	DF

303.3.1-FG-Williams-Adhoc

FG3-12

PART I – IFGC

Committee Action:

Disapproved

Committee Reason: The proposed text refers to section 303 which would allow unvented heaters to be installed in such occupancies. Unvented heaters do not belong in such spaces.

Assembly Action: None

PART II – IMC

Committee Action:

Disapproved

Committee Reason: Disapproval is consistent with the action taken on Part I. The referenced Section 303.3.1 would not exist.

Assembly Action: None

PC FG3 – 12

303.3.1 (New); IMC: 901.5 (New), 901.6 (New)

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

Part I - Approved as Submitted

Part II – Approved as Submitted

Reason: **Awaiting reason statement Sharon Myers**

G76 – 12

407.5

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

Revise as follows:

407.5 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) in Group I-2 occupancies and not more than 40,000 square feet in Group I-2 hospitals 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.

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>

This code change addresses outdated code material. Historically, smoke compartment size has been driven by the allowable travel distance within the smoke compartment. Past code changes have increased the travel distance without a corresponding change in smoke compartment size. Secondly, the size of the functional patient areas has increased, but the occupant load has remained the same or has been reduced. Therefore, we are asking for an increase in smoke compartment size to accommodate the operational needs of the modern hospital.

A summary of the history of smoke compartment requirements is as a requirement is as follows:

- October 1984 BCMC – Maximum length and width equals 150 feet.
- 1987 BOCA – 610.5 – Maximum length and width equals 150 feet
- 1992 BOCA Supplement – 610.4 – 22,500 square feet, with maximum travel distance of 150 feet.
- Code Change No. B20-95 – 22,500 square feet, with maximum travel distance proposed to be increased to 200 feet.
- 1996 BOCA – 409.4 - 22,500 square feet, with maximum travel distance of 200 feet.
- 2000 IBC – 407.4 - 22,500 square feet, with maximum travel distance of 200 feet.

Originally, there was no limit to smoke compartment size, other what was imposed by travel distance. The 22,500 square foot requirement was based on the old travel distance requirement of 150 feet, and used it to extrapolate an area (150ft x150ft = 22,500 square feet). This proposal uses the same logic and applies the current 200 foot travel distance maximum (200ft x200ft), resulting in a 40,000 square foot smoke compartment. This proposal would maintain the existing requirement that each floor be divided into two smoke compartments. Practically the requirement for 200' travel distance within smoke compartments will still drive smaller smoke compartment sizes in some cases.

Over the past 20 years, there has been a steady increase in the size of patient treatment rooms in hospitals. The primary reason for the increase is the equipment and utilities necessary for the treatment of a patient, such as patient monitoring, gases, and diagnostics equipment, while maintaining space for staff access to the patient. In response, the widely adopted and enforced

"Guidelines for the Design and Construction of Health Care Facilities" from the FGI Institute have also increased, making these operational considerations actual code requirements. In the case of the inpatient units, the adoption of a single bed in a patient room has had the largest impact on square footage, while not significantly increasing the number of occupants on the unit.

The concept of an "individual patient space" is becoming the standard design in other types throughout the hospital. Many emergency departments are opting for private patient exam spaces with hard walls, primarily for infection control and patient privacy considerations. Similarly, radiology areas are being driven by technology and clearance issues which go beyond the required minimums, and have impacts on square footages to achieve clearances. In some units, there has also been an increase in the types of required support spaces, including ratios of equipment storage per treatment room, the increased importance of computer equipment rooms, and various staff areas. However, support spaces have remained largely the same, while the main increases have been in the size of the patient treatment areas themselves. While these spaces have been increasing in size, the smoke compartment size requirements have been left unchanged in the building codes.

When studying the contemporary sizes of functions such as emergency departments, radiology operations, and bed units, the larger size allows for greater visualization from the staff to the patient, which is a crucial aspect of planning a patient area. This operational consideration could more easily be achieved before the increase in patient areas, but the same operational considerations require an increase to the smoke zone size to match contemporary requirements, delivery of care and technologies. Attached is a study of space programs which compare the 2010 Guideline requirements with the 1996-97 Guidelines. In short, today's hospital takes more square footage to care for the same amount of patients. These programs demonstrate the need to increase to 40,000 square foot smoke compartment. See program analysis at the following link.
<http://www.iccsafe.org/cs/AHC/Pages/WG-General.aspx>

Cost Impact: This proposal will help to decrease the cost of construction. Increasing the compartment size will reduce the number of smoke and fire dampers and lifetime maintenance costs could proportionately decrease.

