



West Virginia Construction & Design Exposition

The 2014 FGI Guidelines: A Road Map to Better Health Care Design

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Skip Gregory, NCARB
Health Facility Consulting

Introduction

The views and opinions expressed in this presentation/article are the opinions of the speaker/author and not the official position of the Health Guidelines Revision Committee.



A Brief History of The FGI Guidelines

For many years, advancements in what could be attempted in medical/surgical practice often out paced improvements in the equipment and physical plant facilities that supported this practice.

This often led to uncomfortable situations.

Surgery before the FGI Guidelines



As this poor fellow has discovered, a trip to the OR is not a walk in the park.

Infants on Display at Coney Island

Premature infants were put on display as a side-show attraction until 1943.



The Development of the Guidelines

- 1947** General Standards published in Federal Register as part of regulations required by the Hill-Burton Act. Not revised on a regular basis and with no public input.
- 1974** Renamed *Minimum Requirements for Construction and Equipment for Hospital and Medical Facilities* to indicate “minimum standards” rather than best practice. First public input was requested but still revised by federal employees.
- 1983-84** Removed from Regulation and renamed *Guidelines for Construction and Equipment of Hospital and Medical Facilities*. Still used by many AHJs and organizations, it retained some regulatory language. This was the last edition revised and published by the federal government.

The Development of the Guidelines

1987



Because President Reagan terminated the US publication after the 1984 edition, an agreement was reached to publish one more edition with AIA/AAH support. Committee included 52 members.

1992-93



After this, revision of the Guidelines would have ceased but for the dedication of 3 people, Armund Bergun, Joe Sprague, and Doug Erickson who worked to procure needed funding from DHHS, AHA and AIA. The result was a document from a multidisciplinary group of federal, state, and private content experts.

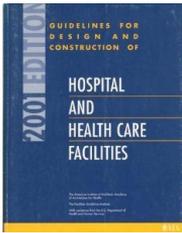
1996-97



Expanded the committee to 65 people to include more AHJs. Received over 2,000 proposals. Name changed to Guidelines for the Design and Construction of Hospitals and Health Care Facilities.

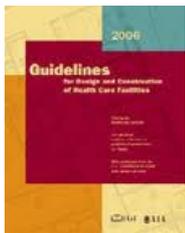
The Development of the Guidelines

2001



In 1998 the Facility Guidelines Institute (FGI) was founded as a non profit entity to manage the Guidelines development process, protect the intellectual property, and manage funding of research supporting Guidelines development. Committee expanded to 103 w/23 AHJs.

2006



Received funding from DHHS/CMS; AIA provided staff/ technical support. Name changed to Guidelines for the Design and Construction of Health Care Facilities (more facility balanced). Goal to make it more user friendly and to generate more content. Committee expanded to 124.

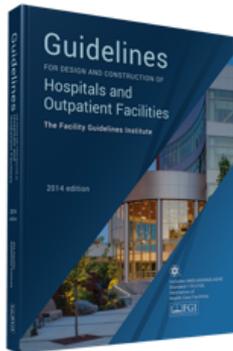
2010



Published and supported by ASHE. Reformatted again, added new chapter for ASHRAE 170, added sections on lighting, noise control, patient handling, other areas.

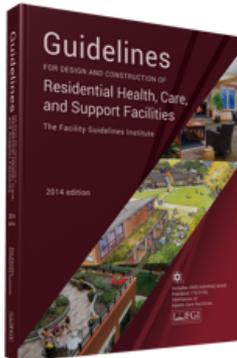
The Development of the Guidelines

2014



With the 2014 edition, the FGI Guidelines has expanded into two separate documents that include design and construction elements for a wide spectrum of health care facilities.

Book 1 is titled, *Guidelines for the Design and Construction of Hospitals and Outpatient Facilities*. This book contains design and construction information for hospitals, outpatient facilities, birth centers, urgent care centers, mobile units, cancer treatment facilities, free standing emergency facilities and dental clinics.



Book 2 is titled *Guidelines for Residential Health, Care, and Support Facilities*. This book contains design and construction information for nursing homes, assisted living facilities, independent living facilities, hospice facilities, adult day care, wellness facilities and outpatient rehabilitation facilities.

The Development of the Guidelines

The Future is Now

FGI's Continuing Mission is to:

Establish and promote consensus-based guidelines and publications, ADVISED by *research* (being revised to the broader term, *evidence*) to advance quality health care.

The Health Guidelines Revision Committee (HGRC) has just been formed to revise the 2018 Edition of FGI Guidelines. The sub committees will begin meetings this spring. Revisions to the 2014 edition will be open until October of 2015. The full HCRC will begin to meet in Spring of 2016.

- May be an additional volume for only Outpatient Facilities.
- May be a titled “Fundamentals” with “Beyond Fundamentals” volumes to follow.
- Some new concepts being explored in the NICU design
- New technologies and modalities will be considered
- Corrections and revisions to make the Guidelines easier to use and apply

The FGI Guidelines Committee



PHOTO COURTESY OF FGI

The April 2011 gathering of the 2014 Health Guidelines Revision Committee was the first all-hands meeting in the 2014 Guidelines revision cycle.

