Major Final Amendments for RICE—NESHAP

On January 14, 2013, the EPA issued final amendments to the National Emission Standards for Hazardous Air Pollutants (NESHAP) for Reciprocating Internal Combustion Engines (RICE). Of particular interest, the NESHAP final amendments changed the limits on emergency generator operating hours.

So, what specific compliance requirements will apply to your emergency generators? Here is a summary of these final amendments that affect most of the emergency generators operated at area (non-major) sources of hazardous air pollutants, such as universities, schools, health care facilities, hospitals and some industrial facilities.

SUMMARY:

1. The use of an emergency generator is restricted to the following:

OPERATION	LIMIT*
• Emergency (power outage)	Unlimited
• Maintenance, Readiness Testing • Emergency Demand Response * Energy Emergency Alert Level 2 is called * Voltage or frequency deviation of 5 percent or > below the standard • Non-Emergency (see below)	100 hours/ year
• Non-Emergency Situations (without financial arrangement) • Local Reliability (with financial arrangement with another entity in certain cases) • Peak Shaving (until May 3, 2014)	50 hours/ year

Important Note: Many states limit the operating hours of emergency generators irrespective of the nature of operations. Check your state regulations or consult with your state regulatory authority for specific requirements that apply to your emergency generators.

2. A generator engine must be inspected and maintained per the regulations.
3. Additional operational, maintenance, monitoring and/or reporting requirements may apply to an emergency generator, if any of the following conditions applies:

   A. if you operate or are contractually obligated to make available an emergency generator for more than 15 hours per year for demand response purposes, or
   B. if you operate the emergency generator for local reliability.

For more detailed information, go to epa.gov/airtoxics/rice/20130306webinar.pdf

June 2013—Codes & Standards *is offered to NEHES members as a way to keep informed about key technical information for very busy healthcare engineers. Information is gathered from many sources, with the major items coming from the American Society for Healthcare Engineers (ASHE), the Environmental Protection Agency (EPA), the Joint Commission and industry magazines and publications designed for healthcare engineers and facility managers. Most of all, we welcome information from you, the NEHES members, about information that you have found that will be helpful to your fellow members. Feel free to send links to articles and information or to send your own articles for Codes & Standards. Send to rvachon@stmarysmaine.com.-*

News from ASHE

50th Annual ASHE Conference & Technical Exhibition - July 21—24, Atlanta, Georgia

We realize that many NEHES members may not be able to attend the ASHE Annual Conference. However, it is one of the best educational opportunities available for Healthcare Engineers.

Here's a sampling of topic presentations that will be rolled out on the first day of the conference! Imagine what else you could learn in the course of three days!

- Benchmarking 2.0: Operations and Maintenance Benchmarks for Health Care Facilities
- Excellence in Facility Management
- Hybrid Heating at the New Nemours Children's Hospital
- Managing Electrical Systems for Reliability
- Hazmat Regulation Changes: OSHA and DOT
- Reducing Operational Costs by Implementing a Low-Cost Energy Program
- 10 Forces Continuing to Change Healthcare Design

For more info on the conference, go to www.ashe.org/annual/index.html

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CMS to propose adoption of 2012 Life Safety Code

ASHE reported to members in this issue brief that the Centers for Medicare & Medicaid Services (CMS) has moved a step closer to adopting the 2012 edition of NFPA 101: *Life Safety Code*®.

This step in the right direction is great news for those involved with the health care physical environment, and ASHE applauds CMS for moving toward updated codes. CMS has filed a federal agenda item that indicates the agency will submit a notice of proposed rulemaking on the issue later this year. The proposed rule would adopt the 2012 edition of the *Life Safety Code* and eliminate references in CMS regulations to all earlier editions, according to the agenda item.

The federal rulemaking process can be complex and lengthy, but the next step is for CMS to publish its proposed rule. That could happen later this year (CMS hopes to have it complete by August). Then there will be a public comment period before CMS prepares and later publishes its final rule, which can be different from the original proposed rule.

