Formal Interpretations
Guidelines for Design and Construction of Health Care Facilities, 2010 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 those 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 state authority having jurisdiction.

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

Note: The HGRC Steering Committee has approved the concept that text from subsequent editions of the FGI *Guidelines* can serve as an interpretation of the intent of similar text in earlier editions.

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: **2010** *Paragraph reference:* **1.2-1.2**

Question: Is it the intent of Section 1.2-1.2 (Functional Program) that an authority having jurisdiction regulate the content of the functional program for a health care project?

Response: No, that is not the intent. The primary purpose of a functional program is to communicate the functional planning assumptions and decisions of the governing body (owner) to the designers of record for a project. The functional program is not part of the construction documents (CDs) and is not a legally binding document. An authority having jurisdiction (AHJ) may choose to use the functional program as a reference document, but this does not mean the functional program should be regulated by the AHJ.

In response to questions from *Guidelines* users, during the 2014 *Guidelines* revision cycle the HGRC put much effort into clarifying the functional program requirements in Section 1.2-1.2 (Functional Program) of the 2014 *Guidelines for Design and Construction of Hospitals and Outpatient Facilities* and the 2014 *Guidelines for Design and Construction of Residential Health, Care, and Support Facilities*. The

resulting streamlined text is considered an interpretation of what the HGRC intended with the language in the same section in the 2010 *Guidelines for Design and Construction of Health Care Facilities*.

Thus, users of the 2010 edition should follow the requirements in Section 1.2-1.2 in the 2014 *Guidelines* documents when planning hospital, outpatient, and residential health, care, and support facility projects.

REQUEST

Guidelines edition: **2010 HOP** *Paragraph reference:* **2.1-2.4.2.4 (1)(c)**

Question: We recently added two airborne infection isolation (AII) rooms to our hospital as part of a renovation project. The AHJ ruled that Section 2.1-2.4.2.4 (1)(c) requires that all edges of an AII room door (i.e., top, sides, *and* bottom) must be sealed. It was our understanding that a half-inch gap is allowed at the bottom of a negative pressure isolation room door to allow for airflow into the room to create the negative pressure. Is it the intent of Section 2.1-2.4.2.4 (1)(c) that there be no gap at the bottom of the door?

> **2.1-2.4.2.4 Special design elements**
>
> (1) Architectural details. These requirements are in addition to those in Section 2.1-7.2.2 (Architectural Details) that apply to AII rooms.
>
> (a) AII room perimeter walls, ceiling, and floor, including penetrations, shall be sealed tightly so that air does not infiltrate the environment from the outside or from other spaces.
>
> (b) AII rooms shall have self-closing devices on all room exit doors.
>
> (c) Doors shall have edge seals.

Response: It is not necessary to seal the bottom of an AII room door if the negative pressure of the room can be maintained at a negative 0.01 inches of water column (negative 2.5 pascals) without a door sweep.

Please note: This interpretation also applies to Section 2.1-2.4.2.4 (1)(c) in the 2014 *Guidelines for Design and Construction of Hospitals and Outpatient Facilities*.

Further Comments

Health care environment specialist: Sealing an AII room is extremely important. and the three edges around the door and the bottom are weak links. However, if the room is sufficiently sealed, any leakage into it from the use of a door undercut should not be an issue. The room perimeter walls, floor, and ceiling (above and below the dropped ceiling) need to be sealed to minimize infiltration. If there is too much leakage and minimum pressure is not attainable, a door sweep can be added to help obtain the required negative pressure. Sealing the room and providing a proper ventilation offset will assure pressure management. If a door with an undercut can maintain the minimum negative pressure differential (.01"WC), that is acceptable.

Facility manager (mechanical engineer): I have seen two different design paths for providing airflow to an AII room. The first is to utilize the undercut of the door to allow transfer air into the room, while providing a ducted exhaust system for the room that carries air out of the building. The second is to provide a traditional HVAC system where the supply diffuser is located near the entrance door and the exhaust grille is located near the head of the patient.

So, the bottom door sweep may be omitted if the designer thinks the undercut of the door yields sufficient clean makeup air into the room to maintain required airflow, temperature, and pressurization in the room.

