Formal Interpretations

***Guidelines for Design and Construction of Outpatient Facilities*, 2018 edition**

Decisions published here were rendered after a multi-person panel of Health Guidelines Revision Committee (HGRC) members reviewed the request and consensus was achieved. These decisions are considered formal interpretations of the HGRC, but they are not binding for states that reference the *Guidelines*. Rather, they are advisory in nature and are intended to help users and adopting authorities having jurisdiction (AHJ) maximize the value of the *Guidelines*.

Further comments from members of the Interpretations Committee have been added to some interpretations. These comments are intended as explanatory information for users of the *Guidelines* and are not to be considered part of the formal interpretation.

Formal interpretations are rendered on the text of the requested edition of the *Guidelines*. However, any interpretation issued shall apply to all editions in which the text is identical, except when deemed inappropriate by the HGRC.

In all cases, it is important to remember that the ultimate interpretation of information contained in the *Guidelines* is the responsibility of the authority having jurisdiction.

The Facility Guidelines Institute administers the procedure for developing formal interpretations. Please visit the FGI website at www.fgiguidelines.org/interpretations to read "Rules for Requesting a Formal Interpretation" before submitting a request. Also on the FGI website is an electronic form for requesting a formal interpretation.

This document has been downloaded from the FGI website at the address just above. Interpretations are compiled continuously, and this summary document is periodically updated.

REQUEST

Guidelines edition: **2018 Outpatient** *Paragraph references:* **2.1-3.2.1**

Our regional health care system is developing a standard layout for exam rooms and working with our local AHJ on multiple projects. Before we finalize the designs, we want to clarify two requirements in Section 2.1-3.2.1 (Examination Rooms) in the 2018 FGI *Guidelines for Design and Construction of Outpatient Facilities*.

1 – Means for providing visual privacy in an exam room

Section 2.1-3.2.1.1 (1) requires appropriate levels of patient speech and visual privacy. Our health care system has a children's specialty center that only uses a room layout with the exam table against the wall. For infection control and patient safety reasons, we prefer not to have cubicle curtains in exam rooms. Instead, the door swing is intended to provide privacy by preventing observation from outside the room.

Question: Is it acceptable for the door into an exam room to be the only method of providing privacy?

Follow-up questions: If yes, is there a door angle requirement? 45 degrees? 90 degrees? If the door is acceptable as a privacy measure, does it need to have a door swing restrictor to limit it to a 90-degree swing?

Response: Yes, the *Guidelines* permits use of the exam room door as the only means of providing privacy. There is no door angle requirement, but to be accessible doors must be able to open 90 degrees. A door swing restrictor is not required for privacy, although may be needed if a cabinet or equipment is located in the way.

Further Comments

Regional health system architect: Often the opposite swing of the door blocks the foot of the exam table while the provider is entering, so anyone in the hallway cannot see into the exam room. I find this a totally acceptable solution to patient privacy, although I have done it both ways (swung the door toward and away from the foot of the table) in exam rooms that do not require patients to undress. Clinical providers have learned to knock before entering.

From an infection prevention perspective, the entire ambulatory care industry is challenged with not wanting to use cubicle curtains to provide patient privacy. Hence, I would vote that a door is sufficient if the patient is not undressing. However, there is a cultural and gender bias I believe we need to consider where patients are required to gown. In those rooms, I believe more than a door is required. That said, I would hate to require something for all exam rooms that addresses less than 10 percent of the typical exam rooms (where undressing is required).

Architect: The second sentence of appendix section A2.1-3.1.2-a (highlighted in pink in the *Guidelines* text excerpt below) states the entry door can be used "to achieve visual privacy...." The goal of writing this appendix language was to reduce the dependence on cubicle curtains in patient care and diagnostic spaces as a result of questions related to infection control of fabric or paper curtains. The appendix lists options for achieving privacy without cubicle curtains and indicates that a single, solid door leaf, oriented to provide privacy of the exam table from the corridor or outside the room, is acceptable. The options for privacy mentioned are not all inclusive; that being said, it is not necessary to have both a door (oriented for privacy) and a cubicle curtain unless there is some unique situation where this would be necessary.