For now, ASHE members do not need to take any action on this issue. ASHE will keep members posted on when the public comment period opens, and will inform members of ways they can help spur the adoption of the 2012 edition of the *Life Safety Code*.

ashe.org/resources/sshenews/2013/pdfs/issue_brief_cms_adopts_2012_lsc_130411.pdf

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How to use the CMS waiver to lower OR humidity requirements

The Centers for Medicare & Medicaid Services (CMS) is lowering the operating room relative humidity requirement from a minimum of 35 percent to a minimum of 20 percent. ASHE has been working with CMS on this topic and sent an issue brief to members today explaining the issue.

In a survey and certification memo, CMS offers the following guidance on how to take advantage of its waiver to lower the OR humidity level:

- Individual waiver applications are not required because this is a categorical waiver.
- Facilities **must** document their decision to use the waiver. They must show written documentation of this decision to surveyors during the entrance conference for any survey assessing *Life Safety Code* compliance. If a facility fails to show documentation of its prior decision to use the waiver, it could result in a citation.
- Facilities must still monitor relative humidity levels in operating rooms and other anesthetizing locations. Facilities must take action when needed to ensure that relative humidity remains at or above 20 percent.
- The waiver does not apply if more stringent humidity levels are required under state or local laws or regulations, or if the reduction of the relative humidity would negatively affect ventilation system performance.

The waiver is effective immediately. Is your facility planning to take advantage of this waiver?

ashe.org/resources/ashenews/2013/pdfs/issue_brief_cms_lowers_or_humidity_requirements_130423.pdf

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Natural disasters spur consideration of relocating equipment

Natural disasters such as Hurricane Sandy have called attention to the issue of where facility infrastructure is located. For example, are backup generators elevated above ground so they are safe from water in the event of flooding? What factors should critical facilities such as hospitals consider when determining their risks and ways to mitigate them? An article from the National Electrical Manufacturers Association outlines issues for facilities to consider when determining whether they should relocate their equipment.

nema.org/Storm-Disaster-Recovery/Replacing-and-Relocating-Equipment/Pages/Emergency-Preparedness-and-the-Importance-of-Equipment-Repositioning.aspx?goback=.gde_2132968_member_239256604

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Hospitals See Surge of Products to Fight Superbugs, But Do They Work?

A recent Associated Press story examined the surge of products being introduced to hospitals to help fight hard-to-kill "superbugs" such as Clostridium difficile. Among the products mentioned in the story are copper bed rails, antimicrobial linens, and machines "that resemble *Star Wars*." The story says the products can help clean rooms, but their true impact on preventing infection or deaths is debatable.

finance.yahoo.com/news/hospitals-see-surge-superbug-fighting-063400543.html

Want industry info sent directly to your e-mail? You can be placed on e-mail lists with ASHE, The Joint Commission and other industry organizations. Simply go to their website to sign up for their online e-mails or update alerts.

Also consider Google Alerts as a source of information. Set key words in a search query and the frequency that you want to receive updates.

When an item is found in the Internet that matches your search query, an alert is sent to your e-mail. Go to www.google.com/alerts?hl=en to create your own Google Alert categories.

Joint Commission alert addresses medical device alarm safety in hospitals

The constant beeping of alarms and an overabundance of information transmitted by medical devices such as ventilators, blood pressure monitors and ECG (electrocardiogram) machines is creating "alarm fatigue" that puts hospital patients at serious risk, according to a Sentinel Event Alert issued today by The Joint Commission.

The Joint Commission Alert urges leaders at hospitals to take a focused look at this serious patient safety issue. Over a recent four-year period, a U.S. Food and Drug Administration (FDA) database shows that there were more than 560 alarm-related deaths and The Joint Commission's sentinel event database includes reports of 80 alarm-related deaths and 13 serious alarm-related injuries during a similar period. Patient deaths related to alarms on monitoring devices have also been the focus of national media attention and special reports by the Association for the Advancement of Medical Instrumentation (AAMI) and ECRI Institute. The Joint Commission, AAMI, ECRI Institute and American College of Clinical Engineering also brought together patient safety and health care experts at a 2011 summit to seek solutions to problems with medical device alarms.

