

**AHC Meeting #9
March 21-22, 2013
Mean of Egress Work Group Report**

The following 2013 Group B changes have been compiled for the above noted AHC Work Group. Code changes with an (*) indicate AHC sponsored Code changes. These changes are intended to serve as the agenda for the AHC in order to establish AHC positions, if any, for the upcoming 2013 Group B Committee Action Hearings.

EB39-13	F188-13	F238-13*
EB40-13	F208-13*	F239-13*
EB41-13*	F209-13*	F240-13*
F145-13	F212-13*	F241-13*
F146-13	F233-13*	F242-13*
F187-13	F237-13*	

EB39-13

805.10 (NEW), 805.10.1 (NEW), 805.10.2 (NEW)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care and Carl Baldassarra, Code Technologies Committee

Add new text as follows:

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 and 805.10.2.

805.10.1 Smoke compartments. In Group I-2 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.

805.10.2 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: When a space in a Group I-2 facility 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 was a correlative change proposed and accepted for IBC Chapter 34/IEBC Chapter 4.

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 8 open meetings and over 150 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 is being co-sponsored by the ICC Code Technology Committee. The ICC Board established the ICC Code Technology Committee (CTC) as the venue to discuss contemporary code issues in a committee setting which provides the necessary time and flexibility to allow for full participation and input by any interested party. The code issues are assigned to the CTC by the ICC Board as "areas of study". Information on the CTC, including: meeting agendas; minutes; reports; resource documents; presentations; and all other materials developed in conjunction with the CTC effort can be downloaded from the following website: <http://www.iccsafe.org/cs/CTC/Pages/default.aspx>. Since its inception in April/2005, the CTC has held twenty five meetings - all open to the public.

Cost Impact: This code change proposal will not increase the cost of construction.

EB40 – 13

805.10 (NEW), 805.10.1 (NEW), 805.10.2 (NEW)

Proponent: Robert J Davidson, Davidson Code Concepts, LLC, representing self
(rjd@davidsoncodeconcepts.com)

Add new text as follows:

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 and 805.10.2.

805.10.1 Smoke compartments. In Group 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.

805.10.2 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: When a jail 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. The intent is to mirror the language proposed by the Adhoc Health Care for hospitals for consistency in protection.

Cost Impact: This code change proposal will not increase the cost of construction.

EB41–13*

805.10 (NEW), 805.10.1 (NEW), 808.10.2 (NEW)

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

Revise 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 and 805.10.2.

IEBC 805.10.1 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 805.10.2 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: The provisions to separate Ambulatory Care facilities with four or more persons may not be capable of self-preservation is fairly new in the code. However, when a different tenant in the building makes alterations, it needs to be verified that the areas of refuge are maintained. The intent is to mirror the language proposed by the Adhoc Health Care for hospitals.

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 8 open meetings and over 150 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>.

Cost Impact: This code change proposal will not increase the cost of construction.

F145–13

904.11.5 (New) [IBC [F] 904.11.5], Chapter 80

Proponent: Bob Eugene, representing UL LLC (Robert.Eugene@ul.com)

Add new text as follows:

904.11.5 (IBC [F] 904.11.5) Residential range top extinguisher units. Where residential range top cooking appliances are permitted to be used in occupancies regulated by this Code, and an automatic fire-extinguisher unit is required to protect the cooking surface, it shall be listed and labeled in accordance with UL 300A. The extinguisher unit shall be installed in accordance with its listing and the manufacturer's installation instructions.

Add new standard to Chapter 80 as follows:

300A – 06 Outline of Investigation for Extinguishing System Units for Residential Range Top Cooking Surfaces904.11.5

Reason: The UL 300A Outline of Investigation includes requirements for conducting fire testing with extinguisher units intended to extinguish fires occurring on residential range top cooking surfaces. To date two manufacturers have several automatic extinguisher units that are listed and comply with UL 300A, that include both wet and dry chemical extinguishing agents.

It is recognized that code officials allow residential range tops to be installed in a variety of situations in addition to dwelling units. This includes office break rooms, churches, and similar venues. It is not the intent of the proposal to require all of these installations to be protected by UL 300A extinguisher units. The proposal clearly indicates that these units are only to be provided when required.

One application where UL 300A extinguisher units will be required is for residential range tops installed in Group I-2, Condition 1 occupancies. This was recently required as a result of the public comment to proposal G65-12 that was passed at the Final Action Hearing in Portland.

Cost Impact: None

F146–13

904.12 (IBC [F] 904.12) (New), 904.12.1 (IBC [F] 904.12.1 (New)), 904.12.2 (IBC [F] 904.12.2 (New)), Table 906.1 (IBC [F] Table 906.1), Chapter 80 (IBC Chapter 35)

Proponent: Carl Baldassarra, P.E., FSFPE, Chair, ICC Code Technology Committee (cbaldassarra@RJAGroup.com)

Revise as follows:

904.12 (IBC [F] 904.12) Domestic cooking system in Group I-2 Condition 1. In Group I-2 Condition 1 occupancies where cooking facilities are installed in accordance with Section 407.2.5 of the *International Building Code*, the domestic cooking hood provided over the cooktop or range shall be equipped with an automatic fire-extinguishing system of a type recognized for protection of domestic cooking equipment. Pre-engineered automatic extinguishing systems shall be tested in accordance with UL 300A and listed and labeled for the intended application. The system shall be installed in accordance with this code, its listing and the manufacturer's instructions.

904.12.1 (IBC [F] 904.12.1) Manual system operation and interconnection. A manual actuation device for the hood suppression system shall be installed in accordance with Section 904.11.1 and 904.11.2

904.12.2 (IBC [F] 904.12.2) Portable fire extinguishers for domestic cooking equipment in Group I-2 Condition 1. A portable fire extinguisher complying with Section 906 shall be installed within 30 feet (9144 mm) travel distance of domestic cooking appliances.

**TABLE 906.1 (IBC [F] TABLE 906.1)
ADDITIONAL REQUIRED PORTABLE FIRE EXTINGUISHERS**

Section	Subject
904.12.2 (IBC 407.2.5)	Domestic cooking hoods in Group I-2 Condition 1 occupancies

(Portions of table not shown remain unchanged)

Add new standard to Chapter 80 (IBC Chapter 35) as follows:

UL

300A-2006 Outline of Investigation for Extinguishing System Units for Residential Range Top Cooking Surfaces

Reason: M76 clarified requirements for domestic appliance located in facilities such as nursing homes and assisted living where they are only used for domestic (not commercial) cooking. G65 requires a range hood with a UL300A protection system in a Group I-2 Condition 1 (nursing home). The purpose of this change is for the standard to be required in the Fire Code. The requirements follow what passed in G65 in Items 6, 7 and 9.

The ICC Board established the ICC Code Technology Committee (CTC) as the venue to discuss contemporary code issues in a committee setting which provides the necessary time and flexibility to allow for full participation and input by any interested party. The code issues are assigned to the CTC by the ICC Board as "areas of study". Information on the CTC, including: meeting agendas; minutes; reports; resource documents; presentations; and all other materials developed in conjunction with the CTC effort can be downloaded from the following website: <http://www.iccsafe.org/cs/CTC/Pages/default.aspx>. Since its inception in April/2005, the CTC has held twenty five meetings - all open to the public.

Cost Impact: None

Analysis: The standard proposed for inclusion in the code, UL 300A, was accepted as a referenced standard in the IBC by approval of Group A code change G65-12 (AMPC).

F187-13

909.5.2 (IBC [F] 909.5.2, IMC [F] 513.5.2), 909.5.2.1 (New) [IBC [F] 909.5.2.1 (New), IMC [F] 513.5.2.1 (New)],

Proponent: Al Godwin, CBO, CPM, Aon Fire Protection Engineering, representing Aon Fire Protection Engineering Corporation (al.godwin@aon.com)

Revise as follows:

909.5.2 (IBC [F] 909.5.2, IMC [F] 513.5.2) Opening protection. Openings in *smoke barriers* shall be protected by automatic-closing devices actuated by the required controls for the mechanical smoke control system. Door openings shall be protected by fire door assemblies complying with Section 716.5.3 of the *International Building Code*.

Exceptions:

1. Passive smoke control systems with automatic-closing devices actuated by spot-type smoke detectors *listed* for releasing service installed in accordance with Section 907.3.
2. Fixed openings between smoke zones that are protected utilizing the airflow method.
3. In Group I-1 Condition 2, Group I-2 and ambulatory health care facilities, where ~~such doors~~

~~are installed across corridors~~, a pair of opposite-swinging doors are installed across a corridor in accordance with Section 909.5.2.1, the doors shall not be required to be protected in accordance with Section 716 of the *International Building Code* without a center mullion shall be installed having vision panels with fire protection-rated glazing materials in fire protection-rated frames, the area of which shall not exceed that tested. The doors shall be close-fitting within operational tolerances and shall not have a center mullion or undercuts in excess of 3/4-inch, louvers or grilles. The doors shall have head and jamb stops, and astragals or rabbets at meeting edges and shall automatic-closing by smoke detection in accordance with Section 716.5.9.3 of the *International Building Code*. Where permitted by the door manufacturer's listing, Ppositive-latching devices are not required.