G76-12

Public Hearing: Committee: AS AM D
Assembly: ASF AMF DF

407.5-G-Williams-Adhoc

G76-12

Committee Action:

Disapproved

Committee Reason: This proposal was disapproved based upon lack of technical justification. Travel distance was not felt to be a sufficient justification for the increase. Also the increase was seen as too large and perhaps can be accomplished in an incremental fashion. Also there was concern that this increase was being made without revising the occupant loads in Chapter 10. There was also concern with the size of refuge areas based upon a potential increase in occupant load.

Assembly Action: None

PC G76-12 (it is suggested that just one public comment with clarified justification and the following revisions be included)

Approval as Modified by PC

Further modify proposal as follows:

407.5 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) in **Group I-2 occupancies Condition 1 and not more than 40,000 square feet in Group I-2 hospitals Condition 2** 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.

Reason: This PC addresses the clarification of types of facilities made by G257-12. The revised smoke compartment size was specifically intended only to apply to hospitals.

Need additional reason statement from Jeff O'Neill

G92 – 12

422.3

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

Revise as follows:

422.3 Smoke compartments. Where the aggregate area of one or more *ambulatory care facilities* is greater than 10,000 square feet (929 m²) on one *story*, the *story* shall be provided with a *smoke barrier* to subdivide the *story* into no fewer than two *smoke compartments*. The area of any one such *smoke compartment* shall be not greater than ~~22,500~~ 40,000 square feet (~~2092 m²~~ 3719 m²). 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 installed in accordance with Section 709 with the exception that *smoke barriers* shall be continuous from outside wall to an outside wall, a floor to a floor, or from a *smoke barrier* to a *smoke barrier* or a combination thereof.

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>.

Intent and Summary

This code change addresses outdated code material. Historically, smoke compartment size has been driven by the allowable travel distance within the smoke compartment. Past code changes have increased the travel distance without a corresponding change in smoke compartment size. Secondly, the size of the functional patient areas has increased, but the occupant load has remained the same or has been reduced. Therefore, we are asking for an increase in smoke compartment size to accommodate the operational needs of these facilities.

A summary of the history of smoke compartment requirements is as follows:

- October 1984 BCMC – No area limitations. Maximum length and width equals 150 feet.
- 1987 BOCA – 610.5 – No area limitations. Maximum length and width equals 150 feet
- 1992 BOCA Supplement – 610.4 – 22,500 square feet, with maximum travel distance of 150 feet.
- Code Change No. B20-95 – 22,500 square feet, with maximum travel distance proposed to be increased to 200 feet.
- 1996 BOCA – 409.4 - 22,500 square feet, with maximum travel distance of 200 feet.
- 2000 IBC – 407.4 - 22,500 square feet, with maximum travel distance of 200 feet.

Originally, there was no limit to smoke compartment size, other what was imposed by travel distance. The 22,500 square foot requirement was based on the old travel distance requirement of 150 feet, and used it to extrapolate an area (150ft x150ft = 22,500 square feet). This proposal uses the same logic and applies the current 200 foot travel distance maximum (200ft x200ft), resulting in a 40,000 square foot smoke compartment. This proposal would maintain the existing requirement that each floor be divided into two smoke compartments. Practically the requirement for 200' travel distance within smoke compartments will still drive smaller smoke compartment sizes in some cases.

The application of the smoke compartment size for Ambulatory Care facilities was taken from the hospital requirement in Section 407. There was no specific reason given for using 22,500 square feet as a threshold other than mirroring the hospital requirement.

When studying the contemporary sizes of functions within ambulatory surgery areas, the area provided has increased. Attached is a study of space programs which compare the 2010 Guideline requirements with the 1996-97 Guidelines. In short, today's ambulatory surgery facility takes more square footage to care for the same amount of patients. These programs demonstrate the need to increase to 40,000 square foot smoke compartment. See program analysis at the following link. <http://www.iccsafe.org/cs/AHC/Pages/WG-General.aspx>

Cost impact: This proposal will help to decrease the cost of construction. Increasing the compartment size will reduce the number of smoke and fire dampers and lifetime maintenance costs could proportionally decrease.