Infection preventionist: Not sure I'd expect AII room perimeter barriers to be completely sealed, that is, that there would be no gap between the entry door and the floor. Most AII rooms I've seen have a narrow gap at the bottom of the door. This is permitted in the 2005 CDC TB guideline as well. The broader envelope of the room (i.e., ceiling, walls, and windows) or an improper HVAC pressure relationship to adjacent spaces is a more likely source of leakage from this space. I scanned the CDC requirements and do not see any language that specifies a complete seal between the door and the floor.

In my visits to numerous facilities, I can't recall seeing a sweep or other feature that provides a 100% seal. My sense is that release of particles carrying infectious agents would more likely come from a breach in the room envelope or improper pressure relationship to adjacent spaces than from release of these particles underneath a narrow gap at the bottom of the entry door.

Designer (mechanical engineer): Even though the HVAC system serving the room may be able to maintain the required negative pressure, the greater the aggregate size of openings in the room construction (including under the door), the greater the energy spent to maintain that pressure. Thus, the opening under the door should be the minimum required for proper door operation.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **2.1-7.2.2.5 (2)**

Question: Is it the intent of the *Guidelines* to require facilities to meet the window area requirements found in section 2.1-7.2.2.5 (2) during renovations?

Response: No, section 2.1-7.2.2.5 (2) applies only to new construction. The *Guidelines* requires a window in each patient room to allow light into the room, permit views from the room, and connect the patient with the diurnal cycle of natural light. If an existing patient room has a window providing natural light, then the facility would not be required to increase the window area in existing buildings.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **2.1-8.3.1.3 (1) and (2)**

Question: Do the requirements in Section 2.1-8.3.1.3 (1) and (2) apply to nurse call systems that use voice communication in addition to the requirements they already meet via certification under UL 1069: *Hospital Signaling and Nurse Call Equipment*?

Response: No, the 2010 *Guidelines* does not require nurse call systems to comply with a Speech Transmission Index (STI) beyond the requirements of UL 1069. Section 2.1-8.3.1.3 should be applied only to overhead paging and fire alarm intelligibility and not to nurse call systems.

Further Comments

The confusion about whether nurse call systems must comply with Section 2.1-8.3.1.3 appears to be the result of titles in the Electrical Systems section in Chapter 2.1, Common Elements for Hospitals. The title for Section 2.1-8.3.7 is "Call Systems," which discusses "hospital signaling and nurse call equipment." The acoustics requirements in Section 8.3.1.3 include a section titled "Paging and call systems." Two different groups wrote these two sections, and the meaning of the titles was not coordinated.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **2.1-8.3.4.3 (1)(a)(iii)**

Question: If an LED-type lighting fixture is used for the reading light in a patient room, is a diffuser or lens required?

Response: Yes. Neither the *Guidelines* nor the *National Electrical Code* (NEC) has modified the need for a diffuser or a lens when using LED lamps. The use of LED technology is new, and later studies may prove it does not have the same inherent risks as an incandescent or fluorescent lamp. Designers or facility managers can appeal to the authority having jurisdiction in the state where a project is being designed to see if the AHJ would grant an exception for LED fixtures.

Further Comments

AHJ: Although I agree that "there is very little danger from having these lamps exposed," the NEC does not currently exclude this type of lighting from its requirements for protection when used in overhead applications. Therefore, I don't think we can exclude LED fixtures from the requirements either.

Health care architect: Use of the word "diffuser" in this subparagraph doesn't appear to be based on the safety of the patient below the fixture; a diffuser wouldn't keep any pieces of a lamp, should it break or come apart for some reason, from dropping onto the patient. I believe this requirement was meant more to protect the visual comfort of the patient. A diffuser or lens would obscure the actual lamp in a fixture from a patient lying in the bed below it, preventing the fixture from shining directly into the patient's face. Low-voltage or not, it is still a light source which, over time, could cause discomfort for a patient. Therefore, I don't think an LED fixture should be eliminated from the requirement. This section is specific to a "reading light" in the patient room and all the clarifications in (a) (i) through (iv) are about the comfort of the patient and the accessibility of the "reading light."

Electrical engineer: These lamps are *not* "specifically designed to protect the space below"; therefore, according to the letter of the law, I think the language is currently clear. The practical question is whether there is a danger in having the lamps exposed. In my opinion, there is very little danger if they are exposed *if* they are inside a cone, that is, if they are not hanging bare and thus subject to being broken.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **2.1-8.4.3.2 (2)(b)**

Question: When measuring the "actual" area of a standard health care sink basin with an oval design, the "actual" area of a 14.3" x 12.31" [(14.375/2) x (12.31/2) x pi] sink is 139 sq. in. The sink more than meets the 9-in. minimum dimension requirement but, depending on code interpretation may not meet the minimum bowl area requirement. Is the intent of this section to define "area" as the bowl size (length x width) dimensions provided by the manufacturer regardless of shape? Or is a bowl size less than 144 inches permissible in an oval design?