4. Group I-3.
5. Openings between smoke zones with clear ceiling heights of 14 feet (4267 mm) or greater and bank-down capacity of greater than 20 minutes as determined by the design fire size.

909.5.2.1 (IBC [F] 909.5.2.1, IMC [F] 513.5.2.1) Group I-1 Condition 2, I-2 and ambulatory care facilities. In Group I-1 Condition 2, Group I-2 and ambulatory care facilities, where doors are installed across a corridor, the doors shall be automatic closing by smoke detection in accordance with Section 716.5.9.3 of the *International Building Code* and shall have a vision panel with fire-protection rated glazing materials in fire-protection-rated frames, the area of which shall not exceed that tested.

909.5.2.1 (IBC [F] 909.5.2.1, IMC [F] 513.5.2.1) 909.5.2.2 (IBC [F] 909.5.2.2, IMC [F] 513.5.2.2) Ducts and air transfer openings. (No change to current text)

Reason: Code changes FS76-07/08, G15-09/10 and FS40-12 have made amendments to IBC Section 709.5, exception 1 that are not reflected in Section 909.5.2. G31-12 added a new requirement for Group I-1 Condition 2 that needs to be picked up in 909.5.2.

Cost Impact: This is just a correlation between the two codes. Thus, there will be no increase in cost not already encountered.

F188–13

909.5.2 (IBC [F] 909.5.2, IMC [F] 513.5.2)

Proponent: John Woestman, Kellen Company, representing Builders Hardware Manufacturers Association (BHMA) (jwoestman@kellencompany.com)

Revise as follows:

909.5.2 (IBC [F] 909.5.2, IMC [F] 513.5.2) Opening protection. Openings in *smoke barriers* shall be protected by automatic-closing devices actuated by the required controls for the mechanical smoke control system. Door openings shall be protected by fire door assemblies complying with Section 716.5.3 of the *International Building Code*.

Exceptions:

1. Passive smoke control systems with automatic closing devices actuated by spot-type smoke detectors *listed* for releasing service installed in accordance with Section 907.10.
2. Fixed openings between smoke zones that are protected utilizing the airflow method.
3. In Group I-2 and ambulatory care facilities, where such doors are ~~installed across corridors~~, a pair of opposite-swinging doors installed across a corridor and without a center mullion, ~~shall be installed having vision panels with fire protection-rated glazing materials in fire protection-rated frames, the area of which shall not exceed that tested.~~ The doors shall be close-fitting within operational tolerances and shall not have undercuts in excess of 1 inch, louvers or grilles. The doors shall have head and jamb stops, astragals or rabbets at meeting edges. Vision panels shall have fire-protection rated glazing materials in fire-protection-rated frames. The doors and shall be automatic-closing by smoke detection in accordance with Section

716.5.9.3 of the *International Building Code*. Where permitted by the door manufacturer's listing, positive-latching devices are not required.

4. In Group I-2 and ambulatory care facilities, where such doors are special purpose horizontal sliding, accordion, or folding door assemblies installed in accordance with Section 1008.1.4.3 and are automatic closing by smoke detection in accordance with Section 716.5.9.3 of the *International Building Code*.
45. Group I-3.
56. Openings between smoke zones with clear ceiling heights of 14 feet (4267 mm) or greater and bank-down capacity of greater than 20 minutes as determined by the design fire size.

Reason: IFC Section 909.5.2 (and IBC Section 909.5.2) addresses requirements for opening protection in smoke barriers, as does IBC Section 709.5. This proposal updates IFC Section 909.5.2 (and IBC Section 909.5.2). The changing language, in IFC Section 909.5, requires smoke barriers to comply with the IBC, thus this language provides greater consistency with pertinent IBC requirements.

Also, IBC Section 709.5 includes an exception for doors complying with 1008.1.4.3 of the IBC, and IBC Section 1008.1.4.3 was revised for the 2015 IBC. The proposed language in Exception 4 for special purpose horizontal sliding, accordion, or folding door assemblies is intended to reflect this.

Cost Impact: None

F208-13*

1030.2.1

Proponents: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care (john.williams@doh.wa.gov) and Carl Baldassarra, P.E., FSFPE, Chair, ICC Code Technology Committee (cbaldassarra@RJAGroup.com); John Woestman, Kellen Company, representing Builders Hardware Manufacturers Association (BHMA) (jwoestman@kellencompany.com)

Revise as follows:

1030.2.1 Security devices and egress locks. Security devices affecting *means of egress* shall be subject to approval of the *fire code official*. ~~Special Security devices and locking arrangements in the means of egress including, but not limited to access-controlled egress doors, security grills, locks and latches, and delayed egress locks that restrict, control, or delay egress shall be installed and maintained as required by this chapter.~~

Reason:

Williams/Baldassarra: Revisions approved in the 2012 ICC code development cycle for Chapter 10 of the 2015 IBC, and corresponding sections of Chapter 10 of the 2015 IFC, regarding "shall be permitted" locking systems should be coordinated in this section of the IFC.

The proposed modification deletes the "including, but not limited to" clause and clarifies that any security device or locking arrangement that restricts, controls, or delays egress is to be maintained as required by this chapter of the IFC.

The table below lists the expected titles of these extensively revised sections, and the code change proposals affecting these sections.

2012 IBC and 2012 IFC	2015 IBC and 2015 IFC	Code Change Proposals
1008.1.9.6 Special locking arrangements in Group I-2.	1008.1.9.6 Controlled egress doors in Group I-1 and I-2.	E66-12 AMPC E67-12 AM E69-12 AMPC
1008.1.9.7 Delayed egress locks.	1008.1.9.7 Delayed egress.	E70-12 AM E72-12 AM E74-12 AMPC
1008.1.9.8 Access-controlled egress doors.	1008.1.9.8 Sensor release of electrically locked egress doors.	E77-12 AS E78-12 AM E80-12 AS
1008.1.9.9 Electromagnetically locked egress doors.	1008.1.9.9 Electromagnetically locked egress doors.	E77-12 AS E81-12 AS E82-12 AM

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This proposal is being co-sponsored by the ICC Code Technology Committee. The ICC Board established the ICC Code Technology Committee (CTC) as the venue to discuss contemporary code issues in a committee setting which provides the necessary time and flexibility to allow for full participation and input by any interested party. The code issues are assigned to the CTC by the ICC Board as "areas of study". Information on the CTC, including: meeting agendas; minutes; reports; resource documents; presentations; and all other materials developed in conjunction with the CTC effort can be downloaded from the following website: <http://www.iccsafe.org/cs/CTC/Pages/default.aspx>. Since its inception in April/2005, the CTC has held twenty five meetings - all open to the public.

Woestman: Revisions approved in the 2012 ICC code development cycle for Chapter 10 of the 2015 IBC, and corresponding sections of Chapter 10 of the 2015 IFC, regarding "shall be permitted" locking systems should be coordinated in this section of the IFC.

The proposed modification deletes the "including, but not limited to" clause and clarifies that any security device or locking arrangement that restricts, controls, or delays egress is to be maintained as required by this chapter of the IFC.

The table below lists the expected titles of these extensively revised sections, and the code change proposals affecting these sections.

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1008.1.9.6 Special locking arrangements in Group I-2.	1008.1.9.6 Controlled egress doors in Group I-1 and I-2.	E66-12 AMPC E67-12 AM E69-12 AMPC
1008.1.9.7 Delayed egress locks.	1008.1.9.7 Delayed egress.	E70-12 AM E72-12 AM E74-12 AMPC
1008.1.9.8 Access-controlled egress doors.	1008.1.9.8 Sensor release of electrically locked egress doors.	E77-12 AS E78-12 AM E80-12 AS
1008.1.9.9 Electromagnetically locked egress doors.	1008.1.9.9 Electromagnetically locked egress doors.	E77-12 AS E81-12 AS E82-12 AM

Cost Impact: None

F209-13*

1030.3.1 (New)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care (john.williams@doh.wa.gov) and Carl Baldassarra, P.E., FSFPE, Chair, ICC Code Technology Committee (cbaldassarra@RJAGroup.com)

Add new text as follows:

1030.3.1 Group I-2. In Group I-2, the required clear width for aisles, corridors and ramps that are part of the required means of egress shall comply with Section 1018.2. The facility shall have a plan to maintain the required clear width during emergency situations.

Exception: In areas required for bed movement, equipment shall be permitted in the required width where all the following provisions are met:

1. The equipment is low hazard and wheeled.
2. The equipment does not reduce the effective clear width for the means of egress to less than 5 feet (1525 mm).
3. The equipment is limited to:

- 3.1 Equipment and carts in use;
- 3.2 Medical emergency equipment;
- 3.3 Infection control carts; and
- 3.4 Patient lift and transportation equipment.
- 4. Medical emergency equipment and patient lift and transportation equipment, when not in use, is required to be located on one side of the corridor.
- 5. The equipment is limited in number to a maximum of one per patient sleeping room or patient care room within each smoke compartment.

Reason: The new language in Section 1030.3.1 is to be placed in the International Fire Code as a procedural requirement. It is recognized that the 8'-0" wide corridor in an Group I-2 occupancy where beds are moved is to remain at 8'-0" in width. The language recognizes and identifies the fact that certain movable pieces of equipment will be present in the corridor during normal operations of the patient care units and seeks to restrict the types and number of such pieces of equipment and the restrictions the equipment may impose on the means of egress.