G92-12

Public Hearing: Committee: AS AM D

G92-12

Committee Action:

Disapproved

Committee Reason: This proposal was disapproved based upon the previous action on G76-12. The main focus of the concern focused upon occupant load, travel distance and refuge areas.

Assembly Action:

None

PC G92-12

Approval as Submitted

Reason: Awaiting reason statement from Jeff O'Neil

G128 – 12

Table 508.4

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

Revise as follows:

**TABLE 508.4
REQUIRED SEPARATION OF OCCUPANCIES (HOURS)**

OCCUPANCY	A, E		I-1 ^a , I-3, I-4		I-2		R ^a		F-2, S-2 ^b , U		B ^e , F-1, M, S-1		H-1		H-2		H-3, H-4		H-5	
	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS
B ^e , F-1, M, S-1	—	—	—	—	—	—	—	—	—	—	N	N	NP	NP	2	3	1	2	1	NP

(Portions of table not shown remain unchanged)

- S = Buildings equipped throughout with an automatic sprinkler system installed in accordance with Section 903.3.1.1.
- NS = Buildings not equipped throughout with an automatic sprinkler system installed in accordance with Section 903.3.1.1.
- N = No separation requirement.
- NP = Not permitted.

- a. See Section 420.
- b. The required separation from areas used only for private or pleasure vehicles shall be reduced by 1 hour but to not less than 1 hour.
- c. See Section 406.3.4.
- d. Separation is not required between occupancies of the same classification.
- e. See Section 422.2 for ambulatory care facilities.

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>.

This footnote reminds the reader that although there is no separation required for many B occupancy to other occupancies that Section 422.2 would still require a 1 hour fire partition between other group B occupancies and F-1, M and S-1 occupancies.

Cost Impact: None

G128-12

Public Hearing: Committee: AS AM D
 Assembly: ASF AMF DF

T508.4-G-WILLIAMS-ADHOC

G128-12

Committee Action:

Approved as Submitted

Committee Reason: This provides a helpful clarification that ambulatory care facilities have specific and more restrictive separation requirements even though they are Group B occupancies.

Assembly Action:

None

PC1 G128 – 12

Table 508.4

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

Modify proposal as follows:

**TABLE 508.4
 REQUIRED SEPARATION OF OCCUPANCIES (HOURS)**

OCCUPANCY	A, E		I-1 ^a , I-3, I-4		I-2		R ^a		F-2, S-2 ^b , U		B ^e , F-1, M, S-1		H-1		H-2		H-3, H-4		H-5	
	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS	S	NS
B ^e , F-1, M, S-1	—	—	—	—	—	—	—	—	—	—	N	N	NP	NP	2	3	1	2	1	NP

(Portions of table not shown remain unchanged)

- S = Buildings equipped throughout with an automatic sprinkler system installed in accordance with Section 903.3.1.1.
- NS = Buildings not equipped throughout with an automatic sprinkler system installed in accordance with Section 903.3.1.1.
- N = No separation requirement.
- NP = Not permitted.
- a. See Section 420.
- b. The required separation from areas used only for private or pleasure vehicles shall be reduced by 1 hour but to not less than 1 hour.
- c. See Section 406.3.4.
- d. Separation is not required between occupancies of the same classification.
- e. See Section 422.2 for ambulatory care facilities.

508.2.4 Separation of occupancies. No separation is required between accessory occupancies and the main occupancy.

Exceptions:

1. Group H-2, H-3, H-4 and H-5 occupancies shall be separated from all other occupancies in accordance with Section 508.4.

2. Group I-1, R-1, R-2 and R-3 *dwelling units* and *sleeping units* shall be separated from other *dwelling* or *sleeping units* and from accessory occupancies contiguous to them in accordance with the requirements of Section 420.

3. Ambulatory care facilities shall be separated from other tenant spaces and from accessory occupancies contiguous to them in accordance with Section 422.2.

508.3.3 Separation. No separation is required between nonseparated occupancies.

Exceptions:

1. Group H-2, H-3, H-4 and H-5 occupancies shall be separated from all other occupancies in accordance with Section 508.4.

