Major Revisions to the FGI 2022 *Guidelines*

Speaker:
John Williams

Vice President, Content and Outreach
Chair, Health Guidelines Revision Committee, 2026
Vice Chair, Health Guidelines Revision Committee, 2022
Facility Guidelines Institute

Executive Director, Facilities and Construction
Washington State Department of Health

Chair, Committee on Healthcare, 2011-2023
International Code Council

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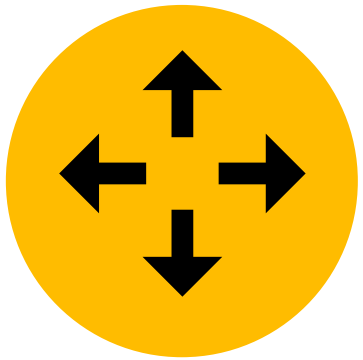
Disclaimer

The views expressed in this presentation are the opinion of the speakers and may not be the official position of the Facility Guidelines Institute (FGI) or the Health Guidelines Revision Committee (HGRC).

AGENDA

Staffing



Major changes in 2022

New Ideas for 2026

Questions

Staffing Updates

DOUGLAS S. ERICKSON, FASHE

Chair of the 2010, 2014 and 2018 editions

Immediate Past Chair 2022

CEO Emeritus of the Facility Guidelines Institute

Senior Healthcare Advisor, Specified Technologies

Retires December 2023

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Westhampton, Massachusetts
CEO

John Williams
Olympia, Washington
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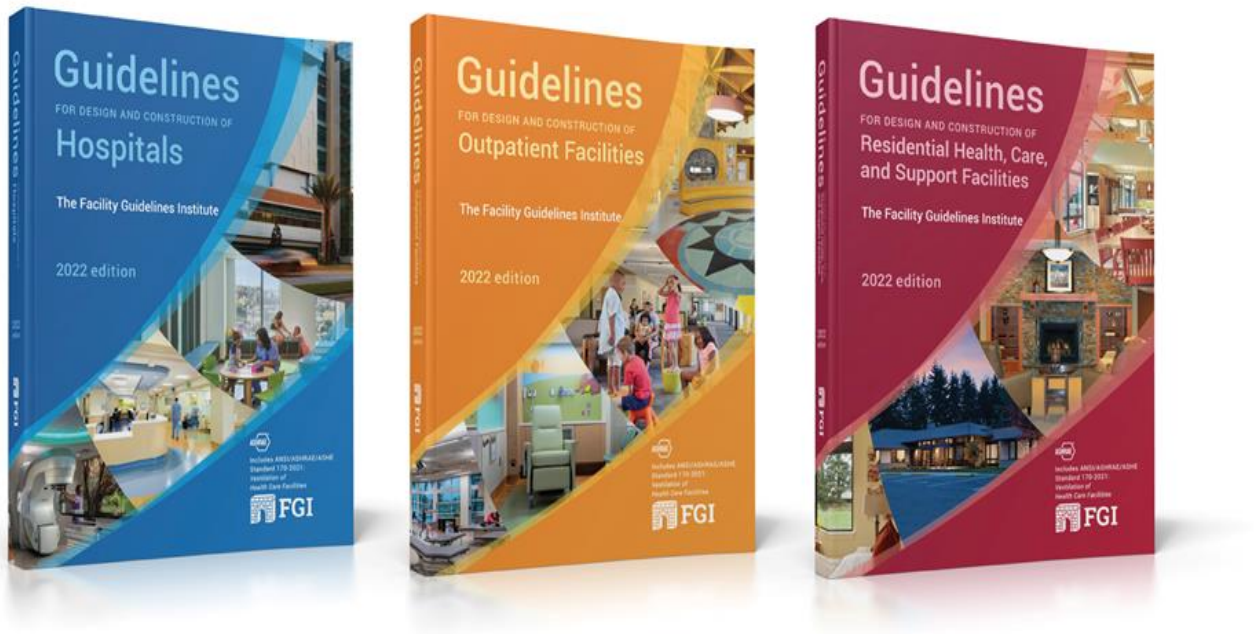
FACILITY GUIDELINES INSTITUTE