The language also recognizes that during emergencies facilities must have an emergency management plan that address the steps that must be taken by the facility and responding staff to ensure that the required 8'-0" wide corridor is kept clear of movable obstructions.

The terminology is consistent with NFPA 101.

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Cost Impact: None

F212-13*

1103.1, 1104.1; IEBC 804.2.2.2 (NEW)

THIS IS A 2 PART CODE CHANGE. PART I WILL BE HEARD BY THE IFC CODE DEVELOPMENT COMMITTEE AND PART II WILL BE HEARD BY THE IEBC CODE DEVELOPMENT COMMITTEE AS SEPARATE CODE CHANGES. SEE THE TENTATIVE HEARING ORDER FOR THESE COMMITTEES.

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care
(john.williams@doh.wa.gov)

PART I – INTERNATIONAL FIRE CODE

Revise as follows:

SECTION 1103 FIRE SAFETY REQUIREMENTS FOR EXISTING BUILDING

1103.1 Required construction. Existing buildings shall comply with not less than the minimum provisions specified in Table 1103.1 and as further enumerated in Sections 1103.2 through 1103.9.

The provisions of this chapter shall not be construed to allow the elimination of fire protection systems or a reduction in the level of fire safety provided in buildings constructed in accordance with previously adopted codes.

Exceptions:

1. Where approved in accordance with Section 102.4, in Group I-2 Condition 2 buildings where an automatic sprinkler system installed in accordance with Section 903.3.1.1 has been added and the building is now sprinklered throughout, the existing fire resistance ratings, opening protectives, penetrations and joints in assemblies are not required to be maintained where such fire resistance ratings, opening protectives, penetrations and joints are not required in new construction for sprinklered buildings.
2. Group U occupancies.

**SECTION 1104
MEANS OF EGRESS FOR EXISTING BUILDINGS**

1104.1 General. *Means of egress* in existing buildings shall comply with the minimum egress requirements when specified in Table 1103.1 as further enumerated in Sections 1104.2 through 1104.23, and the building code that applied at the time of construction. Where the provisions of this chapter conflict with the building code that applied at the time of construction, the most restrictive provision shall apply. Existing buildings that were not required to comply with a building code at the time of construction shall comply with the minimum egress requirements when specified in Table 1103.1 as further enumerated in Sections 1104.2 through 1104.24.

Exception: Where approved in accordance with Section 102.4, in Group I-2 Condition 2 buildings where an automatic sprinkler system installed in accordance with Section 903.3.1.1 has been added and the building is now sprinklered throughout, the existing fire resistance ratings, opening protectives, penetrations and joints in assemblies are not required to be maintained where such fire resistance ratings, opening protectives, penetrations and joints are not required in new construction for sprinklered buildings.

PART II – INTERNATIONAL EXISTING BUILDING CODE

Add new text as follows:

804.2.2.2 Group I-2. Where approved, in Group I-2 Condition 2 buildings where an automatic sprinkler system installed in accordance with Section 903.3.1.1 of the *International Building Code* has been added and the building is now equipped throughout with an automatic sprinkler system, the existing fire resistance ratings, opening protectives, penetrations and joints in assemblies are not required to be maintained where such fire resistance ratings, opening protectives, penetrations and joints are not required in new construction for buildings equipped throughout with an automatic sprinkler system.

Reason: The changes provide tradeoffs for installation of automatic sprinkler systems consistent with those allowed for new construction and also with those allowed by CMS. In many editions of the legacy codes and the ICC Codes dating from the 1980s and even before, the same or similar tradeoffs were allowed when a facility elected to provide sprinkler protection. The Ad Hoc Committee on Health Care is proposing requiring retrofit of sprinklers in Hospitals that we feel provide the best protection available and feel because of this the tradeoffs are justified in existing facilities as has been vetted and justified in new construction for many years. These requirements are part of a package of retrofit requirements that provide a minimum level of safety considered necessary for patients, staff and first responders in an environment in which patients are in many instances not capable of self preservation and must be protected in place. Automatic sprinkler protection is key to any plan for protecting residents in place and for the safety of those responding to emergencies by providing the extra time needed to respond. The requirements are also consistent with current CMS standards that apply to all hospitals nationwide receiving Medicare/Medicaid funding and would not add additional requirements to those facilities beyond current nationwide Federal requirements but would allow the facilities to better meet those requirements without possible costly conflicts in other codes.

If this proposal is successful and the proposal for a new Section 1105 is also approved, the Adhoc Health Care committee will bring forward a corresponding exception to be applicable for the new Section 1105.1 as follows:

**SECTION 1105
CONSTRUCTION REQUIREMENTS FOR EXISTING GROUP I-2**

1105.1 General. Existing Group I-2 shall meet the following requirements:

1. The minimum fire safety requirements in Section 1103, and
2. The minimum egress requirements in Section 1104, and
3. The additional egress and construction requirements in Sections 1105.2 through 1105.7.5.2.

Where the provisions of this chapter conflict with the construction requirements that applied at the time of construction, the most restrictive provision shall apply.

Exception: Where approved in accordance with Section 102.4, in Group I-2 Condition 2 buildings where a sprinkler system installed in accordance with Section 903.3.1.1 has been added and the building is now sprinklered throughout, the existing fire resistance ratings, opening protectives, penetrations and joints in assemblies are not required to be maintained where such fire resistance ratings, opening protective, penetrations and joints are not required in new construction for sprinklered buildings.

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 8 open meetings and over 150 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>.

Cost Impact: None

F233-13*
1104.7

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care
(john.williams@doh.wa.gov)

Revise as follows:

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 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 openings 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.*
7. Door closers and door stops shall be permitted to be 78 inches (1980 mm) minimum above the door.

Reason: Most of this proposal is an editorial coordination with IBC Section 1008.1.1. The addition of the 32" inch clear width for Ambulatory Care Facilities is based on the nature of the activities within the space. This will also coordinate with the federal requirements for accessibility in the 1994 ADAAG and 2010 ADA Standard for Accessible Design for these necessary facilities.

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>.

Cost Impact: None

F237-13*

1105 (New), 1105.1 (New), 1105.7 (New), 1105.8 (New); Table 1103.1; 1103.5.2, 1103.7.3

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care (john.williams@doh.wa.gov) and Carl Baldassarra, P.E., FSFPE, Chair, ICC Code Technology Committee (cbaldassarra@RJAGroup.com)

Add new text as follows:

SECTION 1105 **CONSTRUCTION REQUIREMENTS FOR EXISTING GROUP I-2**

IFC 1105.1 General. Existing Group I-2 shall meet the following requirements:

1. The minimum fire safety requirements in Section 1103, and
2. The minimum mean of egress requirements in Section 1104, and
3. The additional egress and construction requirements in Sections 1105.

Where the provisions of this chapter conflict with the construction requirements that applied at the time of construction, the most restrictive provision shall apply.

1105.7 Group I-2 automatic sprinkler system. An automatic sprinkler system installed in accordance with Section 903.3.1 shall be provided throughout existing Group I-2 fire areas. The sprinkler system shall be provided throughout the floor where the Group I-2 occupancy is located, and in all floors between the Group I-2 occupancy and the level of exit discharge.

1105.8 Group I-2 automatic fire alarm system. An automatic fire alarm system shall be installed in existing Group I-2 occupancies in accordance with Section 907.2.6.2.

Exception: Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses' control stations or other constantly attended staff locations, provided such stations are visible and continuously accessible and that travel distances required in Section 907.5.2.1 are not exceeded.

Revise as follows:

**TABLE 1103.1
OCCUPANCY AND USE REQUIREMENTS^a**

Section	Use			Occupancy Classification																		
	High rise	Atrium or covered mall	Under-ground building	A	B	E	F	H-1	H-2	H-3	H-4	H-5	I-1	I-2	I-3	I-4	M	R-1	R-2	R-3	R-4	S
1104	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
<u>1105</u>	=	=	=	=	=	=	=	=	=	=	=	=	=	<u>R</u>	=	=	=	=	=	=	=	=

(Portions of table not shown remain unchanged)

R = The building is required to comply.

a. Existing buildings shall comply with the sections identified as "Required" (R) based on occupancy classification or use, or both, whichever is applicable.