Alarms are intended to alert caregivers of potential problems, but can compromise patient safety if they are not properly managed. Many patient care areas have numerous alarms and the barrage of warning noises tend to desensitize caregivers and cause them to ignore alarms or even disable them. Other issues associated with effective alarm management include too many medical devices with alarms or individual alarms that are difficult to hear. Preset or default settings also may cause problems because the device sounds a warning even when no action or decision by a caregiver is required. Rather than calling attention to a patient's needs, these settings may distract caregivers.

These issues vary greatly among hospitals and even within different units in a single hospital. Although there are many variables, the Alert makes it clear that in order to reduce risks related to alarms on medical devices, a series of actions still needs to occur related to people, processes and technology.

"Alarm fatigue and management of alarms are important safety issues that we must confront," says Ana McKee, M.D., executive vice president and chief medical officer, The Joint Commission. "The recommendations in this Alert offer hospitals a framework on which to assess their individual circumstances and develop a systematic, coordinated approach to alarms. By making alarm safety a priority, lives can be saved."

The Joint Commission Alert recommends that health care organizations take the following actions, which correspond with recommendations made by both AAMI and ECRI Institute:

- Ensure that there is a process for safe alarm management and response in areas identified by the organization as high risk.
- Prepare an inventory of alarm-equipped medical devices used in high-risk areas and for high-risk clinical conditions, and identify the default alarm settings and the limits appropriate for each care area.
- Establish guidelines for alarm settings on alarm-equipped medical devices used in high-risk areas and for high-risk clinical conditions; include identification of situations when alarm signals are not clinically necessary.
- Establish guidelines for tailoring alarm settings and limits for individual patients. The guidelines should address situations when limits can be modified to minimize alarm signals and the extent to which alarms can be modified to minimize alarm signals.
- Inspect, check and maintain alarm-equipped medical devices to provide for accurate and appropriate alarm settings, proper operation, and detectability. Base the frequency of these activities on criteria such as manufacturers' recommendations, risk levels and current experience.

The Joint Commission Alert also recommends training and education for all clinical care team members on safe alarm management and response in high-risk areas. In addition, organizations should consider how to reduce nuisance alarm signals and to determine whether critical alarm signals can actually be heard in patient care areas. Seeking input from patient care providers, health care engineers, risk managers and information technology professionals, organizations should also establish policies and processes for alarm safety that include the regular review of trends and patterns that reveal improvement opportunities. Finally, the Alert urges organizations to share information about alarm-related incidents, prevention strategies and lessons learned with organizations such as AAMI, ECRI, the FDA and The Joint Commission.

Beyond the Alert, The Joint Commission is considering the possible creation of a National Patient Safety Goal to help health care organizations address this issue. A field review of the proposed Goal occurred in February and the public comments are now under review. The Joint Commission already has numerous accreditation standards in place related to alarm safety. The standards address issues such as leadership, the environment of care, provision of care and staff training and education.

The warning about medical device alarms is part of a series of Alerts issued by The Joint Commission. Much of the information and guidance provided in these Alerts is drawn from The Joint Commission's Sentinel Event Database, one of the nation's most comprehensive voluntary reporting systems for serious adverse events in health care. The database includes detailed information about both adverse events and their underlying causes. Previous Alerts have addressed risks associated with the use of opioids, health care worker fatigue, diagnostic imaging risks, violence in health care facilities, maternal deaths, health care technology, anticoagulants, wrong-site surgery, medication mix-ups, health care-associated infections and patient suicides, among others. The complete list and text of past issues of Sentinel Event Alert can be found on The Joint Commission website.

jointcommission.org/new_joint_commission_alert_addresses_medical_device_alarm_safety_in_hospitals/

Listen to Joint Commission Podcasts regarding this article.

