



**National Fire Protection Association**

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## ***Healthcare Interpretations Task Force***

### **MEMORANDUM**

**TO:** Heathcare Interpretations Task Force

**FROM:** Robert Solomon

**DATE:** May 30, 2014

**SUBJ:** **HITF Meeting Agenda and Meeting Room Location Information**

Attached is an agenda for the Tuesday, June 10, 2014 Healthcare Interpretations Task Force meeting being held at the NFPA Conference & Expo at the Mandalay Bay Convention Center in Las Vegas, NV.

The meeting will be held in the South Building, Level 2, Reef B of the Mandalay Bay Conference Center. The meeting is scheduled to begin at 1:00 pm and adjourn by 6:00 pm; beverages and snacks will be provided.

Thank you.



## **Healthcare Interpretations Task Force AGENDA**

Mandalay Bay Convention Center  
South Building, Level 2 – Reef B  
Las Vegas, NV  
June 10, 2014  
1:00 P.M. to 6:00 P.M.

1. Call to Order 1:00 P.M.
2. Introduction of Members and Guests.
3. Review of Questions.
  - Defining the term “Compartment”: NFPA 101
  - Transmission of Fire Alarm Signals: NFPA 101
  - Physician Nap Rooms: NFPA 101
  - Multiple Outlet Connections: NFPA 99
4. Old Business.
  - Equipment in Exit Stairwells – Mr. Dagenais
  - Bylaw Review Task Group. (Robert Solomon, Chad Beebe, Jim Merrill and George Mills)
  - CMS NPRM's
    - Emergency Response Planning / Emergency Power
    - Adoption of NFPA 99-2012 and NFPA 101-2012
5. New Business.
6. Date / Location for Next Meeting.
7. Adjournment by 6:00 PM.

# HITF INTERPRETATION REQUEST

## JUNE 2014

DOCUMENT TO BE INTERPRETED:

101

EDITION:

2012

### BACKGROUND INFORMATION (optional):

This is a re-occurring interpretation by surveyors that the term “compartment” refers to the entire fire or smoke compartment. The type of heads in an adjacent room (or NFPA 13 Compartment, with lintel depth of 8”) has no performance effect on the QR heads. This has become difficult for facilities to comply and is actually a disincentive for facilities to upgrade to QR. It is difficult to coordinate the head replacement throughout an entire smoke compartment, it may be necessary to complete all patient rooms on one side of a corridor before the patient rooms on the other side, then ultimately the corridor. During this process facilities are often being cited for non-compliance. It is much easier and less of a risk for citation for a facility only to replace with standard response heads.

### QUESTION:

Is it the intent of NFPA 101 , (and with reference to NFPA 13; 8.3.3.2) that when sprinklers in an **compartment (Per NFPA 13)** are replaced with quick response sprinklers, that all sprinklers in the *fire/smoke compartment(per NFPA 101)* need to be quick response? [Note that this refers to 2013 text so we should probably check for the correct paragraphs in the 1999 and 2010 Editions.]

**NFPA 13: 8.3.3.2.** Where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in 8.3.3.3.

**NFPA 13: 3.3.6 Compartment.** A space completely enclosed by walls and a ceiling. Each wall in the compartment is permitted to have openings to an adjoining space if the openings have a minimum lintel depth of 8 in. (200 mm) from the ceiling and the total width of the openings in each wall does not exceed 8 ft. (2.4 m). A single opening of 36 in. (900 mm) or less in width without a lintel is permitted when there are no other openings to adjoining spaces.

**NFPA 101: 3.3.48 Compartment.**

**3.3.48.1\* Fire Compartment.** A space within a building that is enclosed by fire barriers on all sides, including the top and bottom.

**3.3.48.2\* Smoke Compartment.** A space within a building enclosed by smoke barriers on all sides, including the top and bottom.

### ANSWER:

No. the definition of compartment found in NFPA 13 should be followed to determine the extent of heads that need to be replaced when QR heads are installed.

## HITF QUESTION

**JUNE 2014**

**Document to be interpreted:** NFPA 101, 19.7.1.2 (2000 edition) and 19.7.1.4 (2012 edition)

**Editions:** 2000 and 2012

**Subject:** Transmission of fire alarm signal during fire drills

**Background:** Many healthcare occupancies have their fire alarm system off-premises transmission equipment connected to third-party monitoring companies who will contact the local fire responders once they receive an electronic signal from the healthcare occupancy's fire alarm system. The transmission of the fire alarm signal between the healthcare organization and the third-party monitoring company can be confirmed by automatic monitoring and recording of the electronic signals, and reports can be easily generated. However, the transmission of the signal (however it is conducted) between the third-party monitoring company and the local fire responding agency is not as easily recorded nor are reports as available of that signal transmission to the healthcare organizations.