1103.5.2 Group I-2. ~~An automatic sprinkler system shall be provided throughout existing Group I-2 fire areas. The sprinkler system shall be provided throughout the floor where the Group I-2 occupancy is located, and in all floors between the Group I-2 occupancy and the level of exit discharge. In Group I-2, an automatic sprinkler system shall be provided in accordance with Section 1105.7.~~

1103.7.3 Group I-2. ~~An automatic fire alarm system shall be installed in existing Group I-2 occupancies in accordance with Section 907.2.6.2. In Group I-2, an automatic fire alarm system shall be installed in accordance with Section 1105.8.~~

Exception: ~~Manual fire alarm boxes in resident or patient sleeping areas shall not be required at exits if located at all nurses' control stations or other constantly attended staff locations, provided such stations are visible and continuously accessible and that travel distances required in Section 907.5.2.1 are not exceeded.~~

Reason: This change adds minimum requirements for existing Group I-2 into Chapter 11. The intent is to increase the bare minimum safety requirements due to the fragile and sensitive populations within these facilities. These requirements are meant to be applied retroactively. This is not a new concept for these facilities – it aligns with the current approach by the Center for Medicaid and Medicare Services (CMS), the federal authority having jurisdiction. Hospitals are now required by CMS to have a life safety survey on a regular basis. If the facility does not meet certain life safety minimums, they are required to upgrade their existing facility. This code change will align the Fire Code with those CMS minimum requirements and will hopefully lead to industry consolidation. These retroactive requirements are added to assist code officials and surveyors during the ongoing regular inspection of hospital facilities and are consistent with the inspections required by federal laws for certification and reimbursement. The requirements consider the minimum previously approved construction methods. These requirements will provide jurisdictions the ability to adopt minimum retroactive provisions that have been vetted by the industry as well as code officials and that are consistent with current national standards used by the Federal Government providing a more uniform level of safety and eliminating many of the current code conflicts for existing facilities.

We looked at several sources to determine what the appropriate minimum bar should be, including the current building and fire code, current CMS guidelines, and previous versions of the ICC and model codes. On all issues, enforcement agencies and the regulated facilities weighed in to ensure that these changes are both necessary and achievable.

The intent of this proposal is to create a new Section 1105, to have a section for Group I-2 specific and unique requirements. Section 1105.1 General, provides a general scoping for this section. Areas in the hospital and nursing homes not in patient care areas will use the general provisions in Section 1103 and 1104. Where there are more restrictive provisions for hospitals or nursing homes, they will be listed in Section 1105.

Current provisions that were relocated to this section (1105.7 – automatic sprinkler system; 1105.8 – automatic fire alarm system) will remain applicable to all Group I-2. Section 1105.7, sprinkler requirements is relocated from 1103.5.2. Section 1105.8, automatic fire alarm system is relocated from 1103.7.3.

There is a package of proposal that are intended to be incorporated into this section. Below is how a new Section 1105 will look if all the proposals are accepted.

**IFC SECTION 1105
CONSTRUCTION REQUIREMENTS FOR EXISTING GROUP I-2**

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March 21-22, 2013

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IFC 1105.1 General. Existing Group I-2 shall meet the following requirements:

1. The minimum fire safety requirements in Section 1103, and
2. The minimum mean of egress requirements in Section 1104, and
3. The additional egress and construction requirements in Sections 1105.

Where the provisions of this chapter conflict with the construction requirements that applied at the time of construction, the most restrictive provision shall apply.

1105.2 Construction. Group I-2 Condition 2 shall not be located on a floor level higher than the floor level limitation in Table 1105.2 based on the type of construction.

**Table 1105.2
FLOOR LEVEL LIMITATIONS FOR GROUP I-2 Condition 2**

Construction Type	Automatic Sprinkler System	Allowable Floor Level ^a			
		1	2	3	4 or more
IA	Note b	P	P	P	P
	Note c	P	P	P	P
IB	Note b	P	P	P	P
	Note c	P	P	P	P
IIA	Note b	P	P	P	NP
	Note c	P	NP	NP	NP
IIB	Note b	P	P	NP	NP
	Note c	NP	NP	NP	NP
IIIA	Note b	P	P	NP	NP
	Note c	P	NP	NP	NP
IIIB	Note b	P	NP	NP	NP
	Note c	NP	NP	NP	NP
IV	Note b	P	P	NP	NP
	Note c	NP	NP	NP	NP
VA	Note b	P	P	NP	NP
	Note c	NP	NP	NP	NP
VB	Note b	P	NP	NP	NP
	Note c	NP	NP	NP	NP

P = Permitted; NP = Not Permitted

- a. Floors level shall be counted based on the number of stories above grade.
- b. The building is equipped throughout with an automatic sprinkler system in accordance with Section 903.3.1.1.
- c. The building is equipped with an automatic sprinkler system in accordance with Section 1105.7.

1105.3 Corridor construction. In Group I-2, in areas housing patient sleeping or care rooms, corridor walls and the opening protectives therein shall provide a barrier designed to resist the passage of smoke in accordance with Sections 1105.3.1 through 1105.3.7.

1105.3.1 Materials. The walls shall be of materials permitted by the building type of construction.

1105.3.2 Fire-resistance rating. Unless required elsewhere in the code, corridor walls are not required to have a fire-resistance rating.

1105.3.3 Corridor Walls Continuity. Corridor walls shall extend from the top of the foundation or floor below to one of the following:

1. The underside of the floor or roof sheathing, deck or slab above.
2. The underside of a ceiling above where the ceiling membrane is constructed to limit the passage of smoke.
3. The underside of a lay-in ceiling system where the ceiling tiles weigh at least one pound per square foot of tile.

1105.3.4 Openings in corridor walls. Openings in corridor walls shall provide protection in accordance with 1105.3.4.1 through 1105.3.4.3.

1105.3.4.1 Windows. Windows in corridor walls shall be sealed to limit the passage of smoke, or the window shall be automatic closing upon detection of smoke, or the window opening shall be protected by an automatic closing device that closes upon detection of smoke.

Exception: In smoke compartments not containing patient sleeping rooms, pass-through windows or similar openings shall be permitted in accordance with Section 1105.3.4.3.

1105.3.4.2 Doors. Doors in corridor walls shall comply with Sections 1105.3.4.2.1 through 1105.3.4.2.3.

1105.3.4.2.1 Louvers. Doors in corridor walls shall not include louvers, transfer grills or similar openings.

Exception: Doors shall be permitted to have louvers, transfer grills or similar openings at toilet rooms or bathrooms; storage rooms that do not contain storage of flammable or combustible material; and storage rooms that are not required to be separated as incidental uses.

1105.3.4.2.2 Corridor doors. Doors in corridor walls shall limit the transfer of smoke by complying with the following:

1. Doors shall be constructed of not less than 1-3/4 inch (44 mm) thick solid bonded core wood or capable of resisting fire for a minimum of 1/3 hours.

Exception: Corridor doors in buildings equipped throughout with an automatic sprinkler system.

2. Frames for side hinged swinging doors shall have stops on the sides and top to limit transfer of smoke.
3. Where provided, vision panels in doors shall be a fixed glass window assembly installed to limit the passage of smoke. Existing wired glass panels with steel frames shall be permitted to remain in place.
4. Doors undercuts shall not exceed 1 inch (25 mm).
5. Doors shall be positive latching with devices that resist not less than 5 pounds (22.2 N). Roller latches are prohibited.
6. Mail slots or similar openings shall be permitted in accordance with Section 1105.3.4.3.

1105.3.4.2.3 Dutch doors. Where provided, dutch doors shall comply with Section 1105.3.4.2.2. In addition, dutch doors shall be equipped with latching devices on either the top or bottom leaf to allow leaves to latch together. The space between the leaves shall be protected with devices such as astragals to limit the passage of smoke.

1105.3.4.2.4 Self- or automatic-closing doors. Where self- or automatic-closing doors are required, closers shall be maintained in operational condition.

1105.3.4.3 Openings in corridor walls and doors. Mail slots, pass through windows or similar openings shall not be required to be protected where the aggregate area of the openings between the corridor and a room are not greater than 80 square inches (51 613 mm²) and are located with the top edge of any opening no higher than 48 inches above the floor.

1105.3.5 Penetrations. The space around penetrating items shall be filled with an *approved* material to limit the passage of smoke.

1105.3.6 Joints. Joints shall be filled with an *approved* material to limit the passage of smoke.

1105.3.7 Ducts and air transfer openings. The space around a duct penetrating a smoke partition shall be filled with an *approved* material to limit the passage of smoke. Air transfer openings in smoke partitions shall be provided with a *smoke damper* complying with Section 717.3.2.2 of the International Building Code.

Exception: Where the installation of a *smoke damper* will interfere with the operation of a required smoke control system in accordance with Section 909, *approved* alternative protection shall be utilized.

1105.4 Means of egress. In addition to the means of egress requirements in Section 1104, Group I-2 facilities shall meet the means of egress requirements in Section 1105.4.1 through 1105.4.7.

1105.4.1 Exit signs and emergency illumination. The power system for exit signs and emergency illumination for the means of egress shall provide power for not less than 90 minutes and consist of storage batteries, unit equipment or an on-site generator.

1105.4.2 Emergency power for operational needs. The essential electrical system shall be capable of supplying services in accordance with NFPA 99.

1105.4.3 Size of Door. Means of egress doors used for the movement of patients in beds shall provide a minimum clear width of 41.5 inches (1054 mm). The height of door opening shall not be less than 80 inches (2032 mm).

Exception: Door closers and door stops shall be permitted to be 78 inches minimum above the floor.

1105.4.4 Ramps. In areas where ramps are used for movement of patients in beds, the clear width of the ramp shall not be less than 48 inches (1219 mm).

1105.4.5 Corridor width. In areas where corridors are used for movement of patients in beds, the clear width of the corridor shall not be less than 48 inches (1219 mm).

1105.4.6 Dead end corridors. In smoke compartments containing patient sleeping rooms and treatment rooms, dead end corridors shall not exceed 30 feet unless approved by the fire official.