***2.1-3.1.2 Patient Privacy**
Each facility design shall ensure appropriate levels of patient speech and visual privacy and dignity throughout the care process.

A2.1-3.1.2 Patient privacy
a. Visual privacy can be achieved using various means, including cubicle curtains, blinds, and electronically controlled vision panels. In single-patient rooms, the entry room door can be used to achieve visual privacy provided the door is solid or has non-transparent glass. Where doors with vision panels or transparent glass are used, provisions for visual privacy should be made. Consideration should be given to designing the room so the foot of the table does not face the door, using door orientation, privacy hinges, or a cubicle curtain to provide visual privacy.
b. Speech privacy...

AHJ: Although a door alone can be used to provide privacy, privacy is dependent on context. I believe this is why the actual requirement for privacy in exam rooms is very non-specific. The appendix note gives us some of that context—solid doors, no windows in the door. The function, layout, and character of the space also contribute to the provision of privacy. If an exam room is arranged so a door alone won't provide sufficient privacy, the actual performance would compel us to look at it more closely, but these are special conditions. Overwhelmingly, most exam rooms do not need a privacy curtain in addition to a door.

AHJ: If doors work for privacy based on the type of room and type of exam being performed, use of a door alone for privacy is fine. Operational practices will support this. For instance, anyone entering the room will knock. Also, a light or flip tag indicating the room is occupied can be used.

We very rarely see cubicle curtains. They create more issues than anything else. Where OB/gyn exams are performed, the rooms are generally larger and the exam table is always placed at an angle from the door.

National health system architect: We have added a privacy curtain where more privacy is needed (e.g., for OB/gyn patients). In our latest exam room template, we have a sliding door, and we have a privacy curtain is optional, since most visits are now more consultative vs. requiring physical examination. Operationally, our clinicians also knock prior to entering so exposure/privacy is no longer an issue.

Architect: A description of the privacy level intended for a particular exam room and how that level of privacy will be achieved with the reverse door swing in combination with operational protocol (e.g., "in use" indicators for the room) should be included in the functional program.

2 – Door swing in an exam room

Section 2.1-3.2.1.2 (2)(a)(ii) requires the exam room to accommodate a minimum clearance of 2 feet 8 inches at the foot and sides of the exam table or recliner.

Question: Can the exam room door swing into this 2'-8" clearance when it opens into the room?

Response: Yes, the door can swing into this clearance when it opens into the room. Once the door has been closed, as it would be when an exam takes place, the door no longer infringes on the clear floor area and thus does not impede the function of the room.

Further Comments

Health system architect: I see no problem with the door swing impeding on the 2'8" clearance. The exams are done with the doors closed, and therefore the clearance requested is available in the room when it is needed. I believe that is the intent in the clear floor area definition in the *Guidelines* (see gray box to the right).

Architect: If a 2'-8" door—with the clearance between stops—meets accessibility requirements, it is an allowed opening size. The *Guidelines* glossary definition for "clear floor area" applies to Section 2.1-3.2.1.2 (2)(a)(i). This definition clearly states that "Door swings and floor space below sinks, counters, cabinets, modular units, or other wall-hung equipment that is mounted to provide usable floor space count toward 'clear floor area.'" This clarification was added to the glossary in the 2018 *Guidelines* as a result of an earlier interpretation request.

2018 FGI *Guidelines* Glossary

Clearance: The required minimum distance between a specified object (e.g., a patient bed or exam table) and any fixed or immovable element of the environment. ***Note:*** Movable equipment and furniture that do not interfere with functions or could be easily moved out of the way are not used to calculate minimum clearance.