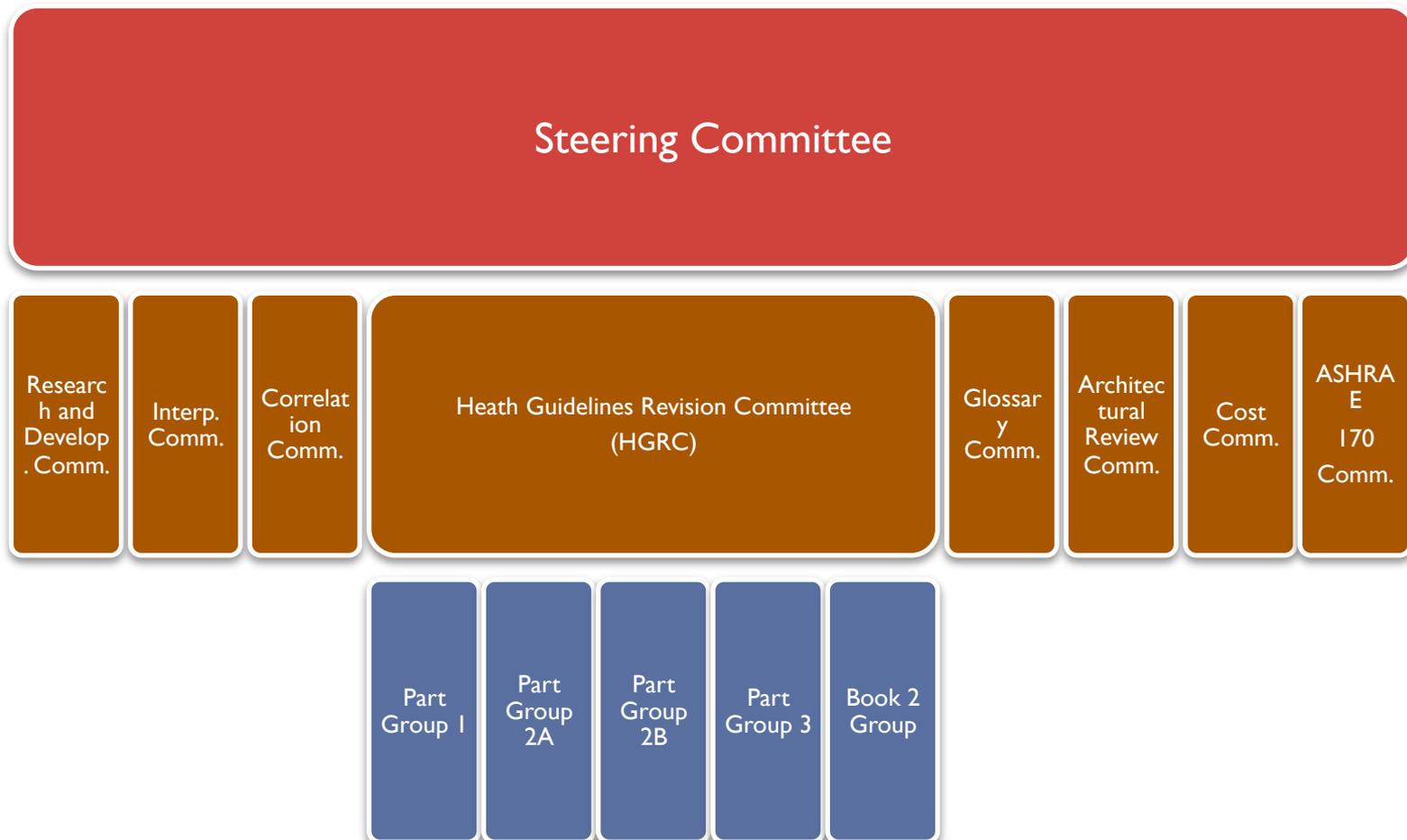
The committee now has over 118 members. With the Development of the *Guidelines*, standards have been set and best practices have been developed and codified into descriptive language design professionals can apply to new building projects.

FGI Guidelines Boards and Committees

- HGRC Steering Committee
(16 members of the HGRC)
- 17 HGRC Focus and Task Groups
- 12 Specialty Subgroups
(includes non-HGRC participants)
- Facility Guidelines Institute
(8-person Board of Directors + 1 adviser)

- All HGRC members and sub-committee participants are appointed volunteers
- No monetary compensation for HGRC members,
- All of income goes to “Guidelines” research and development

How the HGRC is Structured



Some HGRC Facts

HGRC Multidisciplinary Committees

20% - Architects

18% - Medical professionals

16% - State AHJs

13% - Engineers

10% - HC administrators/HC org. reps

8% - Federal AHJs (IHS, CMS, HUD, VA, ACE)

7% - Infection control experts + NIH/CDC

4% - Construction professionals

4% - Interior designers

How the Guidelines are Written: Performance vs. Prescriptive

Performance based: Standard states goals and objectives to be achieved and describes methods that can be used to demonstrate whether or not products and services meet the specified goals and objectives.

Prescriptive standard: Sets minimum requirement that typically prescribes materials, design and construction methods frequently without stating goals and objectives

How the Guidelines are Written: Shall versus Should

Main Body: The main body of the text contains prescriptive requirements introduced by the word “shall” and that are able to be adopted by rules or codes and enforced by Authorities having Jurisdiction (HJs).

Appendix Material: Contains “best practice” information introduced by the word “should” and is not adoptable or enforceable. Has been a place for new standards to slowly come into the Guidelines but now it is a place for additional information regarding a prescriptive requirement

Purpose of the Guidelines

To set Minimum Standards for Program, Space, & Equipment for new and renovated construction for Hospitals, Nursing Homes, Outpatient, Rehabilitation, Psychiatric, Mobile & other health care facilities

Referenced by JCAHO, PHS, IHS, HUD 242 Hospital Mortgages & Over 40 states for Licensure and/ or Accreditation of Health Care Facilities

Standards set forth in the *Guidelines* shall be considered **minimum** and do not prohibit designing facilities and systems that exceed these requirements where desired by the governing body of the health care facility.

What is Minimum?

Difficult to define...

Minimum standard: The *Guidelines* is considered to be a series of minimum consensus requirements for the design and construction of new or renovated health care facilities.