1105.4.7 Aisles. In areas where aisles are used for movement of patients in beds, the clear width of the aisle shall not be less than 48 inches (1219 mm).

1105.5 Smoke compartments. Smoke compartments shall be provided in existing Group I-2 Condition 2, in accordance with Sections 1105.5.1 through 1105.5.4.

1105.5.1 Design. Smoke barriers shall be provided to subdivide each story used for patients sleeping with an occupant load of more than 30 patients into no fewer than two smoke compartments.

1105.5.1.1 Refuge areas. 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 stretcher.
2. Not less than 15 square feet (1.4 m²) for each resident in a Group I-2 using mobility assistance devices.
3. Not less than 6 square feet (0.56 m²) for each occupant not addressed in Items 1 and 2.

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

1105.5.2 Smoke barriers. Smoke barriers shall be constructed in accordance with Section 709 of the *International Building Code*.

Exceptions:

1. Existing smoke barriers with a minimum of 1/2 –hour fire-resistance rating are permitted to remain.
2. Smoke barriers shall be permitted to terminate at an atrium enclosure in accordance with Section 404.6 of the *International Building Code*.

1105.5.3 Opening protectives. Openings in smoke barriers shall be protected in accordance with Section 716 of the *International Building Code*. Opening protectives shall have a with a minimum fire-protection-rating of 1/3 hours.

Exception: Wired glass vision panels in doors shall be permitted to remain.

1105.5.4 Duct and air transfer openings. Penetrations in a smoke barrier by duct and air transfer openings shall comply with Section 717 of the *International Building Code*.

Exception: Where existing duct and air transfer openings in smoke barriers exist without smoke dampers, they shall be permitted to remain. Any changes to existing smoke dampers shall be submitted for review and approved in accordance with IBC Section 717 of the *International Building Code*.

1105.6 Group I-2 care suites. Care suites in existing Group I-2 Condition 2 occupancies shall comply with Section 407.4.3 through 407.4.3.6.2 of the *International Building Code*.

1105.7 Group I-2 automatic sprinkler system. An automatic sprinkler system installed in accordance with Section 903.3.1 shall be provided throughout existing Group I-2 fire areas. The sprinkler system shall be provided throughout the floor where the Group I-2 occupancy is located, and in all floors between the Group I-2 occupancy and the level of exit discharge.

1105.8 Group I-2 automatic fire alarm system. An automatic fire alarm system shall be installed in existing Group I-2 occupancies in accordance with Section 907.2.6.2.

Exception: Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses' control stations or other constantly attended staff locations, provided such stations are visible and continuously accessible and that travel distances required in Section 907.5.2.1 are not exceeded.

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 8 open meetings and over 150 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 is being co-sponsored by the ICC Code Technology Committee. The ICC Board established the ICC Code Technology Committee (CTC) as the venue to discuss contemporary code issues in a committee setting which provides the necessary time and flexibility to allow for full participation and input by any interested party. The code issues are assigned to the CTC by the ICC Board as "areas of study". Information on the CTC, including: meeting agendas; minutes; reports; resource documents; presentations; and all other materials developed in conjunction with the CTC effort can be downloaded from the following website: <http://www.iccsafe.org/cs/CTC/Pages/default.aspx>. Since its inception in April/2005, the CTC has held twenty five meetings - all open to the public.

Cost Impact: None

F238-13*

1105.2 (New), Table 1105.2 (New)

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

Add new text as follows:

SECTION 1105 **CONSTRUCTION REQUIREMENTS FOR EXISTING GROUP I-2**

1105.2 Construction. Group I-2 Condition 2 shall not be located on a floor level higher than the floor level limitation in Table 1105.2 based on the type of construction.

Table 1105.2
FLOOR LEVEL LIMITATIONS FOR GROUP I-2 Condition 2

<u>Construction Type</u>	<u>Automatic Sprinkler System</u>	<u>Allowable Floor Level^a</u>			
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4 or more</u>
<u>IA</u>	<u>Note b</u>	<u>P</u>	<u>P</u>	<u>P</u>	<u>P</u>
	<u>Note c</u>	<u>P</u>	<u>P</u>	<u>P</u>	<u>P</u>
<u>IB</u>	<u>Note b</u>	<u>P</u>	<u>P</u>	<u>P</u>	<u>P</u>
	<u>Note c</u>	<u>P</u>	<u>P</u>	<u>P</u>	<u>P</u>
<u>IIA</u>	<u>Note b</u>	<u>P</u>	<u>P</u>	<u>P</u>	<u>NP</u>
	<u>Note c</u>	<u>P</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>
<u>IIB</u>	<u>Note b</u>	<u>P</u>	<u>P</u>	<u>NP</u>	<u>NP</u>
	<u>Note c</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>
<u>IIIA</u>	<u>Note b</u>	<u>P</u>	<u>P</u>	<u>NP</u>	<u>NP</u>

	<u>Note c</u>	<u>P</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>
<u>IIIB</u>	<u>Note b</u>	<u>P</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>
	<u>Note c</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>
<u>IV</u>	<u>Note b</u>	<u>P</u>	<u>P</u>	<u>NP</u>	<u>NP</u>
	<u>Note c</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>
<u>VA</u>	<u>Note b</u>	<u>P</u>	<u>P</u>	<u>NP</u>	<u>NP</u>
	<u>Note c</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>
<u>VB</u>	<u>Note b</u>	<u>P</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>
	<u>Note c</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>	<u>NP</u>

P = Permitted; NP = Not Permitted

a. Floors level shall be counted based on the number of stories above grade.

b. The building is equipped throughout with an automatic sprinkler system in accordance with Section 903.3.1.1.

c. The building is equipped with an automatic sprinkler system in accordance with Section 1105.7.

Reason: This change adds minimum requirements for existing hospitals (Group I-2, Condition 2) into Chapter 11. The intent is to increase the bare minimum safety requirements due to the fragile and sensitive populations within these facilities. These requirements are meant to be applied retroactively. This is not a new concept for these facilities – it aligns with the current approach by the Center for Medicaid and Medicare Services (CMS), the federal authority having jurisdiction. Hospitals are now required by CMS to have a life safety survey on a regular basis. If the facility does not meet certain life safety minimums, they are required to upgrade their existing facility. This code change will align the Fire Code with those CMS minimum requirements and will hopefully lead to industry consolidation. These retroactive requirements are added to assist code officials and surveyors during the ongoing regular inspection of hospital facilities and are consistent with the inspections required by federal laws for certification and reimbursement. The requirements consider the minimum previously approved construction methods. These requirements will provide jurisdictions the ability to adopt minimum retroactive provisions that have been vetted by the industry as well as code officials and that are consistent with current national standards used by the Federal Government providing a more uniform level of safety and eliminating many of the current code conflicts for existing facilities.

We looked at several sources to determine what the appropriate minimum bar should be, including the current building and fire code, current CMS guidelines, and previous versions of the ICC and model codes. On all issues, enforcement agencies and the regulated facilities weighed in to ensure that these changes are both necessary and achievable.

These provisions are written specifically for hospitals (Group I-2, Condition 2). These 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.

The revision to Section 1105.2 is proposed this retroactive limitation requirement for the allowable height based upon construction type because it is a key component of the regulatory approval for a health care facility, and 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 most if not all existing hospitals were constructed to comply with these minimum construction requirements, many were constructed using methods that pre-dated the current construction type matrix, and 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.

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 8 open meetings and over 150 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>.

Cost Impact: None

F239–13*

1105.3 (New); 202 (New)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care (john.williams@doh.wa.gov) and Carl Baldassarra, P.E., FSFPE, Chair, ICC Code Technology Committee (cbaldassarra@RJAGroup.com)

Add new text as follows:

IFC SECTION 1105
CONSTRUCTION REQUIREMENTS FOR EXISTING GROUP I-2

1105.3 Corridor construction. In Group I-2, in areas housing patient sleeping or care rooms, corridor walls and the opening protectives therein shall provide a barrier designed to resist the passage of smoke in accordance with Sections 1105.3.1 through 1105.3.7.

1105.3.1 Materials. The walls shall be of materials permitted by the building type of construction.

1105.3.2 Fire-resistance rating. Unless required elsewhere in the code, corridor walls are not required to have a fire-resistance rating.

1105.3.3 Corridor Walls Continuity. Corridor walls shall extend from the top of the foundation or floor below to one of the following:

1. The underside of the floor or roof sheathing, deck or slab above.
2. The underside of a ceiling above where the ceiling membrane is constructed to limit the passage of smoke.
3. The underside of a lay-in ceiling system where the ceiling tiles weigh at least one pound per square foot of tile.

1105.3.4 Openings in corridor walls. Openings in corridor walls shall provide protection in accordance with 1105.3.4.1 through 1105.3.4.3.

1105.3.4.1 Windows. Windows in corridor walls shall be sealed to limit the passage of smoke, or the window shall be automatic closing upon detection of smoke, or the window opening shall be protected by an automatic closing device that closes upon detection of smoke.

Exception: In smoke compartments not containing patient sleeping rooms, pass-through windows or similar openings shall be permitted in accordance with Section 1105.3.4.3.