Clear floor area: The floor area of a defined space that is available for functional use excluding toilet rooms, closets, lockers, wardrobes, alcoves, vestibules, anterooms, and auxiliary work areas. ***Note:*** Door swings and floor space below sinks, counters, cabinets, modular units, or other wall-hung equipment that is mounted to provide usable floor space count toward "clear floor area." Space taken up by minor fixed encroachments that do not interfere with room functions can be included in calculating clear floor area.

AHJ: A door alone can be used to provide privacy; however, privacy is dependent on context. I believe that is why the actual requirement is very non-specific. The appendix note gives us some of that context—solid doors, no windows in the door. The function, layout, and character of the space also contribute to the provision of privacy. If an exam room is arranged so a door alone won't provide sufficient privacy, the actual performance would compel us to look at it more closely. These are special conditions. Overwhelmingly, though, most exam rooms do not need a privacy curtain in addition to a door.

Architect: See the definition of clear floor space [in the comment above]. This is a question we have encountered from different AHJs and received clarification regarding the matter. I believe the definition of clear floor area adequately expresses that in the 2018 edition.

AHJ: Door swings into the clear floor area are not an issue for new construction.
Rooms are required to be handicap-accessible so even though FGI doesn't require it, the clearances can become a moot point at times.

Health system architect: Privacy for our exam rooms is not an issue because our design template places the exam table farther into the room. Our use of a sliding door also eliminates the door swing clearance issue.

REQUEST

Guidelines edition: **2018 Outpatient** *Paragraph references:* **2.1-3.5.1.3 (1)(d)**

Question: There is a conflict between the control room door requirements for hybrid ORs and Class 2 and 3 imaging rooms in the 2018 Hospital *Guidelines* (see explanation just following). Should the exception to omit the control room door permitted for the hybrid OR also be permitted for imaging rooms?

> **Walls and a door required between control room and OR or imaging room:** Section 2.2-3.3.4.3 ([Hybrid OR:] Control room) and Hospital Section 2.2-3.4.1.3 (1) and corresponding Outpatient Section 2.1-3.5.1.3 (1) ([Imaging Services: General] Shielded control alcove or room) require walls and a door between a control room and a hybrid OR or Class 2 or 3 imaging room.
>
> **Exception to omit door for hybrid OR:** Section 2.2-3.3.4.3 (2) permits this exception: "The door shall not be required where the control room serves only one operating room and is built, maintained, and controlled the same as the operating room." This exception does not appear in the imaging section.

Response: It is acceptable to omit a door between the control room and a single Class 2 or Class 3 imaging room when the entire space is maintained at the same ventilation standards. It appears the HGRC missed the opportunity to coordinate this issue when updating the imaging requirements for 2018, but it is the task group's view that the intent was the same for a control room serving a single OR and for a control room serving a single imaging room.

The task group agreed this discrepancy should be addressed by adding the second sentence currently in the hybrid OR text at 2.2-3.3.4.3 (2) to the imaging text in Hospital Section 2.2-3.4.1.3 (1)(d) and in Outpatient Section 2.1-3.5.1.3 (1)(d), as shown below.

As a result of this change, the task group found the language in paragraph (1)(e) confusing and

unnecessary as paragraph (1)(d) now addresses the issue of room pressurization, stating that the control room and imaging room will be "maintained" and "controlled the same."

***2.1-3.5 Imaging Services**
***2.1-3.5.1 General**
...
***2.1-3.5.1.3 Radiation protection....**
(1) Shielded control alcove or room....
...
(d) The control room shall be physically separated from the Class 2 or Class 3 imaging room with walls and a door. The door shall not be required where the control room serves only one imaging room and is built, maintained, and controlled the same as the imaging room.
~~(e) Where an imaging room requires positive (or negative) pressure, a door shall be provided between the control room and the imaging room.~~

NOTICE

Guidelines edition: **2018 Outpatient** *Paragraph reference:* **2.1-3.5.2.1 (3)**

A correction was made to the cross-reference in Section 2.1-3.5.2.1 (3) to space requirements for imaging rooms used for Class 3 procedures (see the excerpt from the 2018 Outpatient errata sheet below). In the process of making this correction, it was noticed that the space requirements for a Class 3 imaging room in the 2018 Hospital and Outpatient *Guidelines* documents differ. It was the intention of the Health Guidelines Revision Committee that requirements for imaging facilities in hospitals and outpatient facilities be the same. Thus, to bring the Outpatient space requirements for a Class 3 imaging room into alignment with the same requirements in the Hospital document, the task group agreed the language shown below should be added to the Outpatient text.