In many instances, health care organizations may need to exceed these guidelines to meet the clinical or staff needs for a safe and effective environment. A health care organization's functional program must address the need to exceed the stated minimums (scalability).

What is Minimum?

Difficult to define...

- Risk of being too minimal
- Risk/benefit for new minimum
- The minimum benchmark changes over time

Organization of the Guidelines

- Organized into **Parts, Chapters, Sections, Paragraphs**
 - **Parts:** There are 4 Parts: General, Hospitals, Outpatient Facilities and Ventilation (ASHRAE 170)
 - **Chapters:** Each part is divided into several chapters. The first chapter contains Common Elements that appear in two or more Chapters. (e.g. Part 2 has 6 distinct types of hospitals)
 - **Sections:** Major headings under each Chapter. (e.g. Nursing Units)
 - Paragraphs and subparagraphs: The details with-in each section
 - **Appendix** material always starts with an “A”
 - **Remember:** First Consult the *Contents* pages

Major Revisions to the 2014 Edition

Book 1: *Guidelines for Design and Construction of Hospitals and Outpatient Facilities*

Part 1 General:

- Revised and regrouped sections in a more logical order.
- Safety Risk Assessment (SRA) Combines the ICRA, PHAMA, Patient Fall Prevention, Medication Safety, and etc under one heading

Part 2 Hospitals:

- Requirements for Small Primary Care Hospitals incorporated into Acute & Critical Access Hospitals.
- New Chapters for Free Standing Emergency Departments & Children's Hospital

Major Revisions to the 2014 Edition

Part 3 Outpatient Facilities:

- Deleted, relocated and added types of Outpatient Facilities including:
- Deleted Small Primary Care Facilities
- Relocated Birth Centers, Mobile Units
- Added Dental Clinic
- Retained and revised Office Based Surgery
- Left Outpatient Surgical Facilities as Chapter 3.7

Part 4 Ventilation of Health Care Facilities:

- Incorporated the 2013 edition of ASHRAE Standard 170: Ventilation of Health Care Facilities

Major Revisions FGI Guidelines 2014

Location terminology

(terms for relationship to an area or room)

In	Located within the identified area or room
Directly accessible	Connected to the identified area or room through a doorway, pass-through, or other opening without going through an intervening room or public space
Adjacent	Located next to but not necessarily connected to the identified area or room
Immediately accessible	Available either in or adjacent to the identified area or room
Readily accessible	Available on the same floor as the identified area or room
In the same building	Available in the same building as the identified area or room, but not necessarily on the same floor

Functional Program

- There were 679 references to the functional program in the proposed 2014 edition
- 2001 edition had just under 80 references.
- FP references have become a way to get information into the document without it being an actual requirement
- A task force was created to specifically reduce the number of the references.
- Now less than 100 references

Functional Program

Because the Guidelines must provide requirements for all hospital functions, not all hospitals will use all of the requirements.

Those will be determined by the functional program is typically reference as “the number, type and location of *[widgets]* shall be determined by the functional program.

State licensure rules may dictate the parts and pieces required for a particular hospital design

Functional Program

The functional program is referred to in many different ways: “If the program requires...” *or* “if required by the functional program” you shall provide... Then the requirements are given but not in the appendix.

If it must be provided because it is part of the functional program, then these are the parts and pieces that it must contain.

Functional Program in the 2014 Edition

When is Functional Program Required?

- New construction, major renovations, and projects that change the functional use of any facility space
- Completed as part of the project planning phase and updated, as needed, throughout the design and construction phases.
- Facility shall retain the functional program with other design data to facilitate future alterations, additions, and program changes.

Functional Program in the 2014 Edition

What is the Functional Program?

The functional program is a very important first step to health care design. It shall serve as the basis for the project design and construction documents

- Develops direction for design team
- Records decisions
- Assesses organizational priorities

Who Should do it?

The governing body shall be responsible for developing, documenting, and updating the functional program

Why is it done?

Shall be used to determine the application of the Guidelines when developing facility projects

Functional Program in the 2014 Edition

Nomenclature:

The names for spaces and departments used in the functional program shall be consistent with those used in the Guidelines for Design and Construction of Hospitals and Outpatient Facilities. If acronyms are used, they shall be defined clearly.

The names and spaces indicated in the functional program shall also be consistent with those used on submitted floor plans.

Functional Program in the 2014 Edition

What is it?

- Functional Program Executive Summary
- Purpose of the project
- Project Type and Size
- Construction Type/Occupancy and Building Systems
- Project Components and Scope
- Indirect Support Functions
- Operational Requirements
- Architectural Space Requirements



Major Revisions FGI Guidelines 2014

Patient Safety was addressed in the 2010 edition.
It has become a central Focus in the 2014 Edition

Revisions for Patient Safety 2010 Edition... Single Patient Rooms



Revisions for Patent Safety

2010 Edition...More hand washing facilities



Revisions to the 2014 Edition Safety Risk Assessment (SRA)

The SRA is a multidisciplinary, documented assessment process intended to proactively identify hazards and risks and mitigate underlying conditions of the built environment that can contribute to adverse safety events.