1105.3.4.2 Doors. Doors in corridor walls shall comply with Sections 1105.3.4.2.1 through 1105.3.4.2.3.

1105.3.4.2.1 Louvers. Doors in corridor walls shall not include louvers, transfer grills or similar openings. **Exception:** Doors shall be permitted to have louvers, transfer grills or similar openings at toilet rooms or bathrooms; storage rooms that do not contain storage of flammable or combustible material; and storage rooms that are not required to be separated as incidental uses.

1105.3.4.2.2 Corridor doors. Doors in corridor walls shall limit the transfer of smoke by complying with the following:

1. Doors shall be constructed of not less than 1-3/4 inch (44 mm) thick solid bonded core wood or capable of resisting fire for a minimum of 1/3 hours.

Exception: Corridor doors in buildings equipped throughout with an automatic sprinkler system.

2. Frames for side hinged swinging doors shall have stops on the sides and top to limit transfer of smoke.

3. Where provided, vision panels in doors shall be a fixed glass window assembly installed to limit the passage of smoke. Existing wired glass panels with steel frames shall be permitted to remain in place.
4. Doors undercuts shall not exceed 1 inch (25 mm).
5. Doors shall be positive latching with devices that resist not less than 5 pounds (22.2 N). Roller latches are prohibited.
6. Mail slots or similar openings shall be permitted in accordance with Section 1105.3.4.3.

1105.3.4.2.3 Dutch doors. Where provided, dutch doors shall comply with Section 1105.3.4.2.2. In addition, dutch doors shall be equipped with latching devices on either the top or bottom leaf to allow leaves to latch together. The space between the leaves shall be protected with devices such as astragals to limit the passage of smoke.

1105.3.4.2.4 Self- or automatic-closing doors. Where self- or automatic-closing doors are required, closers shall be maintained in operational condition.

1105.3.4.3 Openings in corridor walls and doors. Mail slots, pass through windows or similar openings shall not be required to be protected where the aggregate area of the openings between the corridor and a room are not greater than 80 square inches (51 613 mm²) and are located with the top edge of any opening no higher than 48 inches above the floor.

1105.3.5 Penetrations. The space around penetrating items shall be filled with an *approved* material to limit the passage of smoke.

1105.3.6 Joints. Joints shall be filled with an *approved* material to limit the passage of smoke.

1105.3.7 Ducts and air transfer openings. The space around a duct penetrating a smoke partition shall be filled with an *approved* material to limit the passage of smoke. Air transfer openings in smoke partitions shall be provided with a *smoke damper* complying with Section 717.3.2.2 of the International Building Code.

Exception: Where the installation of a *smoke damper* will interfere with the operation of a required smoke control system in accordance with Section 909, *approved* alternative protection shall be utilized.

1104.17 Corridors construction. Corridors serving an occupant load greater than 30 and the openings therein shall provide an effective barrier to resist the movement of smoke. Transoms, louvers, doors and other openings shall be kept closed or *be* self closing. In Group I-2, corridors in areas housing patient sleeping or care rooms shall comply with Section 1105.3.

Exceptions:

1. Corridors in occupancies other than in Group H and I-2, which are equipped throughout with an approved automatic sprinkler system.
2. ~~Patient room doors in corridors in occupancies in Group I-2 where smoke barriers are provided in accordance with the International Building Code.~~
32. Corridors in occupancies in Group E where each room utilized for instruction or assembly has at least one-half of the required means of egress doors opening directly to the exterior of the building at ground level.
43. Corridors that are in accordance with the *International Building Code*.

SECTION 202
GENERAL DEFINITIONS

Dutch door. A door divided horizontally so that the top can be operated independently from the bottom.

Reason: This change adds minimum requirements for existing Group I-2 into Chapter 11 by adding specific retrofit requirements. This change will move the existing retrofit requirements for corridors in I-2 occupancies to proposed new section 1105.3 and add more detailed specific requirements. The intent is to increase the bare minimum safety requirements due to the fragile and sensitive populations within these facilities. These requirements are meant to be applied retroactively. This is not a new concept for these facilities as it aligns with the current approach by the Center for Medicaid and Medicare Services (CMS), the federal authority having jurisdiction. Hospitals are now required by CMS to have a life safety survey on a regular basis. If the facility does not meet certain life safety minimums, they are required to upgrade their existing facility. These retroactive requirements are added to assist code officials and surveyors during the ongoing regular inspection of hospital facilities and are consistent with the inspections required by federal laws for certification and reimbursement. The requirements consider the minimum previously approved construction methods. These requirements will provide jurisdictions the ability to adopt minimum retroactive provisions that provide a more uniform level of safety and eliminate many of the current code conflicts for existing facilities.

We looked at several sources to determine what the appropriate minimum bar should be, including the current building and fire code, current CMS guidelines, and previous versions of the ICC and model codes. On all issues, enforcement agencies and the regulated facilities weighed in to ensure that these changes are both necessary and achievable.

These provisions are written specifically for hospitals (Group I-2, Condition 2). These are retrofit requirements that provide a minimum level of safety considered necessary for patients, staff and first responders in an environment in which patients are in many instances not capable of self preservation and must be protected in place. The changes also provide tradeoffs for automatic sprinkler systems consistent with those allowed for new construction and also with those allowed by CMS. In no way does this affect the existing requirement that existing, approved construction must be maintained in the manner that it was approved. It simply provides a tool for evaluating historical construction techniques.

Specific points include:

- Existing corridor construction should primarily be evaluated for its ability to resist or limit the transfer of smoke, regardless of the code at the time of construction. Corridor walls, even if they were built 60 years ago, should be regularly assessed confirm that they minimize the transfer of smoke. This section describes some criteria by which this can be assessed.
- The requirements clearly indicate that portions of corridor walls required to have a fire resistance ratings by other code provisions must meet those provisions. This addresses where a corridor wall also happens to be a smoke barrier, incidental use area separation, etc.
- The Ad Hoc Committee added a specific section on dutch doors. Dutch doors have been used in health care facilities for many years for various necessary operational reasons. While existing language in the IBC does not specifically speak of dutch doors, their use is not prohibited but if used must meet the requirements contained in Section 407.3 including positive latching and limiting the transfer of smoke. This change will provide clarity for existing installations by giving specific guidance on the minimum acceptable requirements including positive latching and smoke transfer for their use in corridor walls. A definition is provided for additional clarity.
- The Ad Hoc committee also proposes similar detail for doors, windows, louvers and other potential penetrations or openings in corridor walls in an attempt to add clarity to the intent of the code on limiting the transfer of smoke. These proposals are consistent with current CMS standards.
- There are exceptions that deal with existing mail slot, pass-through and similar openings that are commonly found in hospitals. These are needed for privacy, medication security and other operational needs. Our proposal places restrictions on these existing openings similar to the current federal requirements.

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 8 open meetings and over 150 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 is being co-sponsored by the ICC Code Technology Committee. The ICC Board established the ICC Code Technology Committee (CTC) as the venue to discuss contemporary code issues in a committee setting which provides the necessary time and flexibility to allow for full participation and input by any interested party. The code issues are assigned to the CTC by the ICC Board as "areas of study". Information on the CTC, including: meeting agendas; minutes; reports; resource documents; presentations; and all other materials developed in conjunction with the CTC effort can be downloaded from the following website: <http://www.iccsafe.org/cs/CTC/Pages/default.aspx>. Since its inception in April/2005, the CTC has held twenty five meetings - all open to the public.

Cost Impact: None

F240-13*

1105.4 (New), 1104.5.1, 1104.7, 1104.15, 1104.17.2, Table 1104.17.2, 1104.22

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care (john.williams@doh.wa.gov) and Carl Baldassarra, P.E., FSFPE, Chair, ICC Code Technology Committee (cbaldassarra@RJAGroup.com)

Revise as follows:

SECTION 1105
CONSTRUCTION REQUIREMENTS FOR EXISTING GROUP I-2

1105.4 Means of egress. In addition to the means of egress requirements in Section 1104, Group I-2 facilities shall meet the means of egress requirements in Section 1105.4.1 through 1105.4.7.

1105.4.1 Exit signs and emergency illumination. The power system for exit signs and emergency illumination for the means of egress shall provide power for not less than 90 minutes and consist of storage batteries, unit equipment or an on-site generator.

1105.4.2 Emergency power for operational needs. The essential electrical system shall be capable of supplying services in accordance with NFPA 99.

1105.4.3 Size of Door. Means of egress doors used for the movement of patients in beds shall provide a minimum clear width of 41.5 inches (1054 mm). The height of door opening shall not be less than 80 inches (2032 mm).

Exception: Door closers and door stops shall be permitted to be 78 inches minimum above the floor.

1105.4.4 Ramps. In areas where ramps are used for movement of patients in beds, the clear width of the ramp shall not be less than 48 inches (1219 mm).

1105.4.5 Corridor width. In areas where corridors are used for movement of patients in beds, the clear width of the corridor shall not be less than 48 inches (1219 mm).

1105.4.6 Dead end corridors. In smoke compartments containing patient sleeping rooms and treatment rooms, dead end corridors shall not exceed 30 feet unless approved by the fire official.