Take 5—Alarm Safety, Part II
Hear the engineer perspective from George Mills, director of Engineering at The Joint Commission, who talks candidly about alarm safety.
http://traffic.libsyn.com/jointcommission/Take_5_alarms_GMills_FINAL.mp3

Take 5—Medical Device Alarm Safety
Hear this podcast featuring Pat Adamski, director of The Joint Commission's Standards Interpretation Group, talking about alarm safety challenges and offering practical advice.
http://traffic.libsyn.com/jointcommission/Take_5_Adamski_alarms_FINAL.mp3

Two New England hospitals earn 2013 Energy Star Label, Kent Hospital (RI) and St Joseph Hospital (NH)

Congratulations to both Kent Hospital in Warwick, Rhode Island and Saint Joseph Hospital in Nashua, New Hampshire. There are now 9 hospitals in New England that have earned the Energy Star label in at least one year since 2003.

Can You Earn the Energy Star Label?

You can use Portfolio Manager to measure and track the energy use of any commercial or industrial building. However, for certain types of buildings including hospitals, you can go a step further and rate their energy performance on EPA's ENERGY STAR 1-100 energy performance scale relative to similar buildings nationwide. Buildings that achieve an ENERGY STAR energy performance score of 75 or higher—meaning they are in the top 25 percent for energy efficiency in the nation compared with similar buildings—and are professionally verified to meet current indoor environment standards are eligible to apply for the ENERGY STAR.

ENERGY STAR certified buildings typically use 35 percent less energy than average buildings and cost 50 cents less per square foot to operate. .

For more information on Energy Star label and how to apply, go to energystar.gov/index.cfm?c=evaluate_performance.bus_portfoliomanager_intro

New Augusta, Maine Hospital Highly Energy Efficient

The new regional hospital in northwest Augusta is expected to have about half the utility bills of the current facilities.

The Alfond Center for Health, which will combine inpatient services of MaineGeneral Medical Center's Thayer campus in Waterville and the East Chestnut Street hospital in Augusta, is scheduled to open Nov. 9.

Paul Stein, chief operating officer, says anticipated energy costs at the new campus are projected at $3.27 per square foot, compared to $7.80 per square foot currently.

Stein tells the Kennebec Journal (http://bit.ly/YEro70) the design of the new facility includes energy-saving features including efficient heating/cooling systems, low-water-flow technology, LED lighting, and natural gas. The building even has a white roof to reflect heat.

Fletcher Allen Health Care Among The Greenest Hospitals

Vermont's largest hospital has won national recognition for the fifth year in a row for good environmental practices.

Practice Greenhealth has admitted Burlington-based Fletcher Allen Health Care to its Environmental Leadership Circle, its highest award. The award is given to institutions that have demonstrated an outstanding commitment to reducing the environmental footprint of their operations.

Among the hospital's green practices: using environmentally friendly cleaning supplies, extensive recycling and composting. Between 2007 and 2012, Fletcher Allen increased its annual recycling by more than 60 percent to 1,132 tons.

The hospital also has achieved significant reductions in electrical demand, in part by installing LED lighting.

The Dispensary of Hope

The Dispensary of Hope is a national not-for-profit that recovers short-dated and surplus medications and redistributes them to charitable clinics and pharmacies across the country.

Through their "Fill the Box Fill the Need" campaign, over 1000 physician practices across the country are donating their sample medications 6 months prior to expiration. By doing so, practices are preventing waste, increasing sample management compliance, saving time and destruction costs, and ultimately serving the medication needs of the uninsured. They've worked with some of the largest health systems across the country to incorporate their Hope Boxes and are growing quickly—adding just under 40 practices a month.