[The additional language comes from Section 2.2-3.3.3.2 (2) (Operating room for image-guided surgery using portable imaging equipment or surgical procedures that require additional personnel and/or large equipment) in the 2018 Hospital *Guidelines*, which is cross-referenced from the Hospital requirements for a Class 3 imaging room in the corrected Hospital Section 2.2-3.4.2.1 (3) shown in the 2018 Hospital *Guidelines* errata sheet.]

2.1-3.5.2 Imaging Rooms
2.1-3.5.2.1 General
...
(3) Where an imaging room intended for Class 3 procedures is provided, ~~it~~ the following requirements shall be met:
(a) The room shall meet the requirements for the applicable imaging modality and the requirements for an operating room (see Section 2.1-3.2.3, excluding the area and clearances in Section 2.1-3.2.3.2 (Space requirements).
(b) Space requirements. Class 3 imaging rooms shall:
(i) Be sized to accommodate the personnel and equipment planned to be in the room during procedures.
(ii) Have a minimum clear floor area of 600 square feet (55.74 square meters) with a minimum clear dimension of 20 feet (6.10 meters).
(iii) Where renovation work is undertaken and it is not possible to meet the minimum standards in Section 2.2-3.4.2.1 (3)(b)(i) and (ii), these rooms shall have a minimum clear floor area of 500 square feet (46.50 square meters) with a minimum clear dimension of 20 feet (6.10 meters).

Note: Although the task group doesn't believe 500 square feet is sufficient for a Class 3 imaging room, it was agreed that issue will need to be addressed during the 2022 *Guidelines* revision cycle for both the Hospital and the Outpatient documents.

Excerpt from the 2018 Outpatient *Guidelines* errata sheet:

PAGE	SECTION	ERROR	CORRECTED TEXT
80	2.1-3.5.2.1 (3)	**2.1-3.5.2 Imaging Rooms** **2.1-3.5.2.1 General** … (3) Where imaging ~~procedures meeting Class 3 criteria are performed, a room(s) that~~ meet~~s~~ the requirements for applicable imaging suite and for an operating room (see Section 2.1-3.2.3) ~~shall be provided~~.	**2.1-3.5.2 Imaging Rooms** **2.1-3.5.2.1 General** … (3) Where an imaging room intended for Class 3 procedures is provided, it shall meet the requirements for the applicable imaging modality and the requirements for an operating room in Section 2.1-3.2.3 (Operating Rooms), except for Section 2.1-3.2.3.2 (Space requirements).

REQUEST

Guidelines edition: **2018 Outpatient** *Paragraph reference:* **2.1-3.5.8.19 (2)(b)**

2.1-3.5.8.19 Facilities for processing ultrasound probes. Where cleaning and high-level disinfection of ultrasound probes are performed in a dedicated room or area, the following requirements shall be met:
…

(2) Where ultrasound probes are processed at the point of use or in a separate room or area using a self-contained, automated high-level disinfection unit specifically designed for ultrasound probes:

(a) Space for the device with access to an electrical receptacle shall be provided.

(b) Access to a soiled workroom with an instrument-washing sink shall be provided in the same clinical area to support probe decontamination when necessary.

Question: If a self-contained unit (Trophon) is used for probe decontamination, is a soiled *workroom* required or does the "when necessary" language in 2.1-3.5.8.19 (2)(b) mean it is up to the health care organization to decide whether or not a soiled workroom is provided? Specifically, can a soiled *holding room* be provided instead of a soiled *workroom*?