1105.4.7 Separation of exit access doors. Any patient sleeping room, or any suite that includes patient sleeping rooms, of more than 1,000 square feet shall have at least two exit access doors placed a distance apart equal to not less than one-third of the length of the maximum overall diagonal dimension of the patient sleeping room or suite to be served, measured in a straight line between exit access doors.

1105.4.8 Aisles. In areas where aisles are used for movement of patients in beds, the clear width of the aisle shall not be less than 48 inches (1219 mm).

1104.5.1 Emergency power duration and installation. In other than Group I-2, systems requiring the emergency power system shall provide power for not less than 60 minutes and consist of storage batteries, unit equipment or an on-site generator. In Group I-2, the emergency power essential electrical systems shall comply with Sections 1105.4.1 and 1105.4.2 provide power for not less than 90 minutes and consist of storage batteries, unit equipment or an on-site generator. The installation of the emergency power system shall be in accordance with Section 604.

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, doors serving as means of egress doors in an occupancy in Group I-2 and used for the movement of patients in beds shall comply with

Section 1105.4.3. 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 openings 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.
7. Door closers and door stops shall be permitted to be 78 inches (1980 mm) minimum above the door.

1104.15 Width of ramps. Existing Ramps are permitted to have a minimum width of 30 inches (762 mm) but not less than the width required for the number of occupants served as determined by Section 1005.1. In Group I-2, ramps serving as a means of egress and used for the movement of patients in beds shall comply with Section 1105.8.

~~1104.17.2~~ 1104.18 Dead ends end corridors. Where more than one exit or exit access doorway is required, the exit access shall be arranged such that dead ends do not exceed the limits specified in Table 1104.47-2 18. In Group I-2, in smoke compartments containing patient sleeping rooms and treatment rooms, dead end corridors shall be comply with Section 1105.7.

Exception: A dead-end passageway or corridor shall not be limited in length where the length of the dead end passageway or corridor is less than 2.5 times the least width of the dead-end passageway or corridor.

**TABLE 1104.17.2 1104.18
COMMON PATH, DEAD-END AND TRAVEL DISTANCE LIMITS (by occupancy)**

OCCUPANCY	COMMON PATH LIMIT		DEAD-END LIMIT		TRAVEL DISTANCE LIMIT	
	Unsprinklered (feet)	Sprinklered (feet)	Unsprinklered (feet)	Sprinklered (feet)	Unsprinklered (feet)	Sprinklered (feet)
Group I-1	75	75	20	50	200	250
Group I-2 (Health care)	NR ^e	NR ^e	NR-Note f	NR-Note f	150	200 ^c
Group I-3 (Detention and correctional — Use Conditions II, III, IV, V)	100	100	NR	NR	150 ^c	200 ^c
Group I-4 (Day Care Centers)	NR	NR	20	20	200	250

(Portions of table not shown remain unchanged)

NR = No requirements.

For SI: 1 foot = 304.8 mm, 1 square foot = 0.0929 m².

- a. 20 feet for common path serving 50 or more persons; 75 feet for common path serving less than 50 persons.
- b. See Section 1028.9.5 for dead-end aisles in Group A occupancies.
- c. This dimension is for the total travel distance, assuming incremental portions have fully utilized their allowable maximums. For travel distance within the room, and from the room exit access door to the exit, see the appropriate occupancy chapter.
- d. See the *International Building Code* for special requirements on spacing of doors in aircraft hangars.
- e. In Group I-2, separation of exit access doors within a Any patient sleeping room, or any suite that includes patient sleeping rooms, of more than 1,000 square feet shall have at least two exit access doors placed a distance apart equal to not less than one third of the length of the maximum overall diagonal dimension of the patient sleeping room or suite to be served, measured in a straight line between exit access doors shall comply with Section 1105.4.7.
- f. In Group I-2, in smoke compartments containing patient sleeping rooms and treatment rooms, dead end corridors shall comply with Section 1105.4.6.
- g.f. Where a tenant space in Group B, S and U occupancies has an occupant load of not more than 30, the length of a common path of egress travel shall not be more than 100 feet.

1104.22 Minimum aisle width. The minimum clear width of aisles shall be:

1. Forty-two inches (1067 mm) for aisle stairs having seating on each side.

Exception: Thirty-six inches (914 mm) where the aisle serves less than 50 seats.

2. Thirty-six inches (914 mm) for stepped aisles having seating on only one side.

Exception: Thirty inches (760 mm) for catchment areas serving not more than 60 seats.

3. Twenty inches (508 mm) between a stepped aisle handrail or guard and seating when the aisle is subdivided by the handrail.
4. Forty-two inches (1067 mm) for level or ramped aisles having seating on both sides.

Exception: Thirty-six inches (914 mm) where the aisle serves less than 50 seats.

5. Thirty-six inches (914 mm) for level or ramped aisles having seating on only one side.

Exception: Thirty inches (760 mm) for catchment areas serving not more than 60 seats.

6. Twenty-three inches (584 mm) between a stepped stair handrail and seating where an aisle does not serve more than five rows on one side.

7. In Group I-2, where aisles are used for movement of patients in beds aisles shall comply with 1105.4.8.

Reason: This change adds minimum requirements for existing Group I-2 into Chapter 11. The intent is to increase the bare minimum safety requirements due to the fragile and sensitive populations within these facilities. These requirements are meant to be applied retroactively. This is not a new concept for these facilities – it aligns with the current approach by the Center for Medicaid and Medicare Services (CMS), the federal authority having jurisdiction. Hospitals are now required by CMS to have a life safety survey on a regular basis. If the facility does not meet certain life safety minimums, they are required to upgrade their existing facility. This code change will align the Fire Code with those CMS minimum requirements and will hopefully lead to industry consolidation. These retroactive requirements are added to assist code officials and surveyors during the ongoing regular inspection of hospital facilities and are consistent with the inspections required by federal laws for certification and reimbursement. The requirements consider the minimum previously approved construction methods. These requirements will provide jurisdictions the ability to adopt minimum retroactive provisions that have been vetted by the industry as well as code officials and that are consistent with current national standards used by the Federal Government providing a more uniform level of safety and eliminating many of the current code conflicts for existing facilities.

We looked at several sources to determine what the appropriate minimum bar should be, including the current building and fire code, current CMS guidelines, and previous versions of the ICC and model codes. On all issues, enforcement agencies and the regulated facilities weighed in to ensure that these changes are both necessary and achievable.

These 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, and is designed to assist those that are already tasked with performing those inspections. It is not the intention to add responsibility to the fire official to perform additional inspections. Rather, it is the intention to better define the minimum previously approved construction methods as it relates to the healthcare building type, and are consistent with the federal requirements that these facilities are currently held too.

This newly proposed section has been formatted to consolidate requirements, and is mostly just a move of existing fire code provisions. Since the current provisions are applicable to all Group I-2, this section is written addressing all Group I-2 where applicable. Means of egress in areas where there are movement of patients in stretchers or beds has been reordered to be consistent with IFC 1104. It is noted that many areas of nursing homes do not include movement of patients in beds.

The following is a synopsis of the provisions listed above that have been relocated from other sections:

- 1105.4 Means of egress - Means of egress in areas where there are movement of patients in beds. The order is consistent with IFC 1104.
- 1105.4.1 Exit signs and emergency illumination – existing facilities can continue to use battery packs for exits signs and emergency lighting
- 1105.4.2 Emergency power for operational needs – extending section 1104.5.1 by adding requirements from and references to NFPA 99. Similar to IFC 604.3, requires the facility to analyze the hazards in their particular region and prepare accordingly.
- 1105.4.3 Size of door – Existing language that has been transferred from IFC 1104.7; follows format of IBC 1008.1.1.
- 1105.4.4 Ramps – References from IFC 1104.15 to the healthcare specific requirements.
- 1105.4.5 Corridor width – Follows current federal guidance for existing buildings.
- 1105.4.6 Dead end corridors – References from IFC 1104.15 to the healthcare specific requirements.
- 1105.4.7 Separation of exit access doors – Moved a healthcare specific requirement from footnote e in Table 1014.7.2 into Section 1105.
- 1105.4.8 Aisles – Provides a reference from IFC 1104.22 to more specific healthcare requirements.

Finally, in no way does this change affect the current requirement that existing, approved construction must be maintained in the manner that it was approved. The fire code clearly states that existing, approved safety feature must be maintained to the code at the time of construction. Most hospitals have been around for many decades and have several vintages of construction. This change simply provides a tool for evaluating historical conditions.

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 8 open meetings and over 150 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 is being co-sponsored by the ICC Code Technology Committee. The ICC Board established the ICC Code Technology Committee (CTC) as the venue to discuss contemporary code issues in a committee setting which provides the necessary time and flexibility to allow for full participation and input by any interested party. The code issues are assigned to the CTC by the ICC Board as “areas of study”. Information on the CTC, including: meeting agendas; minutes; reports; resource documents; presentations; and all other materials developed in conjunction with the CTC effort can be downloaded from the following website: <http://www.iccsafe.org/cs/CTC/Pages/default.aspx>. Since its inception in April/2005, the CTC has held twenty five meetings - all open to the public.