The keystone to health care planning, design, and construction

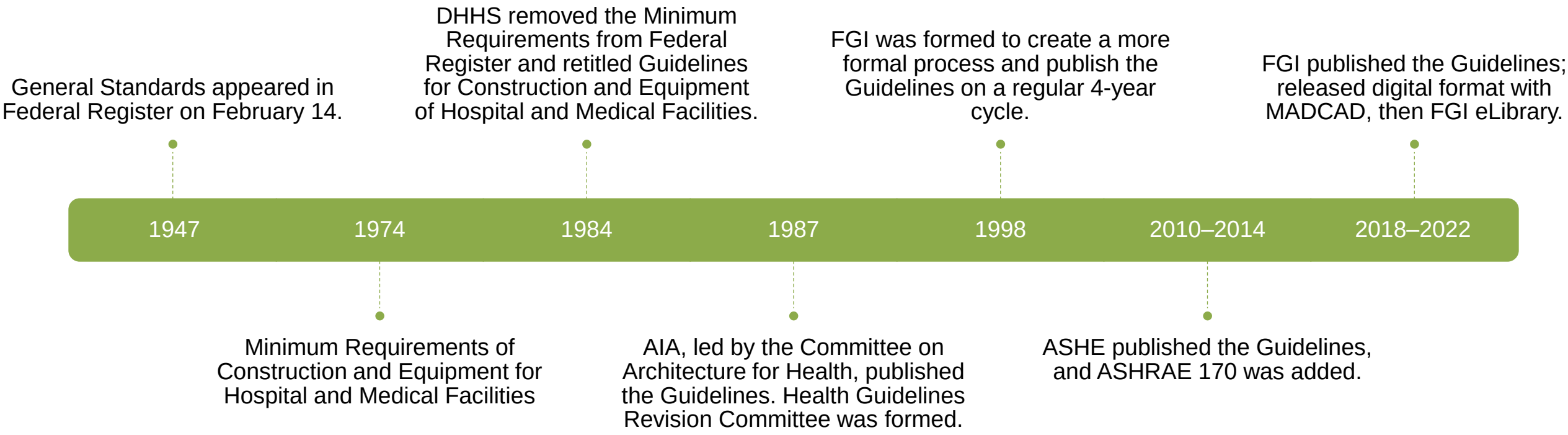


- 501(c)(3) not-for-profit

- Develops and publishes three *minimum* standards
  - New work
  - Scalable
  - Risk based
  - Standard of care
  - Safe harbor
- Various supporting resources