See one hospital's success with The Dispensary of Hope: http://dispensaryofhope.org/sites/default/files/DOH%20Case%20Study_St.%20Vincent.pdf

Hospitals divert 100 million pounds from landfill

The Healthier Hospitals Initiative kept more than 100 million pounds of waste out of landfills in its initial year, according to the program's first progress report.

The program's 370 member hospitals recycled more than 50 million pounds of materials and diverted an additional 61.5 million pounds of construction and demolition from landfills through reuse and recycling last year, according to the initiative's 2012 Milestone Report.

Data in the report was collected from HHI-member hospitals in six key "challenge" areas: leaner energy, less waste, safer chemicals, engaged leadership, smarter purchasing and healthier food. Each HHI member is participating in at least one challenge.

To view the entire article, go to http://www.environmentalleader.com/2013/04/26/hospitals-divert-100-million-pounds-from-landfill/

Contemporary and Alternative Existing-Building Commissioning

Typical savings and paybacks of contemporary existing-building commissioning and a more targeted alternative approach for sensitive budgets

The Great Recession, as the last five-plus years have come to be known, has been tough on building owners and operations-and-maintenance (O&M) staffs. As they face mounting pressure to maximize net operating income, they increasingly are turning to existing-building commissioning (EBCx) to keep maintenance and utility costs down. This article will define contemporary EBCx, describe the contemporary EBCx process, and discuss associated energy and cost savings.

For complete article ; http://hpac.com/archive/contemporary-and-alternative-existing-building-commissioning

EPA Update: 2013 Proposal to Address the Management of Hazardous Waste Pharmaceuticals

The Agency is in the process of developing a new proposal to establish appropriate standards for the management and disposal of hazardous waste pharmaceuticals generated by healthcare facilities.

This most recent effort is a continuation of the December 2, 2008 proposal to add hazardous waste pharmaceuticals to the Universal Waste Program. Public comment on the December 2008 proposal revealed numerous concerns over the lack of notification requirements for those facilities that generate, handle or transport "universal waste" pharmaceuticals as well as for the lack of tracking requirements for the shipment of these wastes. Therefore, the Agency decided to not finalize the 2008 proposed rule, but rather develop another proposal for new standards for the management and disposal of hazardous waste pharmaceuticals.

With the new rule, the concerns raised by the public comments regarding notification and tracking issues can be more fully addressed as well as other hazardous waste pharmaceutical management issues that are more specific to healthcare facilities. This new proposed rulemaking will only pertain to those pharmaceutical wastes the meet the current definition of a RCRA hazardous waste and that are generated by healthcare-related facilities.

- *2013 Proposal Status*

The new proposal for healthcare facility-specific management standards for hazardous waste pharmaceuticals is currently under development. We anticipate that the proposed rule will be published and available for public comment in August 2013. More information available at: http://www.epa.gov/waste/hazard/generation/pharmaceuticals.htm

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Sustainability Dashboard Tools Gives Seven Tips To A More Sustainable Facility

Want to become more sustainable, help reduce operating costs and improve a building's overall environmental impact? Consider these six steps:

- **Transfer to green-certified cleaning products.** This is probably the easiest step in the process; products that have been green-certified have a reduced impact on the environment and are made from more sustainable ingredients.
- **Select products based on their life-cycle assessment.** Know the cradle-to-grave environmental impacts of everything purchased, from the way the product is made to its environmental impact once you're done with it.
- **Set sustainability goals.** It is important to be goal-driven when it comes to sustainability; goals should focus not only on things such as reducing energy and fuel use by a certain time but reducing the costs of those consumables as well.
- **Employ a sustainability reporting system.** You can't manage what you can't measure, and you can't set goals if you have no way of knowing if you are achieving your goals. A reporting system can track, monitor and measure a facility's use of natural resources and consumables.
- **Make sustainability part of your brand.** If your facility or organization is meeting sustainability goals and has made significant progress, integrate this information into business and marketing materials. Sustainability is now a part of who and what you are.