Response: The bowl of the sink shall have a nominal size of 144 square inches with a minimum 9-inch width or length. This will permit standard oval designs and designs with rounded corners (both of which could have an actual bowl size of slightly less than 144 square inches) as well as bowls with curved bottoms to be considered compliant with the *Guidelines*.

The intent of this section is to provide a hand-washing sink that is large enough for clinical staff and

visitors to wash their hands without touching the sides or bottom of the bowl and to prevent splashing of potentially infectious material on surrounding surfaces.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **2.1-8.7.2.3**

Question: Is it the intent of the *Guidelines* to require interior elevator cab dimensions to meet the 5'-8" x 9'-0" as a clear dimension, or are these dimensions meant to specify the size of the platform?

Response: The intent of this provision has always been to require clear interior dimensions for patient elevator cabs. The language and dimensions given in the 2010 edition are for clear dimensions minus handrail protrusions.

Further Comments

AHJ: The elevator requirement for clear dimensions is a minimum standard and the actual use of the elevator (whether for trauma or standard patient movement) should be studied and an appropriate car size selected. Another approach to this is through considerations for patient handling and movement…the appendix in Section A1.2-4.c states, "During the functional programming phase of the project, the owner should provide an assessment of the potential risks to patients inherent in each space and building component that is to be part of the project." Perhaps including the elevator system as part of this assessment would help the architect make the decision about the size of the elevator car—whether to use the minimum clear dimension or to install a larger car.

Health care architect: We have researched two of our elevator manufacturers for cars of this size and find that Otis has two models (Gen2 Machine Roomless 5000H AIA 5'-85/16" x 9'-0" with a single front door and the same model 5000H AIA 5'-8"x 9'-0"with a front and rear door) and Thyssen Krupp has four models (Amee series 50H (AIA) 5'-8" x 9'-0" front and rear door as well as the Continental Holed 50H (AIA) 5'-8" x 9'-0" with front and rear door. Others available are Traction SPF 50H 5'-8" x 9'-0" and Senergy H 5000H 5'-8" x 9'-0"). It is important to note that Otis does not have a hydraulic car that meets this clear inside dimension and their High Rise Gearless does not comply either.

CSI standard format has a placeholder for "platform size," and it is our understanding this is related to the overall out-to-out dimensions of a car…the platform or base of a car defines its size. However, inside clear dimensions are also called for in specifications, and manufacturers most often use the inside dimensions when describing a car.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **2.2-2.12.1.1**

Question: Section 2.2-2.12.1.1 (Nursery Unit—Location) states nurseries shall be "convenient" to the postpartum nursing unit and obstetrical facilities. There is no definition in the glossary for "convenient." In Section 2.2-2.12.1.1 in the 2014 edition, the text remains the same except that "convenient" was changed to "accessible." However, as "accessible" was not defined as a stand-alone term in the 2014 glossary, the requirement was still unclear; an interpretation request was received regarding the 2014 edition, and the response below was provided; this response also applies to the 2010 edition.

Response: The intent was to locate the nursery *in* the obstetrical unit, which includes postpartum rooms, antepartum rooms, LDRP rooms, and related areas.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **2.2-2.3.2**

Question: What is the intent behind requiring all patient rooms in an oncology nursing unit to be protective environment (PE) rooms?

Response: The requirement for all patient rooms in an oncology nursing unit to meet PE room requirements was included in the 2010 edition in error. Current evidence does not justify making this a minimum requirement. See corrected language below.

2.2-2.3.2 Patient Room

2.2-2.3.2.1 Patient rooms in a cancer nursing unit shall comply with the requirements of Section ~~2.1-~~ 2.2-2.2.2 (Patient Room) ~~as well as~~

2.2-2.3.2.2 ~~a~~ Additional requirements in Section 2.2-2.2.4.4 (Protective environment room)~~.~~ shall be met for patient rooms in a cancer nursing unit that will be used for hematopoietic cell transplantation (HCT) patients. The number of these rooms shall be determined by the services to be provided as described in the functional program and an infection control risk assessment.