Cost Impact: None

F241–13*

1105.5 (New)

Proponent: John Williams, CBO, Chair, ICC Ad Hoc Committee on Health Care
(john.williams@doh.wa.gov)

Add new text as follows:

SECTION 1105

CONSTRUCTION REQUIREMENTS FOR EXISTING GROUP I-2

1105.5 Smoke compartments. Smoke compartments shall be provided in existing Group I-2 Condition 2, in accordance with Sections 1105.5.1 through 1105.5.4.

1105.5.1 Design. Smoke barriers shall be provided to subdivide each story used for patients sleeping with an occupant load of more than 30 patients into no fewer than two smoke compartments.

1105.5.1.1 Refuge areas. 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 stretcher.
2. Not less than 15 square feet (1.4 m²) for each resident in a Group I-2 using mobility assistance devices.
3. Not less than 6 square feet (0.56 m²) for each occupant not addressed in Items 1 and 2.

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

1105.5.2 Smoke barriers. Smoke barriers shall be constructed in accordance with Section 709 of the *International Building Code*.

Exceptions:

1. Existing smoke barriers with a minimum of 1/2 –hour fire-resistance rating are permitted to remain.
2. Smoke barriers shall be permitted to terminate at an atrium enclosure in accordance with Section 404.6 of the *International Building Code*.

1105.5.3 Opening protectives. Openings in smoke barriers shall be protected in accordance with Section 716 of the *International Building Code*. Opening protectives shall have a with a minimum fire-protection-rating of 1/3 hours.

Exception: Wired glass vision panels in doors shall be permitted to remain.

1105.5.4 Duct and air transfer openings. Penetrations in a smoke barrier by duct and air transfer openings shall comply with Section 717 of the *International Building Code*.

Exception: Where existing duct and air transfer openings in smoke barriers exist without smoke dampers, they shall be permitted to remain. Any changes to existing smoke dampers shall be submitted for review and approved in accordance with IBC Section 717 of the *International Building Code*.

Reason: This change adds minimum requirements for existing hospitals (Group I-2, Condition 2) into Chapter 11. The intent is to increase the bare minimum safety requirements due to the fragile and sensitive populations within these facilities. These requirements are meant to be applied retroactively. This is not a new concept for these facilities – it aligns with the current approach by the Center for Medicaid and Medicare Services (CMS), the federal authority having jurisdiction. Hospitals are now required by CMS to have a life safety survey on a regular basis. If the facility does not meet certain life safety minimums, they are required to upgrade their existing facility. This code change will align the Fire Code with those CMS minimum requirements and will hopefully lead to industry consolidation. These retroactive requirements are added to assist code officials and surveyors during the ongoing regular inspection of hospital facilities and are consistent with the inspections required by federal laws for certification and reimbursement. The requirements consider the minimum previously approved construction methods. These requirements will provide jurisdictions the ability to adopt minimum retroactive provisions that have been vetted by the industry as well as code officials and that are consistent with current national standards used by the Federal Government providing a more uniform level of safety and eliminating many of the current code conflicts for existing facilities.

We looked at several sources to determine what the appropriate minimum bar should be, including the current building and fire code, current CMS guidelines, and previous versions of the ICC and model codes. On all issues, enforcement agencies and the regulated facilities weighed in to ensure that these changes are both necessary and achievable.

This provision is written in regard to the design, construction and application of smoke compartments for Group I-2 hospital facilities. Smoke compartments are a key component of the defend in place strategy, a strategy where victims are protected from fire without relocation, used in healthcare facilities to limit the movement of smoke. These compartments act as safe locations for patients by preventing the spread of smoke. Through compartmentalization, patients may remain safely in their rooms as fire

suppression systems and fire responders extinguish the fire. Under severe fire conditions that threaten the immediate compartment area, patients may be evacuated horizontally to the safety of an adjacent compartment on the same floor. Being able to do this is critical since due to the health status of many patients their evacuation from the building might put them in grave danger. The proper design, construction and application of smoke compartments will provide added protection, buy valuable time and save lives of critically ill patients before a total evacuation may become necessary.

These 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 too. Specific concepts include:

- 1105.5 Smoke compartments – The defend-in-place concept is a basic minimum level of safety for these facilities. Every facility should be equipped at least two smoke compartments for temporary relocation of patients.
- 1105.5.1 Design - This section addresses existing acceptable configuration of smoke barrier walls and smoke barriers for existing hospitals in areas with sleeping rooms.
- 1105.5.1.1 Refuge area – Addresses adequate sizing of refuge areas. IBC 407.5.1 also includes requirements for independent egress and horizontal assemblies.
- 1105.5.2 Smoke barriers – The intent 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.
- 1105.5.3 Opening protectives - Address doors in smoke barriers in existing Group I-2 occupancies. Reference to 716 is so you that don't lose other requirements.
- 1105.5.4, Guides the inspector of existing facilities on how they would look at opening protectives. Smoke dampers have not always been required in hospitals, and the 2015 IBC would not require them. Therefore, in those hospitals that were originally approved without smoke dampers required, that condition is allowed to remain in place. Any modification of existing smoke dampers would have to go through the normal process for making an alteration to existing construction.

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 8 open meetings and over 150 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>.

Cost Impact: None

F242-13*

1105.6 (New), Table 1104.17.2

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

Revise as follows:

IFC SECTION 1105 **CONSTRUCTION REQUIREMENTS FOR EXISTING GROUP I-2**

1105.6 Group I-2 care suites. Care suites in existing Group I-2 Condition 2 occupancies shall comply with Section 407.4.3 through 407.4.3.6.2 of the *International Building Code*.

TABLE 1104.17.2 1104.18
COMMON PATH, DEAD-END AND TRAVEL DISTANCE LIMITS (by occupancy)

OCCUPANCY	COMMON PATH LIMIT		DEAD-END LIMIT		TRAVEL DISTANCE LIMIT	
	Unsprinklered (feet)	Sprinklered (feet)	Unsprinklered (feet)	Sprinklered (feet)	Unsprinklered (feet)	Sprinklered (feet)
Group I-1	75	75	20	50	200	250
Group I-2 (Health care)	NR ^c Note e	NR ^c Note e	NR	NR	150	200 ^c
Group I-3 (Detention and	100	100	NR	NR	150 ^c	200 ^c

AHC Meeting #9-Means of Egress Work Group Report

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correctional—Use Conditions II, III, IV, V)						
Group I-4 (Day Care Centers)	NR	NR	20	20	200	250

(Portions of table not shown remain unchanged)

NR = No requirements.

For SI: 1 foot = 304.8 mm, 1 square foot = 0.0929 m².

- a. 20 feet for common path serving 50 or more persons; 75 feet for common path serving less than 50 persons.
- b. See Section 1028.9.5 for dead-end aisles in Group A occupancies.
- c. This dimension is for the total travel distance, assuming incremental portions have fully utilized their allowable maximums. For travel distance within the room, and from the room exit access door to the exit, see the appropriate occupancy chapter.
- d. See the *International Building Code* for special requirements on spacing of doors in aircraft hangars.
- e. ~~In Group I-2 Condition 2, Any patient care recipient sleeping room, or any suite that includes patient sleeping rooms, of more than 1,000 square feet shall have at least two exit access doors placed a distance apart equal to not less than one-third of the length of the maximum overall diagonal dimension of the patient sleeping room or suite to be served, measured in a straight line between exit access doors shall comply with Section 1105.6.~~
- f. Where a tenant space in Group B, S and U occupancies has an occupant load of not more than 30, the length of a common path of egress travel shall not be more than 100 feet.

Reason: This change adds minimum requirements for existing hospitals (Group I-2, Condition 2) into Chapter 11. The intent is to increase the bare minimum safety requirements due to the fragile and sensitive populations within these facilities. These requirements are meant to be applied retroactively. This is not a new concept for these facilities – it aligns with the current approach by the Center for Medicaid and Medicare Services (CMS), the federal authority having jurisdiction. Hospitals are now required by CMS to have a life safety survey on a regular basis. If the facility does not meet certain life safety minimums, they are required to upgrade their existing facility. This code change will align the Fire Code with those CMS minimum requirements and will hopefully lead to industry consolidation. These retroactive requirements are added to assist code officials and surveyors during the ongoing regular inspection of hospital facilities and are consistent with the inspections required by federal laws for certification and reimbursement. The requirements consider the minimum previously approved construction methods. These requirements will provide jurisdictions the ability to adopt minimum retroactive provisions that have been vetted by the industry as well as code officials and that are consistent with current national standards used by the Federal Government providing a more uniform level of safety and eliminating many of the current code conflicts for existing facilities.

We looked at several sources to determine what the appropriate minimum bar should be, including the current building and fire code, current CMS guidelines, and previous versions of the ICC and model codes. On all issues, enforcement agencies and the regulated facilities weighed in to ensure that these changes are both necessary and achievable.

This proposal defines the requirements for care suites (both sleeping and non-sleeping) which are an integral design concept for many areas within a hospital. Typical uses include ICU's, Operating Rooms, Emergency Departments and Imaging Departments. The suites allow for better and safer care than non-suite options. The new provisions deal with common path of travel, separation of exit access doors, and number of doors passed through (i.e. previously intervening rooms) in suites. This is much more complete than the current text.

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 8 open meetings and over 150 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>.

Cost Impact: None