Sections 19.7.1.2 (2000 edition) and 19.7.1.4 (2012 edition) begin with the statement: "*Fire drills in healthcare occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.*" But these sections (and neither does the respective Annex sections) define how and to what extent the fire drill must transmit the fire alarm signal.

### **Question 1:**

Is it the intent of 101 2000 edition section 19.7.1.2, and 101 2012 edition section 19.7.1.4 to require healthcare occupancies to confirm the transmission of a fire alarm signal all the way to the local fire responding agency, even if the fire alarm system off-premises transmission equipment is connected to a third-party monitoring company?

### **Question 2:**

If the answer to question 1 is "No", is it the intent of 101 2000 edition section 19.7.1.2, and 101 2012 edition section 19.7.1.4 to require healthcare occupancies to confirm the transmission of a fire alarm signal to the third-party monitoring company if they are so equipped?

# HITF INTERPRETATION REQUEST

## JUNE 2014

**DOCUMENT TO BE INTERPRETED:**

101

**EDITION:**

2012

BACKGROUND INFORMATION (optional):

QUESTION:

Are physician “nap rooms” required to be separated from the healthcare facility and designated as Chapter 26 Lodging or Rooming (or other occupancy).

ANSWER:

No. These areas also do not need to be their own occupancy. Nap rooms are not used normal lodging/rooming occupancy - i.e. no one is making these “home like” – At most a couch may be provided if not a cot. If there is a bed, it is typically a hospital bed. By the very nature that it is within a HC occupancy, the construction type and sprinkler requirements far exceed that of most lodging or rooming houses. These rooms do not contain the typical hazards such as cooking on a hot plate, smoking, etc. The only requirement that these rooms lack that is provided for patient rooms is staff supervision and responsibility for the occupant. For that reason, it would be highly recommended that a smoke alarm audible within the room, however it is not required by the code.

# HITF INTERPRETATION REQUEST

## JUNE 2014

**DOCUMENT TO BE INTERPRETED:**

101

**EDITION:**

2012

### BACKGROUND INFORMATION (optional):

For the purpose of these questions, a Multiple Outlet Connection / Special Purpose Relocatable Power Tap is defined as follows:

- Provided with Hospital Grade attachment plugs and Hospital Grade outlets (receptacles)
- Supplementary overcurrent protection, power switches, and indicator lights singly or in any combination.
- Supplies power to plug-connected components of movable equipment assemblies that is rack-, table-, or pedestal-mounted.
- Permanently attached to the equipment assembly (see NFPA 99 2012 edition 10.2.3.6 - note integral component was stricken from 2009 edition)

### Code References

- Section 10.2.3.6 of NFPA 99 (2012 edition)
- Tentative Interim Amendment (TIA No. 1104) modifications to Sections 10.2.3.6(5) and A.10.2.3.6(5) – July 20-August 1, 2013 meeting
- UL1363A - Special Purpose Relocatable Power Taps
- NFPA 70, Article 517

### QUESTION #1:

#1: In accordance with NFPA 99, 2012 Edition, Section 10.2.3.6, can hospital's use Multiple Outlet Connections and/or Special Purpose Relocatable Power Taps in General Care Areas?

### ANSWER:

No. As you are aware, AHJs are increasingly issuing citations for the use of power strips in clinical areas. In my opinion, this position is impractical and places an unreasonable financial burden on hospitals by forcing unnecessary corrective action (e.g., renovations to increase outlet numbers throughout the hospital).

### QUESTION #2:

#2: In accordance with NFPA 99, 2012 Edition, Section 10.2.3.6, can hospital's use Multiple Outlet Connections and/or Special Purpose Relocatable Power Taps in Critical Care Areas?

**ANSWER:**

No. As you are aware, AHJs are increasingly issuing citations for the use of power strips in clinical areas. In my opinion, this position is impractical and places an unreasonable financial burden on hospitals by forcing unnecessary corrective action (e.g., renovations to increase outlet numbers throughout the hospital).

**QUESTION #3:**

#3: In accordance with NFPA 99, 2012 Edition, Section 10.2.3.6, can hospital's use Multiple Outlet Connections and/or Special Purpose Relocatable Power Taps in the Patient Vicinity?

**ANSWER:**

No. As you are aware, AHJs are increasingly issuing citations for the use of power strips in clinical areas. In my opinion, this position is impractical and places an unreasonable financial burden on hospitals by forcing unnecessary corrective action (e.g., renovations to increase outlet numbers throughout the hospital).

**QUESTION #4:**

#4: In accordance with NFPA 99, 2012 Edition, Section 10.2.3.6 (1), can the hospital permanently attached the Special Purpose Relocatable Power Tap to the equipment assembly?

**ANSWER:**

Yes. As you are aware, AHJs are increasingly issuing citations for the use of power strips in clinical areas. In my opinion, this position is impractical and places an unreasonable financial burden on hospitals by forcing unnecessary corrective action (e.g., renovations to increase outlet numbers throughout the hospital).