Further Comments

Clinician and infection preventionist: The intent was only to require PE specs for patients who are profoundly neutropenic. Current CDC guidelines recommend PE for patients undergoing HCT (hematopoietic cell transplantation or bone marrow transplant). Therefore, if the functional program specifies the facility will provide care for HCT patients, at least some rooms need to be designed with PE specs. In other words, the number of rooms designed with PE specs should accommodate the number of patients needing that type of room at any given time. [See Guidelines for Preventing Infectious Complications among Hematopoietic Cell Transplantation Recipients: A Global Perspective, *Biology of Blood and Marrow Transplantation*, 15:10 (October 2009).]

FGI oncology white paper: Immunocompromised cancer patients vary in their susceptibility to infection depending on the severity and duration of their immunosuppression, but in general they are at risk of adverse outcomes associated with infections. Regular inpatient rooms can accommodate patients with minimal immunosuppression who are not infected with an airborne microbial agent but are subject to some precautions (e.g., contact precautions). Patients who are profoundly immunocompromised, such as those undergoing HCT, require PE rooms.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **2.2-2.12.3.3 (2)(a)**

Question 1: Is it the intent of Section 2.2-2.12.3.3 (2)(a) to require a minimum clear floor area of 120 square feet per infant station?

Response: Yes, the clear floor area size was intentionally increased in the 2010 edition to a minimum clear floor area of 120 square feet per infant station.

Question 2: Is it the intent of Section 2.2-2.12.3.3 (2)(b) to require a clear dimension of 8'-0" between the headwall and 8'-0" between the bassinet and a fixed sidewall?

Response: No, the minimum clear dimensions for space around the infant station should be the same as those for the neonatal intensive care unit (NICU) in Section 2.2-2.10.2.2:

- In multiple-bed rooms, there shall be an aisle adjacent to each infant care space with a minimum width of 4 feet (1.22 meters).
- When single-patient rooms or fixed cubicle partitions are used in the design, there shall be an adjacent aisle with a minimum clear width of 8 feet (2.44 meters) to permit the passage of equipment and personnel.
- In multiple-bed rooms, there shall be a minimum clear dimension of 8 feet (2.44 meters) between infant care beds.

A few points added here for clarity:

- There is no dimensional requirement between a fixed headwall (providing utility services such as electrical, medical gases, monitoring, etc.) and an infant station.
- The clear dimension between the infant station and a fixed sidewall shall be a minimum clear dimension of 4 feet.

Further Comments

Obstetrician: The language for the continuing care bed is essentially the same as for a NICU bed—120 square feet (2.2-2.10.2.2). The bassinet would have to be no larger than 2x4 feet for a 10x12-foot area to get a boundary of 4 feet to the next 10'x12' area. This makes sense if the bed is collocated in the NICU to allow for flexing up to a NICU bed. The NICU single-bed room space requirement is 150 square feet. The *Guidelines* does not address a single-bed continuing care space.

Children's hospital planner: The text specifying a clear dimension of 4 feet on "all sides" is confusing. The intent is not to require 4 feet at the head of the infant bed; rather, that clear dimension would be between a fixed wall and the side of an infant bed. Having 4 feet between the headwall and the infant station could result in 4 feet of dangling cords to outlets from warmer or other equipment. The 4-foot requirement means there must be 8 feet between two beds for continuing care in multiple-bed nurseries.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **2.2-3.1.3.6 (3)**

Question: Section 2.2-3.1.3.6 (3) (emergency department multiple-bed treatment room) refers back to Section 2.1-3.2.2 (common element for multiple-bed examination/treatment room or area). Is it the intention that in the emergency department, this must be an enclosed room as indicated in the title or may it be a defined area as noted in Section 2.1-3.2.2?

Response: A multiple-bed treatment space can be either a separate room or a defined area in an emergency department suite. If a multiple-bed treatment space is a separate room, that room should contain patient treatment bays or cubicles only. If a multiple-bed treatment space is part of a defined area, the bays, cubicles, or rooms used for patient treatment would be in the same space as a nurse station, nourishment room, internal corridors, and so on.

Further Comments

AHJ 1: In [our state], we have always looked at this code section as allowing a large open space with cubicles separated by either hard partitions or curtains. Although the title says "Multiple-bed treatment room(s)," it does not specify or limit the size of that room, nor does it limit the number of treatment bays you may have. For this reason, we have always looked at it as a defined area, and I believe that is what is intended.