These conditions include:

- Infection Control Risk Assessment (ICRA)
- Patient Handling and Movement Assessment (PHAMA)
- Patient Fall Prevention
- Medication Safety
- Behavioral and Mental Health (Patient Injury and Suicide Prevention)
- Patient Immobility Risk Assessment (PIRA)
- Security Risks

Seven Safety Risk Assessments

(Not just for Patients in this Edition)

Table 3: FGI Guidelines Requirements for Safety Risk Assessment (SRA) Components

Assessment	Facility Type/Area	Project Scope	FGI*
Infection control risk assessment (ICRA)	All	1. New construction	1.2-3.2
		2. All renovations	
Patient handling and movement assessment (PHAMA)	Where patient handling, transport, transfer, and movement occur	1. New construction	1.2-3.3
		2. Major renovation and renovations changing functional use of space	
		3. Minor and minimal renovations where patient handling occurs	
Patient fall prevention	Any area to which a patient or family member has access	1. New construction	1.2-3.4
		2. Major renovation and renovations changing functional use of space	
		3. Minor and minimal renovations where patient falls may occur	
Medication safety	Medication safety zones	1. New construction	1.2-3.5
		2. Major renovation and renovations changing functional use of space	
		3. Minor and minimal renovations where medication preparation, processing, and distribution occurs	
Psychiatric injury and suicide risks	Any area where behavioral health patient care is provided	1. New construction	1.2-3.6
		2. Major renovation and renovations changing functional use of space to include the care of behavioral health patients	
		3. Minor and minimal renovations where behavioral health patient treatment occurs	
Patient immobility	Inpatient	1. New construction	1.2-3.7
		2. Major renovation and renovations changing functional use of space to inpatient use	
		3. Minor and minimal renovations where inpatient care occurs	
Security risks	All	1. New construction	1.2-3.8
		2. All renovations	

*References to the 2014 *Guidelines for Design and Construction of Hospitals and Outpatient Facilities*

Safety Risk Assessments

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Safety Risk Assessments

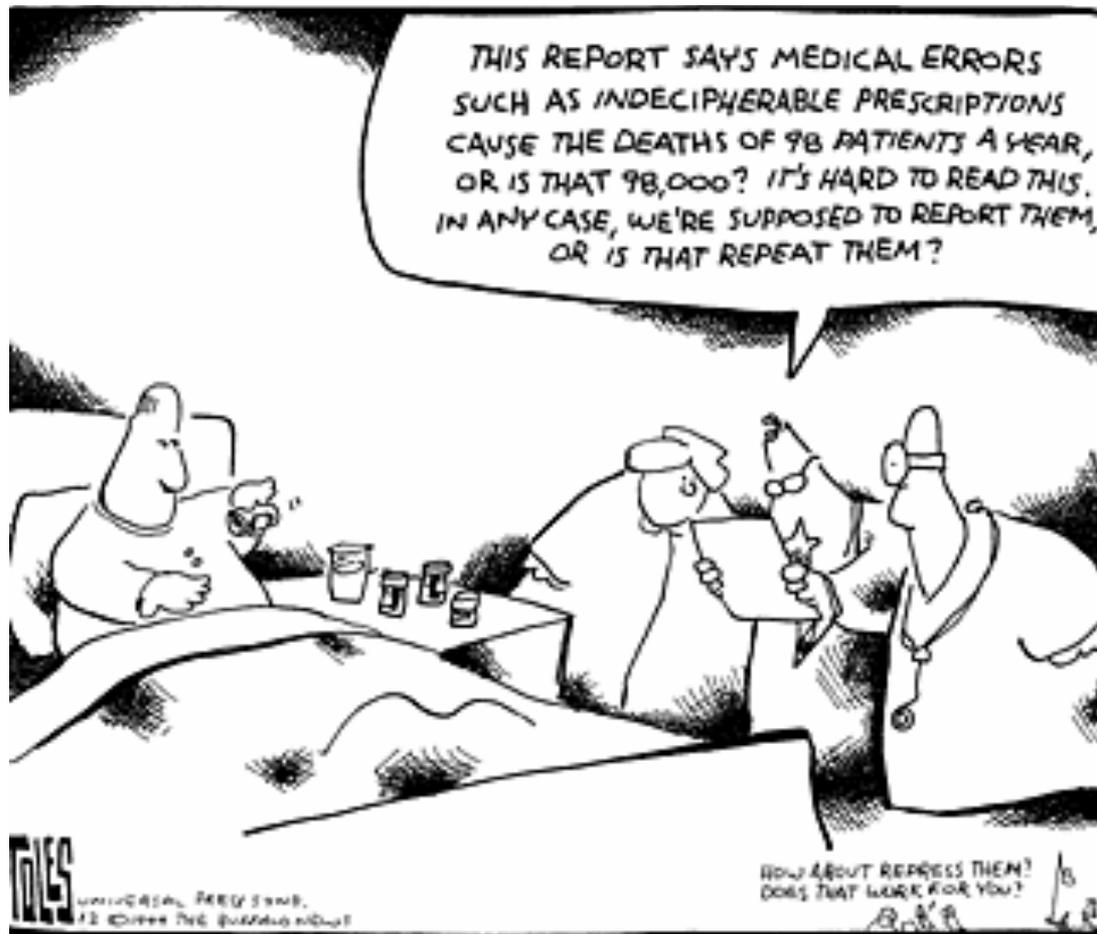
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Safety Risk Assessments

For further information on
Safety Risk Assessments
visit the FGI website and read at:

<http://www.fgiguidelines.org/2014articles.php>

Revisions for Patent Safety Medication Safety Zones



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Medication Safety Zones

- Medication errors are among the most common mistakes in health care delivery today, with huge costs to both patients and the health care system.
- The 2014 *Guidelines* includes new requirements for assessing medication safety risks and identifying and designing *medication safety zones*.
- The goal is to help owners improve safety outcomes and reimbursement under CMS's Hospital Value-Based Purchasing Program.

Medication Safety Zones

As defined in the *U.S. Pharmacopeia-National Formulary* (USP–NF), a Medication Safety Zone is:

A critical area where medications are prescribed, orders are entered into a computer or transcribed onto paper documents, or medications are prepared or administered.