Response: Where ultrasound probes are processed in a separate room or area using a self-contained, automated high-level disinfection unit specifically designed for ultrasound probes (such as a Trophon),

the requirements in (a) and (b) apply; space for the device with access to an electrical receptable shall be provided and access to a soiled workroom with an instrument-washing sink shall be provided in the same clinical area. *A soiled workroom is required*.

Further comments

Vice president, plant services/facilities: The soiled workroom includes a sink, which is necessary in the decontamination process for the probes, even if a Trophon is used. The sink is used to wash bulk material from the probe. "When necessary" refers to when high-level disinfection is necessary, not whether the health care organization decides to include a soiled workroom. High-level disinfection triggers the requirement for the soiled workroom.

Authority having jurisdiction, state plan reviewer: These self-contained, automated high-level disinfection units are not plumbed, so any biological material that is on the probe could not be disposed of in that unit; therefore, the probes should be cleaned, when necessary, prior to being placed in the unit.

Engineering program manager, state department of health: The term "when necessary" refers to occasions when probes must be cleaned in an instrument-washing sink before high-level disinfection. Therefore, the minimum requirement is an instrument-washing sink in the same clinical area as the Trophon. Instrument-washing sinks are generally found in a soiled workroom and not a soiled holding room.

Manager of infection prevention and control: IPC (infection prevention and control) guidelines recommend use of a probe cover with probes that will require high-level disinfection. The probe still needs to be cleaned, but generally the cover prevents gross contamination of the probe that would require a soiled workroom to remove remaining bioburden. As well, other guidelines describe means for transporting probes when and if a soiled workroom is needed. In other words, there are options when a soiled holding room would work as long as staff have access to a soiled workroom somewhere in the same clinical space. Which type of room is chosen needs input from frontline staff or clinicians who are using the space and performing the procedures. In the ultrasound area, they might have a soiled holding room; however, there needs to be a soiled workroom readily accessible (e.g., in the imaging department) to support probe decontamination when it's necessary.

Authority having jurisdiction, state plan reviewer: Probe decontamination requires provision of a soiled workroom with a sink suitable for instrument-washing (e.g., utility sink), not just a soiled holding room. The Trophon unit produces water as a byproduct "that can be disposed of in a sink" per the manufacturer's website. The appropriate fixture for such disposal is an instrument-washing sink, either in an ultrasound probe processing room or in a soiled workroom. There should not be any temptation to use (and contaminate) a handwashing station. "When necessary" means probe disinfection is not necessary after every procedure, but it is required at times; therefore, the soiled workroom shall be provided.

Assistant director, design and construction: A soiled workroom with an instrument-washing sink is mandatory. It may not be necessary to use the instrument-washing sink for every case. Saying that, provision of a soiled workroom specifically for ultrasound is not necessarily required. It shall be provided, but it can be in the same clinical area. It may only be required if the probes are being processed at the point of use or in a specific room solely designated for ultrasound probes as stated in 2.1-3.5.8.19 (2). Even so, staff need access to a soiled workroom in the same clinical area. If the ultrasound room(s) in a facility are in the same clinical area as other modalities that require a soiled workroom and that room can be accessed by ultrasound staff, a soiled holding room may be provided, if necessary, operationally.

REQUEST

Guidelines edition: **2018 Outpatient** *Paragraph references:* **2.7-3.5.9.2**

Question 1: Paragraph (2) of Section 2.7-3.5.9.2 states "The toilets in the staff changing area shall be permitted to meet this requirement." Does this limit or constrain the location of the staff changing area to be adjacent to, or have any other spatial relation to, the PACU?

Response: No. There are no location requirements for the staff changing area.

Question 2: Does a staff toilet in the staff changing area meet the requirements of Section 2.7-3.5.9.2 regardless of the staff changing area location in the facility, as long as it meets the requirements for the staff changing area set forth in other sections of the *Guidelines*?