Architect: I see no reason why the multi-bed treatment area needs to have a door (i.e., be a room), even though it is typically bounded by doors. The cross-reference back to the 2.1 section, in my opinion, is to clarify what is required inside or directly accessible to the patient bay/patient care area.
I believe a traditional (and acceptable as minimum standard) ED can be open to a suite of rooms (a single large room that may incorporate other spaces such as nurse stations, nourishment rooms, internal access to other internal rooms, and fire exits, etc.). If we state this must be a room only for patient treatment separated from all other spaces, we are essentially mandating a wall separating the patient treatment areas from the nurse stations, nourishment rooms, etc. I do not believe we are mandating private treatment rooms as a minimum standard in an ED.

AHJ 2: I believe the "multiple-bed exam/treatment room" described in this section is a room defined by walls, door(s) and possibly windows. The "room" may have several individual treatment spaces within it. These individual treatment spaces may be open to the "room," that is, separated from it by curtains, cubicles, or a combination thereof. I can't find anything in the Guidelines that excludes other functions (such as a nurse station, circulation space, etc.) from being located in the multi-bed treatment room. The only thing I would question in that space would be something that is required to be in a room of its own, such as a trauma room or soiled utility room.

Facility manager: The larger area itself is a room (similar to a PACU or SACU), but it does not preclude having the area broken up into individual cubicles or spaces. The spaces can be separated by curtains (as a minimum standard) or incrementally increased in "hardness" (partitions, knee-walls with curtains, open-ended rooms) as determined by the individual organization and its needs.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **2.2-3.1.3.6 (5)**

Question: If we have a trauma room that is 250 sq. ft., can that same room also function as the bariatric room required by 2.2-3.1.3.6 (5)?

Response: Yes. The intent of the *Guidelines* is to provide adequate space for personnel to care for obese patients. The trauma room minimum space requirement meets that intent.

Further Comments

However, the HGRC members pointed out two other considerations that could affect this decision: (1) The likelihood of a facility seeing bariatric patients—Although obesity is increasing in the United States, many facilities may not serve a large population of obese patients, but facilities that do will want to consider having a dedicated room for patients of that size. (2) The availability of trauma rooms for trauma patients—Facilities need to consider whether using the trauma room for obese patients will mean it is not available for its main purpose, although areas with a sizable obese population are often served by larger facilities, which are likely to have multiple trauma rooms.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **2.2-3.1.4.3**

Question: Is it the intent of Section 2.2-3.1.4.3 (Observation unit) to permit the use of this section for a psychiatric observation unit?

Response: There is no restriction in the 2010 *Guidelines* on the type of patient who may be served in a unit designed and operated as an observation unit. Therefore, the *Guidelines* permits use of this section for a psychiatric observation unit. However, the provisions of Section 2.2-2.14 for psychiatric nursing units and applicable psychiatric safety levels also apply as necessary to assure the safety and quality of care received by patients in the unit.

Further Comments

AHJ: It's permitted but why not just build another, smaller, behavioral health unit that is dedicated to observation? Location (proximity) to the ED is not at issue but some of the FGI language (such as nurse call systems) may need to be included.

Former AHJ: As the noted section does not specify any particular type of observation unit, in [our state] we always took that to mean it could be anything needed as long as the area was properly designed to accommodate the patients intended to be served. Numerous medical centers throughout the state have psych observation units that have been designed under the 2010 and other editions of the FGI *Guidelines*. As long as all requirements for this type of patient are met or provided, there is no reason to exclude a psych observation unit.

Architect: Since the *Guidelines* is a minimum standard, a psych observation unit should be allowed, assuming it complies with the requirements for an observation unit while incorporating psychiatric safety features.

Facility manager: In general, as the *Guidelines* is a minimum standard, we would not prohibit the development of a unit not expressly described in the document. In the preamble, the *Guidelines* states that when the document is used as regulation, "some latitude be granted in complying with the *Guidelines* requirements as long as the health and safety of the facility's occupants are not compromised." We clearly allow for the creation of an observation unit and yet do not define what service types were intended to be provided. As we do not define the services in an observation unit as acute medical or psychiatric, we have left the possibility for the creation of an observation unit to meet psychiatric needs (these individuals need clinical monitoring and assessment for development of treatment considerations).