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Water Walls May Be Banned in New Hospital Construction

Despite the pleasing aesthetic, open, indoor water features may be banned in new hospital construction if a proposed change in the upcoming Facility Guidelines Institute's (FGI) *Guidelines for Design and Construction of Hospitals and Outpatient Facilities* is approved for the 2014 edition.

Current FGI guidelines, approved in 2010, require open water features to manage the safety of water quality to shield patients, workers and visitors from irritating aerosols or those that have been tainted.

The issue of open indoor water features is a controversial one. On one side, hospital donors and patients support the continued use of indoor water features, citing such wide-ranging factors as the positive impact it can have on visitors and staff by creating a calming affect, reduce stress levels and potentially increase satisfaction among patients.

Conversely, professionals who encourage a ban on open, indoor water features argue that documented occurrences of disease and death blamed on waterborne pathogens supersede the lack of substantive data connected with alleged benefits.

To that end, a study published last year in *Infection Control and Hospital Epidemiology* concluded a 2010 outbreak of Legionnaire's disease in Wisconsin was tied to eight patients who spent time near a decorative fountain in a hospital's main lobby. Environmental testing found amounts of Legionnaire's disease in samples collected from the water wall fountain.

After time, all eight patients that were harmed by the outbreak eventually recovered from the disease. .

The American Society for Healthcare Engineering (ASHE) are in support of the FGI change, affecting new hospital construction.

ashe.org/resources/ashenews/2013/open_water_features_130327.html

GOOD READS for NEHES Members

(This list of resources is provided as a service to NEHES members and does not constitute an endorsement by NEHES. These are sources that members have found helpful in their work.)

Outgoing NEHES Newsletter Editor, **Debbie Sullivan** recommends:

TSIG News
a publication of TSIG Consulting
New York City, New York.

"Very good information on a variety of healthcare engineering subjects."
www.tsigconsulting.com
Click on NEWS to reach newsletter.

Results of Codes Advocacy Voting on NFPA Proposals

(At the Spring Conference, attendees voted to agree, disagree or abstain regarding the Code recommendations.)

Pro-posal Number	Code Number	NFPA 101 Codes Advocacy Opportunity	Agree	Disagree	Abstain
1	18.3.7.1 (3)	Change smoke compartment size limit from 22,500 ft^2 to 40,000 ft^2.	**50**	16	1
2	19.3.7.1(1)	For existing, change smoke compartment size limit from 22,500 ft^2 to 40,000 ft^2 when building is fully sprinkler protected and with QR for all patient sleeping compartments.	**46**	20	1
3	18.3.7.2(3)	Change to no longer require smoke barriers on the floor below health care occupancy.	**45**	20	2
4	18.2.3.4(7)	Change to all 6 ft wide corridors in new nursing homes housing not more than 30 patients.	31	**32**	4
5	18.2.5.7.3.3	Change Patient Care Non-Sleeping Suite maximum size from 10,000 ft^2 to 12,500 ft^2 and up to 15,000 ft^2 with total coverage smoke detectors.	**60**	6	1
6	19.2.5.7.3.3	For existing: change Patient Care Non-Sleeping Suite maximum size from 10,000 ft^2 to 12,500 ft^2 with standard sprinkler protection and smoke detection or QR sprinkler protection; and up to 15,000 ft^2 with both QR sprinkler protection and total coverage smoke detectors.	**58**	7	2
7	18.3.6.3.1	To clarify that doors or panels to nurse servers and pass-through openings are permitted, with 1/8 inch gap rule.	**60**	4	3
Pro-posal Number	**Code Number**	**NFPA 99 Codes Advocacy Opportunity**	**Agree**	**Disagree**	**Abstain**
1	1.3.1	Clarifies veterinary does not apply.	**55**	2	6
2	1.3.4	Changes the term from rooms to spaces.	**46**	13	4
3	*1.3.4.1*	Uses categories instead of rooms.	**62**	0	1
4	3.3.18	Adds categories in definitions section	**57**	1	5