Response: No, the staff toilet in the staff changing area does not meet the requirements of Section 2.7-3.5.9.2 regardless of location of the staff area in the facility. A staff toilet room must be immediately accessible to pre- and postoperative patient care areas, as indicated in paragraph (1). If the staff changing area is immediately accessible to the pre- and postoperative care area, a toilet room within it meets the toilet room requirement. If the staff changing area is not immediately accessible to the pre- and postoperative care area, a toilet room within it does not meet the requirement of this section.

Further Comments

Assistant director, design and construction: I believe the intent is to have a staff toilet room immediately accessible to the pre- and post-operative patient care areas so that employees can efficiently access a bathroom and then return to their work duties. It makes logical sense that if a toilet room is provided in the staff changing area and this area is immediately accessible to the pre- and post-operative patient care areas, then the staff changing area (and its associated staff toilet room) would satisfy the requirement. The way I interpret this, a staff changing area that has a toilet room would not meet the requirement if the staff changing area is not immediately accessible to the pre- and post-operative patient care area; in this case, I would expect to see an additional staff toilet room that is immediately accessible to the pre- and post-operative patient care area in addition to the one that is located in the staff changing room.

Principal and senior medical planner, health practice director: The 2014 Outpatient document requires the staff toilet "within" the recovery areas. I believe this was a simple oversight in the update to the 2018 edition. I believe it is important for a staff toilet to be immediately accessible to a PACU, especially in smaller facilities that may have fewer staff to cover patients in the vulnerable state of Stage I recovery when a staff member is absent. Therefore, my recommended interpretation is as shown below:

2.7-3.5.9.2 Staff toilet room

(1) A staff toilet room shall be immediately accessible to pre- and postoperative patient care areas.

(2) *Where the staff changing area is immediately accessible to the pre- and postoperative patient care areas*, the toilets in the staff changing area shall be permitted to meet this requirement.

Authority having jurisdiction (AHJ), state plan reviewer: This is how I've been enforcing the requirement for a staff toilet room if it is located in the staff changing room. If the staff changing room is

immediately accessible to the pre- and postoperative patient care area, then I will allow it to be located in that changing room. Otherwise, it would not be meeting the location requirement of a staff toilet room located immediately accessible to the pre- and postoperative patient care area [as stated in Section 2.7-3.5.9.2 (1)]. Technically, it doesn't meet the definition of immediately accessible because you typically have to go through the changing area to reach the toilet room, but FGI gives that caveat by allowing the staff toilet room to be located in the staff changing room. I also require two separate rooms since they are both required to be provided.

Director of surgical services: This must have been an oversight in the 2018 Outpatient edition. For the safety of patients, it is important for the staff toilet room to be "immediately accessible" to the pre- and postoperative areas in outpatient surgery facilities, including whether this toilet is in an immediately accessible staff changing area. Therefore, my recommended interpretation is:

2.7-3.5.9.2 Staff toilet room

(1) A staff toilet room shall be immediately accessible to pre- and postoperative patient care areas.

(2) *Where the staff changing area is immediately accessible to the pre- and postoperative patient care areas,* the toilets in the staff changing area shall be permitted to meet this requirement.

Clinical lead: It is essential that the staff supporting patients in pre- and postoperative patient care areas have a staff toilet immediately accessible in order to decrease staff walking distances and the time that staff is away from the bedside of these often stressed and vulnerable patients.

My interpretation is that when the staff changing area is immediately accessible to the pre- and postoperative patient care areas, a staff toilet in that particular staff changing area shall be permitted to meet the requirement.