2. Group I-1, R-1, R-2 and R-3 *dwelling units* and *sleeping units* shall be separated from other *dwelling* or *sleeping units* and from other occupancies contiguous to them in accordance with the requirements of Section 420.

3. Ambulatory care facilities shall be separated from other tenant spaces, regardless of occupancy classification, in accordance with Section 422.2.

Reason: G128-12 does adds a footnote to the occupancy separation table to remind code users that for Ambulatory Care Facilities a 1-hour separation is required between an ambulatory care facility and any other tenant space. That requirement is going to apply regardless of which Section of 508 is in use. The same type of requirement occurs in Sections 420.2 and 420.3 for dwelling and sleeping units. To be consistent, exceptions are proposed to Sections 508.2 and 508.3.

T508.4-G-WILLIAMS-ADHOC

G200 – 12

3304.8 (NEW), 3311.3 (NEW)

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

Add new text as follows:

3304.8 Group I-2. For buildings employing a *defend in place* method in Group I-2 occupancies, an on-site fire watch shall be provided in accordance with the Section 901.7 of the *International Fire Code*.

3311.3 Group I-2. Temporary construction within corridors serving bed or stretcher movement in Group I-2 occupancies shall not reduce the corridor width to less than 60 inches.

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>.

This change clarifies the code. Facilities that must remain operational during due to the critical nature of the service that they provide it is not feasible to evacuate the building for renovations. Healthcare facilities are routinely preplanning construction projects as to how the project will affect various fire and life safety functions and features in the building during the project.

However, this section reminds the plan reviewer to coordinate with the fire official for planned shut downs of fire safety equipment and provides an opportunity for the AHJ's to determine the appropriate interim life safety measures to ensure continued operation.

Temporary construction barriers are an operational necessity to contain construction dust, provide infection control, and prevent public entry into potentially hazardous areas. These barriers are required by facility infection control staff, industrial hygienists and other regulatory agencies. A new section of code is added to clarify that temporary construction may not reduce the corridor width to less than 60 inches where bed or stretcher movement is used. This temporary condition will allow for reasonable infection control protection and maintain an appropriate corridor width.

Cost Impact: This proposal will not increase the cost construction. This change is consistent with existing federal certification requirements.

G200-12

Public Hearing:	Committee:	AS	AM	D
	Assembly:	ASF	AMF	DF

3304.8-G-WILLIAMS-ADHOC.doc

G200-12

Committee Action:

Disapproved

Committee Reason: The proposal was disapproved based upon the request of the proponent. Also there was concern that these type of provisions are better located within the IFC and the width of 60 inches was questioned.

Assembly Action:

None

PC1 G200 – 12

3304.8 (NEW), 3311.3 (NEW)

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

Modify proposal as follows:

~~**3304.8 Group I-2.** For buildings employing a *defend in place* method in Group I-2 occupancies, an on-site fire watch shall be provided in accordance with the Section 901.7 of the *International Fire Code*.~~

3310.3 (IFC [B] 3311.3) 3311.3 Group I-2. Temporary construction within corridors serving bed or stretcher movement in Group I-2 occupancies shall not reduce the corridor width to less than 60 inches.

Reason: Regardless of the concerns with the proposed Section 3304.8 it is still felt that the section added addressing a minimum corridor width during construction was still necessary. The section numbering has been corrected to fit with IBC Chapter 33 numbering. This section is also intended to appear in the IFC.

PC2 G200 – 12

3304.8 (NEW), 3311.3 (NEW)

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

Modify proposal as follows:

~~**3302.4 3304.8 Group I-2.** For Group I-2 occupancies buildings employing a *defend in place* method shall revise and implement the fire plan during construction in accordance with Section 404 of the IFC in Group I-2 occupancies, an on-site fire watch shall be provided in accordance with the Section 901.7 of the *International Fire Code*.~~

~~**3311.3 Group I-2.** Temporary construction within corridors serving bed or stretcher movement in Group I-2 occupancies shall not reduce the corridor width to less than 60 inches.~~

Reason: This public comment is addressing the initial intent of the proposed Section 3302.4 which was to make sure that the fire plan was constantly revised to fit with the current conditions during construction due to the condition of the occupants. This is particularly important as Group I-2 occupancies will remain functional during construction and will continue to use a defend in place strategy during construction.