Medication Safety Zones



Medication Safety Zones

Architectural Features:

- Located out of the circulation paths to minimize distraction
- Organized so that staff can access information and perform required tasks
- Shall have work counters to perform all tasks
- Lighting designed in accordance with Chapter 1066 of the USP-NF for all medication work areas
- Shall meet the acoustic design criteria of Section 1.2-5.1

Medication Safety Zones

Architectural Features:

- A documentation area that also serves as a medication safety zone shall meet the requirements of Section 2.1-2.6.6 (Medication Safety Zone).
- A medication preparation room, self-contained medication dispensing unit, or automated medication dispensing station can serve as a medication safety zone as long as they meet all the requirements above and the specific requirements for the room or dispensing unit.

Medication Dispensing Station

Omniceil Cabinet



Operating Room Classification Revisions

Old Classification:

The current classifications are adapted from the American College of Surgeons publication 04GR-0001: *Guidelines for Optimal Ambulatory Surgical Care and Office-Based Surgery* developed by the Board of Governors Committee on Ambulatory Surgical Care and published in May 2000. This classification was primarily based on the anesthetic requirement.

Class A operating rooms provide for minor surgical procedures requiring only topical or local anesthetics with minimal sedation (preoperative oral or intramuscular sedative).

Class B operating rooms provide for minor or major surgical procedures under conscious sedation.

Class C operating rooms provide for major surgical procedures requiring general or regional anesthesia and support of vital bodily functions.

Operating Room Classification Revisions

The new classifications are based on the invasiveness of what is being done with the patient and the resultant risk of infection.

The new classifications are:

- **Examining Rooms**
- **Procedure Rooms**
- **Operating Rooms**
- With this classification, a short-duration general anesthetic can be administered for a cardioversion or an ECT in a very small space, essentially an Examining Room.
- Various levels of sedation and general anesthetics would be permissible in an interventional GI or radiological suites (Procedure Rooms) that do not require the same airflow or sterility requirements of an operating room.
- This should be of particular interest to office-based practitioners.

Operating Room Size

Bigger is not always better

The HGRC realized that:

- The *Guidelines* are meant to be minimum standards with patient safety (risk of infection), first and foremost.
- Size creep was introduced into each new version of the *Guidelines*

Examination Rooms

Examination Room:

- Each single-bed examination room shall have a minimum clear floor area of 120 square feet with a minimum clear dimension of 10 feet.

Procedure Rooms

Procedure Room

- A room designated for the performance of procedures that are not defined as an invasive procedure and do not require location in the restricted area of a surgical suite but may use sterile instruments or equipment.
- Procedure rooms shall have a minimum clear floor area of 150 square feet with a minimum clear dimension of 12 feet.
- Endoscopic procedure rooms shall have a minimum clear floor area of 200 square feet.

Interventional GI – 400 sf



Hospital Operating Rooms

- Each operating room shall have a minimum clear floor area of 400 square feet with a minimum clear dimension of 20 feet.
- Image-guided surgery occurs in rooms equipped with advanced audiovisual technology. Surgical procedures that may require additional personnel and/or large equipment include some cardiovascular, orthopedic, and neurological procedures.
- (a) Operating rooms of this type shall have a minimum clear floor area of 600 square feet with a minimum clear dimension of 20 feet.

Anesthesia Workstation



Da Vinci Robot



Operating Room Size

Hybrid Operating Rooms:

- A minimum clear floor area of 650 square feet is recommended for a hybrid operating room. However, the size of a hybrid operating room is highly dependent on the functional requirements of the room as an operating environment as well as the requirements of the imaging equipment it contains, which generally increase the room area requirements.

Interventional Cardiology – 800 sf



Control Room – 120 sf



Hybrid Operating Room

A room that meets the definition of an operating room and is also equipped to enable diagnostic imaging before, during, and after surgical procedures. Imaging equipment is permanently installed in the room and may include MRI, fixed single-plane and bi-plane tomographic imaging systems, and computed tomography equipment.

Note: Use of portable imaging technology does not make an OR a hybrid operating room.

Hybrid Operating Rooms

New section

- Clear dimensions
- Structure
- Control rooms
- Equipment rooms
- Vibration control

Hybrid OR – 1200 sf



Hybrid OR – 1200 sf



Sterile Processing

No More “Sub-Sterile” Areas



Sterile Processing

OR Flow / Sterile Processing

- Decontamination area and clean work area in a sterile processing room
- One-way traffic flow of “dirty” to “clean”
- Doorway between clean core and operating room

Appendix:

- *One-way traffic flow of “dirty” to “clean” materials/ instruments helps decrease the potential for cross-contamination of sterile instruments.*

Staff Changing Areas has Changed

"Staff changing areas shall be provided."

~~"directly accessible to the semi-restricted area"~~



Outpatient Surgical Facilities

- The previous designation as a Class A operating room is now called a Procedure Room.
- The operating room for outpatient surgery has been reduced from the Class C requirement of 400 sf to 250 sf.
- When operating rooms require more staff and/or larger equipment, such as orthopedic and neurological procedures, it must be sized to meet the clearance recommendations (as large as 600 sf).
- The PACU is an unrestricted area but must have a direct connection of the semi-restricted areas of the surgical suite.
- No more “one way traffic” through the staff locker rooms. These rooms are simply located in the unrestricted area. A control point is still required to monitor movement into the semi-restricted areas.

Freestanding Emergency Facilities

- A freestanding Emergency Facility is an off site emergency department physically separated from the hospital emergency department but that provides all of the same comprehensive emergency services as the hospital emergency department on a 24/7 basis.
- Because it is an extension of the emergency department of the hospital, many Authorities having Jurisdiction (AHJs) require it to meet all hospital design and construction standards for Life Safety.
- It must have at least one Observation bed with full cardiac monitoring and all of the support services found in the emergency department of the hospital.