- Manages a public consensus process to consider revisions

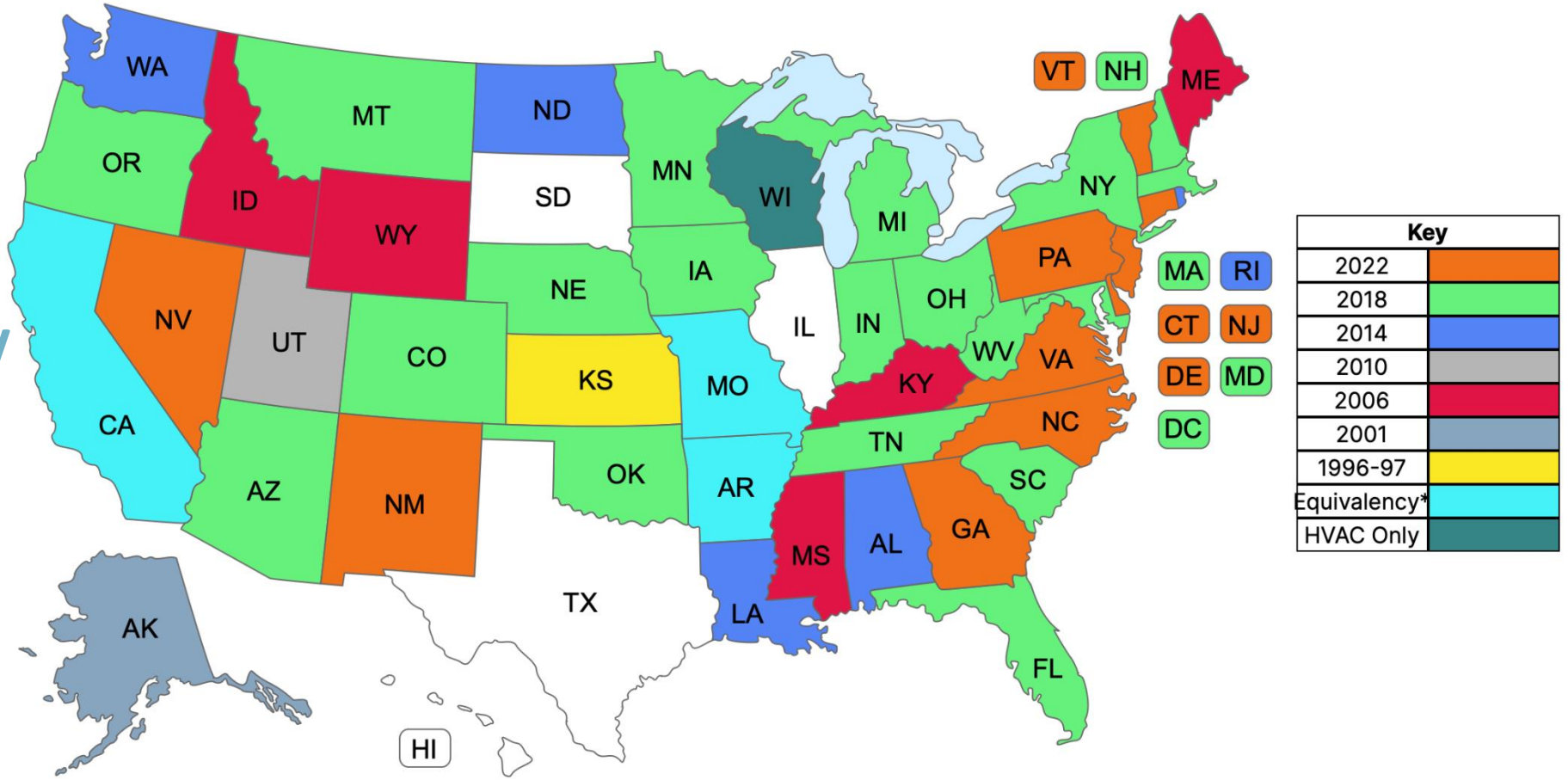
History of the *Guidelines*



State Adoption

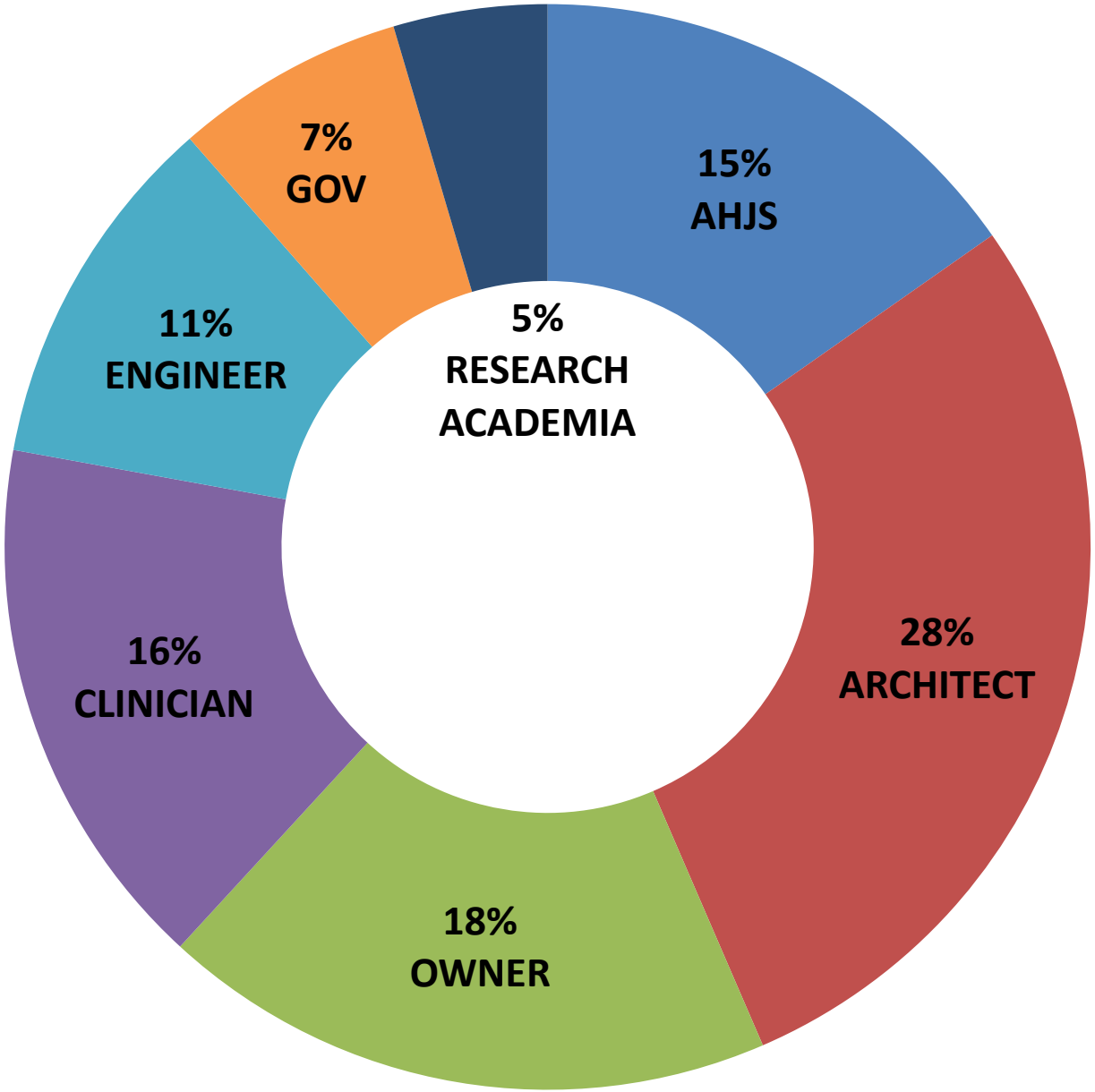
43 states have adopted some edition of the *Guidelines*.