REQUEST

Guidelines edition: **2010** *Paragraph references:* **2.2-3.4.4.2 (3)**

Question: In the design of MRI suites, is it the intent of the *Guidelines* that the anteroom required by Section 2.2-3.4.4.2 (3) be located between the door to the MRI room and the control room so the tech must pass through a door and into the anteroom before reaching the MRI room door?

> **2.2-3.4.4.2 Design configuration of the MRI suite**
>
> (3) An anteroom visible from the control room shall be located outside the MRI scanner room so that patients, health care personnel, and other employees must pass through it before entering the scanning area and control room. This room shall be outside the restricted areas of the MRI's magnetic field.

Response: The intention was to require a secured area (ACR Zone-III) between the MRI scanner room (Zone-IV) and areas where unscreened individuals (Zone-II) might be. (The zones indicated are from the ACR *Guidance Document on MR Practices*.) The description of an anteroom, with view from the operator's console, was not meant to compel the creation of another room (although that would be permitted if desired), but rather to designate an area that is:

- Located within the controlled access perimeter defining Zone-III
- Visible from the operator's console
- Located prior to the entry to the MRI scanner room (Zone-IV)

In most MRI suites, the control room serves as this intermediate space and the secured area is the region of the control room between the access points to Zone-II and Zone-IV.

Changes to Section 2.2-3.4.4.2 (3) in the 2010 *Guidelines* have been made in the 2018 edition to clarify this meaning. The 2018 text, shown below, can be considered an interpretation of the 2014 language.

> **2.2-3.4.5.5 Control vestibule**
>
> (1) The control vestibule shall be located outside the MRI scanner room so that patients, health care personnel, and other employees must pass through it before entering the MRI scanner room.
>
> (2) The control vestibule shall be permitted to be either a part of the MRI control room or directly visible from the control room.

Please note: This interpretation also applies to Section 2.2-3.4.4.3 (4) in the 2014 *Guidelines for Design and Construction of Hospitals and Outpatient Facilities*.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **3.1-7.2.2.3 (1)(b)**

Question: Section 3.1-7.2.2.3 (1)(b) states that "if the outpatient facility serves patients confined to stretchers or wheelchairs, the minimum width of door openings to rooms shall be 3 feet 8 inches." Does this mean that if a patient in a wheelchair is seen in an ambulatory health care setting, that all doors that can possibly be accessed by that wheelchair patient should be 3'-8" wide, or can certain exam rooms or toilet rooms (for example) be designated as wheelchair accessible and therefore limit the number of doors at 3'-8" clear?

Response: After considerable review of Section 3.1-7.2.2.3 (1)(b) and consideration of the universal application this section has on all doors in ambulatory care settings, it is the opinion of the interpretations committee that this section should not apply to those door openings where patients are transported in wheelchairs, but only to those door openings where the care model requires patients to be transported on stretchers or gurneys.

Patients are commonly transported in wheelchairs in outpatient facilities, and it would be a tremendous burden to require all doors (corridor, toilet room, changing room, office, exam/treatment room, etc.) through which a patient in a wheelchair may need to pass to have a minimum clear width of 3'-8". It is highly recommended that federal accessibility codes be followed in ambulatory care settings to establish door widths for patients confined to wheelchairs. For example, the Americans with Disabilities Act *Access to Medical Care for Individuals with Mobility Disabilitie*s recommends on page 5:

> **Entry Doors**
> Under the ADA Standards for Accessible Design, an accessible doorway must have a minimum clear opening width of 32 inches when the door is opened to 90 degrees.

REQUEST

Guidelines edition: **2010** *Paragraph reference:* **Chapter 3.5**

Question: Is a hospital-based (included on the hospital's license), off-site urgent care facility covered under the provisions of Chapter 3.5?

Response: Yes. The intent was to have this chapter apply to both hospital-owned and -licensed facilities and privately owned and operated facilities.

Further Comments

AHJ 1: It seems appropriate for an off-campus urgent care facility to be designed the same as an independent urgent care clinic. I have not heard that the limits or extent of urgent care services or practices offered by a hospital-owned facility are different from those of an independently owned clinic. The accepted definition of an urgent care facility appears to be an outpatient clinic with longer hours but no overnight services.

AHJ 2: In my opinion, the urgent care section does apply to hospital satellites. I also agree that the standard should apply to hospital urgent care satellites. A large percentage of urgent care centers in our state are hospital-licensed satellites.