Building type description

FGI Guidelines (2014) A2.3-1.1

- A freestanding emergency facility provides emergency care in a facility that is located away from an acute care hospital. It must be owned by a hospital or a separate entity not affiliated with a hospital. Freestanding emergency care facilities owned by hospitals provide emergency care 24/7 days a week and receive ambulance patients.

FSED Growing in Numbers

HEALTH CARE REFORM



Health Facilities
Management
February 2015
2015 Hospital
Construction
Survey

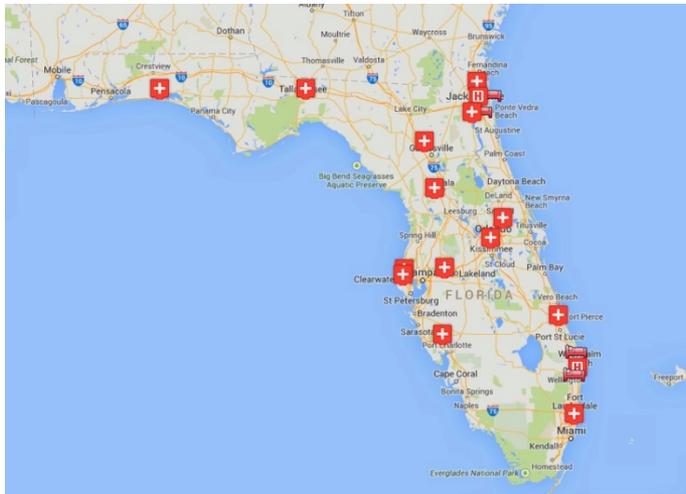
Florida's FSEDs

There are 16 Florida hospitals that have FSEDs

There are a total of 18 FSEDs in the State

Some are located in underserved areas

Some are located near competing hospitals



- Locations of the FSEDs around the State of Florida

Florida's FSEDs



Tallahassee Memorial Hospital
Free Standing Emergency Department

Florida treated an ED as an ED as an ED...

FSED just like the ED
inside the hospital

Same services provided

Same reimbursements

Same patient protections

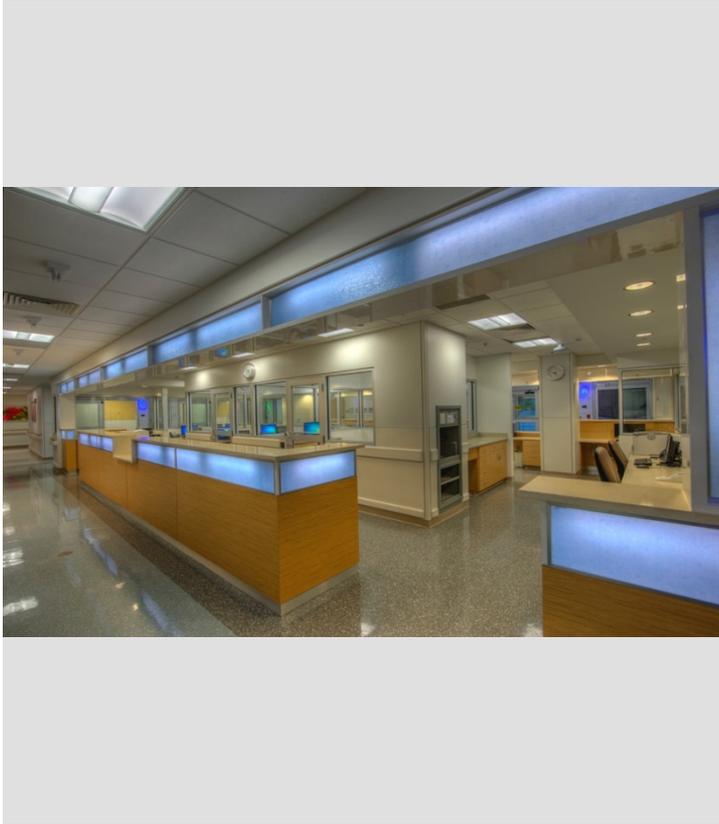
Florida's FSEDs



Same construction codes and standards as a hospital
Revised Florida's "Hospital Rule" to require I-2 FBC & Health Care Occupancy NFPA

Tallahassee Memorial Hospital
Free Standing Emergency Department

Florida's FSEDs



Referenced the *FGI Guidelines* for design requirements.

Including:

Nurse station with exam/
treatment rooms located
around it

Tallahassee Memorial Hospital
Free Standing Emergency Department

Florida's FSEDs

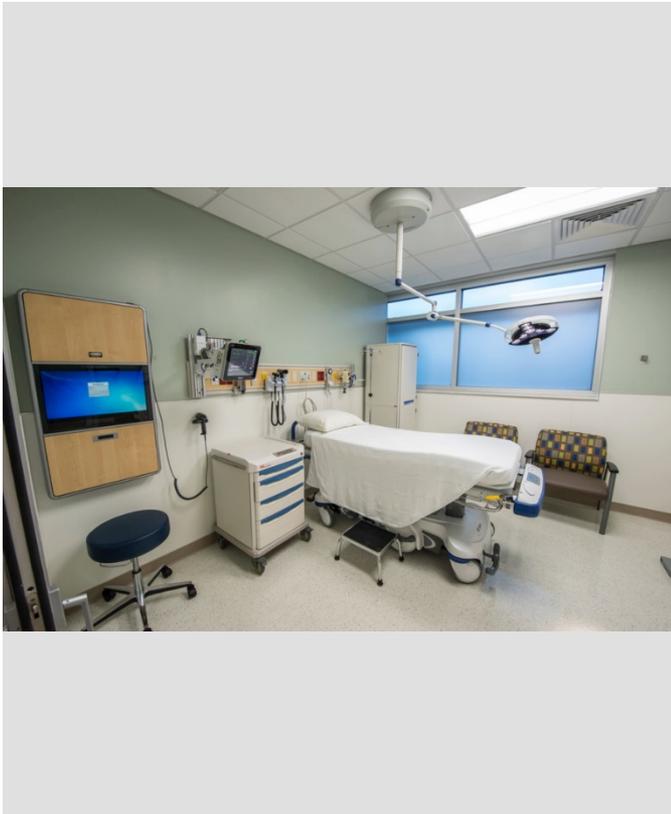
Must provide a triage room.