Authority having jurisdiction (AHJ), state plan reviewer: I do not believe a staff toilet in the staff changing area can support the post-op recovery (Phase-I PACU) if it is remote. Where the staff changing area is immediately accessible to the pre- and postoperative patient care areas, "the toilets in the staff changing area shall be permitted to meet this requirement" is actually the intent. While OP surgery facilities are generally smaller, the concern included in the Hospital *Guidelines* applies in concept: Section 2.2-3.4.5.9 requires the staff toilet room to be located in the postoperative patient care area "to maintain staff availability to patients."

Consequently, I find that given the smaller perioperative suite supporting outpatient surgery, the number of staff toilet rooms can be limited since the total number of staff in the facility is smaller. My interpretation is that **both requirements under Section 2.7-3.9.5.2 apply**. The staff toilet needs to be "immediately accessible" to the pre- and postoperative patient care area(s) and "if the staff changing area is next to the perioperative space," that toilet can be used to satisfy the staff toilet need. The staff toilet does not need to be dedicated to, or in, the perioperative suite. The toilet only needs to be "immediately accessible" as defined in the glossary. It can be in an adjacent space and serve the surgical suite as well. Paragraph (2) does not negate the conditions of paragraph (1) but does emphasize the limitation of the staff toilet count.

REQUEST

Guidelines edition: **2018 Outpatient** *Paragraph references:* **2.8-3.4.2 and 2.8-3.5.3**

Question: Is it permissible for a single room in a hospital or freestanding emergency facility to be used as both a secure holding room and an emergency department (ED) exam/treatment room? If so, what would be needed to make it possible for this room to meet the requirements of both a single-patient treatment room and a secure holding room? That is, how would such a room be made safe for patients who need a secure holding room? When FGI is adopted as state law, AHJs are very careful not to be flexible to avoid inconsistency. Clarifying this would be appreciated for *Guidelines* users and for the real need of such rooms.

Response: The *Guidelines* does not prohibit the use of a single room as both a secure holding room and an ED treatment room as long as the room meets the *Guidelines* requirements for both space types. The room design must be able to provide safety for both functions—accessibility to electrical and medical gas requirements, a hand-washing station, etc. for the treatment room and the ability to secure these services behind a closed door or panel (e.g., a rolling shutter or similar retractable panel) to meet the provisions for the secure holding room.

Further Comments

Architect: I have designed flexible rooms within the ED setting for secure holding rooms and typical treatment rooms with the gases and electrical outlets behind a secure overhead door. This design required coordination and waivers with the local AHJ to provide the flexibility typically required within EDs that cannot afford the space for dedicated secure holding rooms and/or seclusion rooms.

Behavioral health expert: An ED secure holding room is not limited to use by a behavioral health patient and can often be used to hold an agitated or not yet fully stabilized patient until a more appropriate and staffed bed is available. When these rooms will be used as both an ED treatment room and a secure holding room, they must be designed to provide safety for both functions (i.e., exam accessibility to electrical and medical gas requirements and hiding these services behind a closed door or access panel for secure holding).

But the room should also meet expectations for limiting ligature attachment (i.e., a solid ceiling or ceiling with glued or clipped-in-place tiles, impact-resistant lighting, ligature-resistant HVAC grilles, and tamper-resistant electrical outlets protected by GFIC and a remote master switch. The door to the room should have ligature-resistant hardware and, to foil attempts at barricade, swing outward or be double-acting. Lastly, any glazing material, including that in a mirror or picture frame, should be shatter-resistant and, any operable window should be limited to an opening of 4 inches.

Authority having jurisdiction: The *Guidelines* is silent on the use of an ED secure holding room (defined by Section 2.2-3.1.4.3) for any other purpose. However, if the room in question meets the requirements for both uses then, logically, the room is compliant with the *Guidelines*.

I have seen rooms provided with temporary doors, grilles, or shutters that allow the room to meet requirements for both an ED treatment room and a secure holding room. With the temporary doors down, it meets the room dimension requirements and is devoid of outlets, accessories, objects, etc. I also have approved, through the exception or equivalency concepts in *Guidelines* Section 1.1, alternate designs that have larger minimum dimensions than 11'-0". The value added by providing an additional exam room, including shorter wait times and increased access to care, warrants the increase of the maximum

dimension. An ED is typically a highly observed location. If someone is secluded, a staff person is watching them and can intervene with other means if necessary.