Results of Codes Advocacy Voting on NFPA Proposals (Continued)

Proposal Number	Code Number	NFPA 101 Codes Advocacy Opportunity	Agree	Disagree	Abstain
5	3.3.48	Adds new definition “facility fire plan”	**60**	0	3
6	3.3.67	Uses the term human medical care to eliminate veterinary.	**62**	0	1
7	3.3.71	Adds the word space to the definition for hyperbaric facilities.	**61**	0	2
8	3.3.116	New definition for non-medical compressed air.	**57**	3	3
9	3.3.155	New definition for space.	**57**	3	3
10	3.3.169	New section that defines waste water.	**58**	2	3
11	4.2	New section that eliminates risk assessment requirement for category 1.	**56**	4	3
12	5.1.3.5.7	New section that requires a second connection point called auxiliary source connection for gas and vacuum systems.	**57**	4	2
13	5.1.3.7.6.2	Updates the distance requirements for gas and vacuum exhaust to match FGI guidelines.	**61**	2	0
14	5.1.10.11.7.2	Permits two medical gas systems that are the same product to be connected.	**63**	0	0
15	5.1.11.3.1.1	New section that allows outlets to be downstream of a flow control device in sleep labs.	**59**	2	2
16	5.1.12.3.6.4	New requirement for odor test to be conducted on positive pressure gas outlets.	6	**55**	2
17	5.1.14.2.2.5	Clarifies that maintainers of medical gas systems are only required to attend a documented training program.	**48**	14	1
18	6.3.2.2.8.8	New section that prohibits the use of outlets downstream of a GFI in operating rooms.	**63**	0	0
19	6.4.1.1.3	Prohibits fire pumps from being load shed.	**61**	1	1
20	*6.4.1.1.7*	New section on fuel cell technology.	**49**	6	8
21	6.4.2.2.1.5	New section clarifying which parts of article 700 of the National Electrical Code applies to Healthcare.	**56**	2	5
22	6.5.2.2.1.2	Clarifies the required branches in a type 2 emergency electrical system.	**61**	0	2
23	6.6	Deletes a type 3 electrical system.	**53**	5	5
24	7.3.1.2.1.4 (E)	Allows underground utilities beneath an IT entrance facility.	**61**	1	1

Results of Codes Advocacy Voting on NFPA Proposals (Continued)

Proposal Number	Code Number	NFPA 101 Codes Advocacy Opportunity	Agree	Disagree	Abstain
25	7.3.1.2.1.5	Requires IT entrance facilities to be secured.	**59**	2	2
26	8.3.1	Requires plumbing to be installed in accordance with FGI guidelines and plumbing codes.	**56**	2	5
27	8.3.5.1	Requires non-medical air compressors be listed or approved.	**56**	6	1
28	8.3.7.1	Allows for two options for sizing grease interceptors.	**40**	14	9
29	8.3.9	Defines where waste water must be disposed.	**52**	9	2
30	9.3.1.1	Requires HVAC system comply with ASHRAE 170 unless amended by NFPA 99.	**61**	1	1
31	9.3.1.3	Eliminates the need for smoke purge systems in anesthetizing locations.	**51**	7	5
32	10.4.2	In the electrical equipment chapter, this replaces the term room with vicinity.	**51**	8	4
33	10.5.3.1.1	Section clarifies that hospitals' history can be used to establish preventive maintenance strategies.	**58**	4	1
34	13.3.1	Requires a security vulnerability analysis to be conducted annually.	**55**	8	0
35	14.2.1.4.4.1	In hyperbaric facilities, replaces the term acute care with category 1 and non-acute care with category 2.	**62**	0	1

Based on the voting that took place during the 2013 Spring Conference there was only one proposed code change where the membership disagreed significantly with the NFPA technical committee. Your NEHES advocacy team will be advocating to overturn the requirement for odor tests to be conducted on positive pressure gas outlets.