This is an example of a pediatric triage room.



Tallahassee Memorial Hospital
Free Standing Emergency Department

Florida's FSEDs



Must provide exam/
treatment rooms

Must accommodate bariatric
patients

Has one A.I.I. room for
separation of suspect air
borne diseases

Tallahassee Memorial Hospital
Free Standing Emergency Department

Florida's FSEDs



Must provide a trauma room.

In this example, the room was designed with space for the family to promote

Family Centered Care

Tallahassee Memorial Hospital
Free Standing Emergency Department

Florida's FSEDs



Must provide the same services as the hospital ED such as CT scan room

Tallahassee Memorial Hospital
Free Standing Emergency Department

Florida's FSEDs



Must provide a covered ambulance entry with an emergency wash down shower and direct entry to the trauma room area.

Tallahassee Memorial Hospital
Free Standing Emergency Department

Critical Access Hospitals

Due to their size of 25 beds or less, most replacement critical access hospitals are being constructed as single-story facilities because, with few exceptions, costs tend to be less for a one-story building. Multistory construction involves vertical lift expense (elevators), additional life safety code considerations, and increased difficulty in transporting patients.

Children's Hospital

A hospital that identifies itself to the general public as a children's hospital, pediatric health care center, or pediatric center of excellence.

While most of the design requirements are still contained in Chapters 2.1 and 2.2 for General Hospitals, the Children's Hospital has additional requirements for the inclusion of the parents and family, specially designed bathing facilities, palliative care room (250 sf), patient play areas, infant feeding preparation facilities, a sedation room outside of the OR, and other specialty items that are important to children's health and safety.

Mobile Units

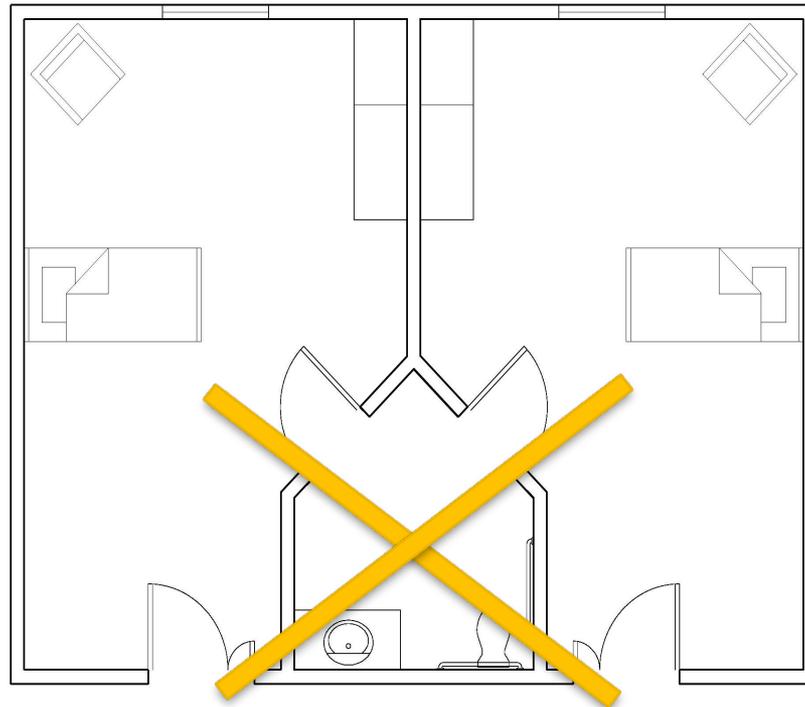
- Divided into those that provide invasive procedures such as cardiac catheterization and those that provide non-invasive procedures such as MRI or CT scans.
- The non-invasive units are exempted from meeting many of the requirements of outpatient facilities but must still have two filter banks on the HVAC units of 30 and 90 percent efficiency.
- A fire alarm system with at least one pull station must be provided in the unit.
- Emergency generator is not required unless there is life support equipment in the mobile unit.

Dental Facilities

- A new chapter covering family practice dentistry, pediatric dentistry, oral surgery, and orthodontics has been added. These are outpatient facilities where patients have less than a 24-hour stay.
- This chapter has very nominal requirements and primarily refers back to the base chapter for outpatient facilities.
- It is unclear who regulates dental facilities in most jurisdictions but these will become nationally recognized standards.

Major Changes in 2014

The patient toilet room shall serve no more than one patient room and no more than two beds.



Small Changes Worth Mentioning

Scrub station windows removed

Number of required scrub stations clearer

Hyperbaric requirements clarified and moved from appendix to the text

Inpatient facilities - handrails to be installed on both sides of the patient use corridor

Bariatric Requirements Revisions

Weight limits have been removed

Determining bariatric requirements for a project is a planning decision



Decorative Water Features

Fountains and other open decorative water features can represent a reservoir for opportunistic human pathogens.

Outdoor Water Features

- Where provided, open water features shall be equipped to safely manage water quality to protect the public from infectious or irritating aerosols.