The original question stated that AHJs are careful not to be flexible to avoid inconsistency. If an AHJ consistently follows an equivalency or exception process that purposefully weighs the intent of the rule and the risks and the benefits of a design, then they are being consistent; the *Guidelines* permit this approach. If an AHJ determines that an exemption or equivalency is valid, then the room meets the requirements of the *Guidelines*.

Architect: A secure holding room can be used as an ED treatment room as long as all the requirements and appendix guidance are followed. The existing *Guidelines* language should allow for this dual use; however, the essence of how a secure holding room works may not be met when the two room uses are combined unless attention is paid to the location of the room. ED treatment rooms are often located on the "front lines" in the emergency department close to the triage area, but it is recommended secure holding rooms be in a more discreet location. Can these two functions work for the operations of the ED? In small settings, such as critical access hospitals, you can easily accomplish both the frontline position and discreet location for a dual-purpose or transformative room combining secure holding and examination. In larger emergency departments, accomplishing this may not be so successful.

REQUEST

Guidelines *edition:* **2018 Outpatient** Guidelines *references:* **2.13-8.2.1 and 2.13-8.2.1.2**

Question: Is it the intent of sections 2.13-8.2.1 (HVAC Systems—General) and 2.13-8.2.1.2 (Class 1 units) in Chapter 2.13, Specific Requirements for Mobile/Transportable Medical Units, to require Class 1 mobile units to meet all the standards of ANSI/ASHRAE/ASHE Standard 170: *Ventilation of Health Care Facilities*?

Response: ASHRAE 170 is not required to be applied to Class 1 mobile units. As a result of this query, the revisions of the 2018 text shown below in green have been made to the 2022 edition of the Hospital *Guidelines* as well as the 2022 Outpatient *Guidelines* in Chapter 2.13.

2.13-8.2 Heating, Ventilation, and Air-Conditioning (HVAC) Systems

2.13-8.2.1 General

~~HVAC systems shall comply with the requirements in Section 2.1-8.2 (HVAC Systems) as modified in this section:~~

2.13-8.2.1.1 HVAC equipment, ductwork, and related equipment shall be installed in accordance with NFPA 90A: *Standard for the Installation of Air-Conditioning and Ventilating Systems*.

2.13-8.2.1.2 Class 1 units. Mobile/transportable medical units that are limited to provision of noninvasive diagnostic and treatment services without use of anesthetics shall meet the following mechanical requirements:

(1) Mechanical system design

(a) A minimum indoor winter design capacity temperature of 75oF (24oC) shall be set for all patient areas.

(b) Controls shall be provided for adjusting the temperature as appropriate for patient activities and comfort.

(2) Ventilation and space-conditioning requirements. All occupied areas shall be ventilated by mechanical means.

~~(3) Where procedures or patients require positive or negative ventilation for infection prevention, the medical unit shall meet the ventilation requirements in Part 3 (ANSI/ASHRAE/ASHE 170: *Ventilation of Health Care Facilities*).~~

~~(4)~~ (3) HVAC ductwork. Air-handling duct systems shall meet the requirements of NFPA 90A: Standard for the Installation of Air-Conditioning and Ventilating Systems.

Further Comments

Health care system facility director: After hearty debate, the Hospital Document Group of the FGI Health Guidelines Revision Committee did not include the mechanical requirements of ASHRAE 170 as a minimum standard for Class 1 mobile units. The intent was for the mechanical requirements for Class 1 to control the space for patient and staff comfort as this class of unit is used for diagnostic work rather than interventional procedures.

***Health care architect and codes expert*:** I agree that a Class 1 mobile unit does not require compliance with ASHRAE 170. Class 1 mobile units should not be used for interventional procedures.