Indoor Water Features

- Installation of indoor, unsealed (open) water features shall not be permitted.
- Covered fish tanks shall be permitted in public areas, but not in oncology nursing units.
- Decorative plant boxes or containers with live plants, dirt, or dried flowers shall not be built inside or immediately adjacent to an oncology nursing unit.



Major changes **NOT** in 2014

Nap rooms

Healing gardens

FGI Guidelines Interpretations

- Walker Duct in Cardiac Cath Procedure Rooms:

Permitted if the joint is sealed to prevent fluids from entering the duct by providing a weatherproof type of installation that would prevent moisture or debris from entering the duct. The joints must not present a tripping hazard for staff.

- Drip Pan overflow drain in Drainage Piping: 2.1-8.4.2.6

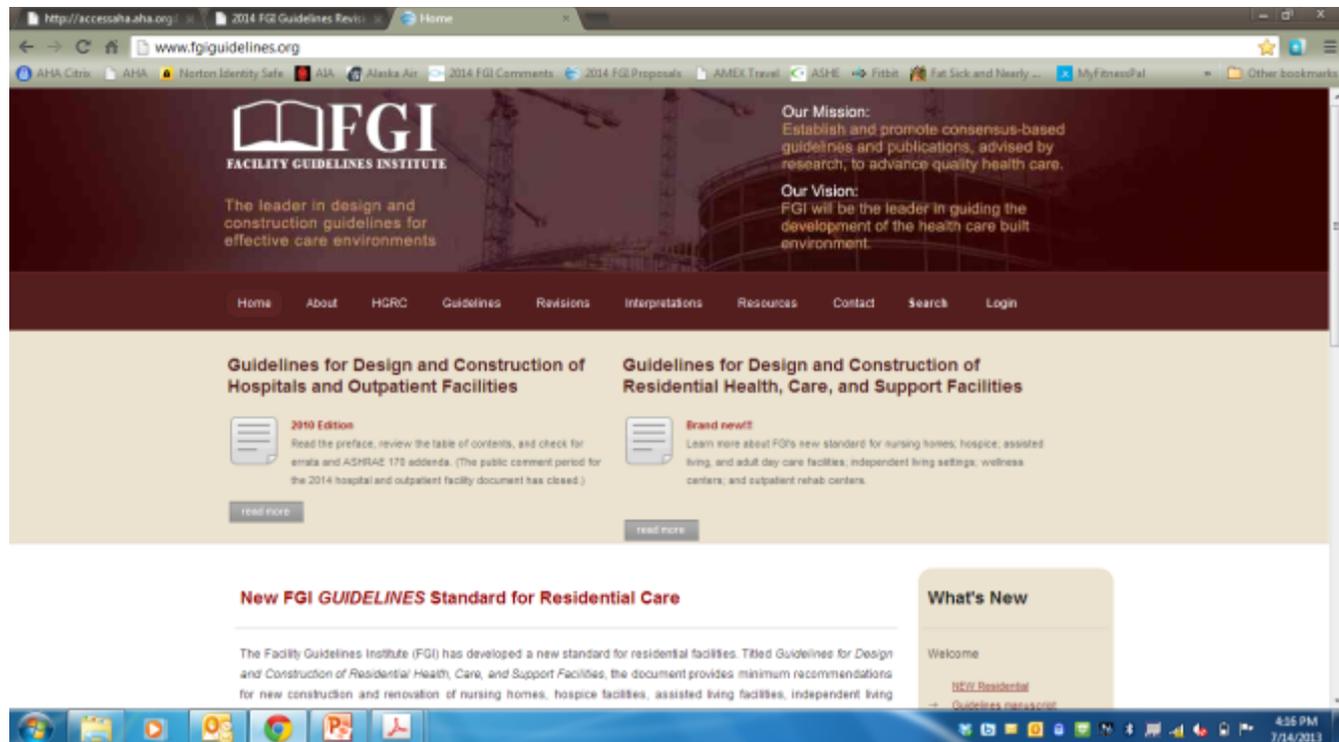
It was not the intent to require an overflow drain from the drip pan.

If one is provided, it may be necessary to empty it into the semi-restricted corridor. The FGI Guidelines makes no such design requirement and this must be approved by the local AHJ.

Go to www.fgiguideines.org for other interpretations and how to write the committee for an opinion or interpretation.

More Information

www.fgiguuidelines.org



The screenshot shows the homepage of the Facility Guidelines Institute (FGI). The browser address bar displays "http://accessaha.aha.org" and "2014 FGI Guidelines Revis...". The website URL is "www.fgiguuidelines.org". The page features a dark red header with the FGI logo and tagline: "The leader in design and construction guidelines for effective care environments". To the right, it states: "Our Mission: Establish and promote consensus-based guidelines and publications, advised by research, to advance quality health care." and "Our Vision: FGI will be the leader in guiding the development of the health care built environment." Below the header is a navigation menu with links: Home, About, HCRC, Guidelines, Revisions, Interpretations, Resources, Contact, Search, and Login. The main content area is divided into two columns. The left column is titled "Guidelines for Design and Construction of Hospitals and Outpatient Facilities" and features a "2010 Edition" section with a "read more" button. The right column is titled "Guidelines for Design and Construction of Residential Health, Care, and Support Facilities" and features a "Brand new!" section with a "read more" button. At the bottom, there is a "New FGI GUIDELINES Standard for Residential Care" section and a "What's New" sidebar with a "Welcome" message and a link to "NEW Residential Guidelines manuscript". The Windows taskbar at the bottom shows the time as 4:15 PM on 7/14/2013.



Questions?

Skip Gregory, NCARB
Health Facility Consulting
Tallahassee, Florida
gregoryskip@gmail.com