Adoption by reference, typically by licensing agencies.

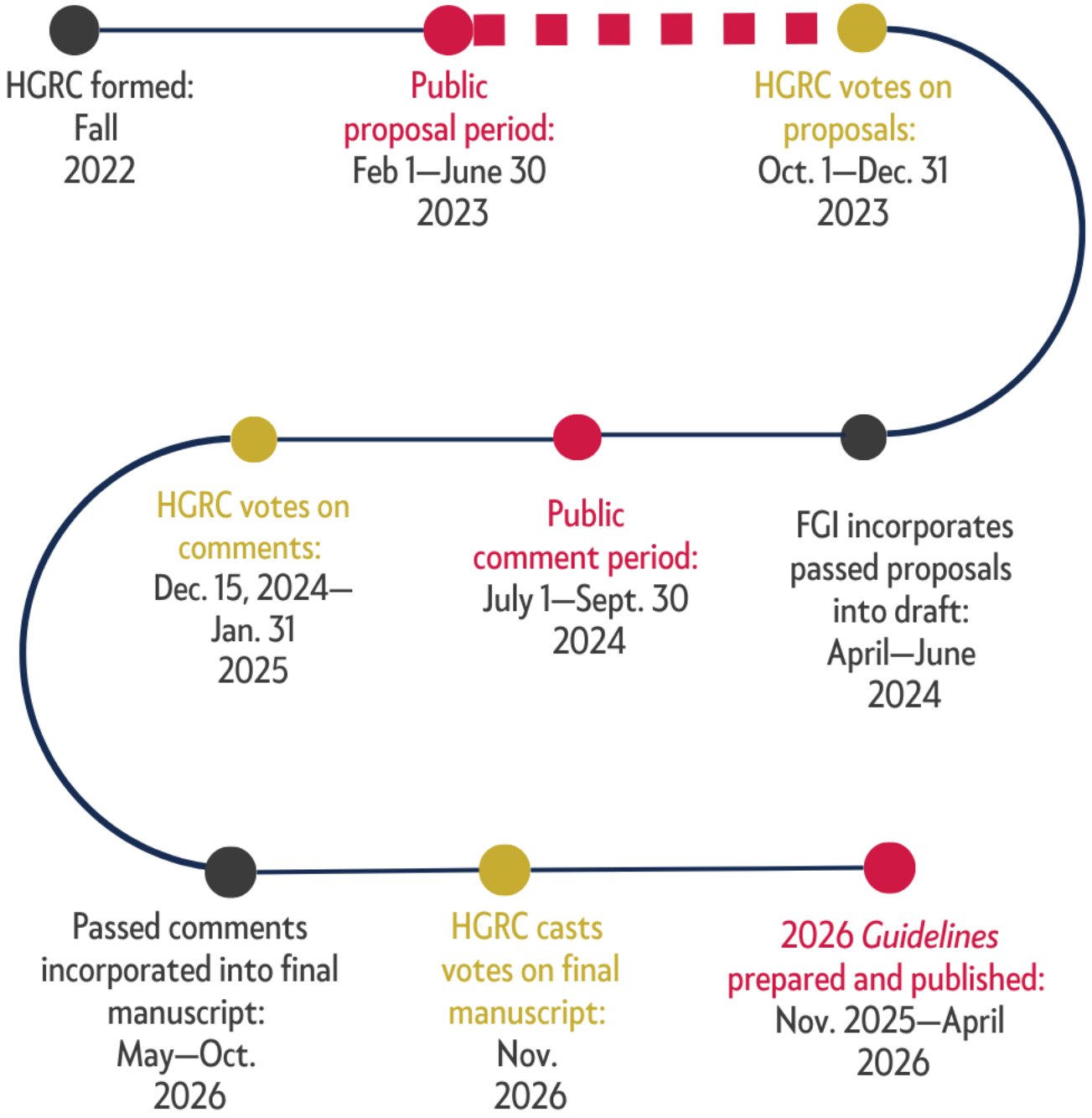


2026 FGI Health Guidelines Revision Committee

138 volunteer members



Where are we in the revision process?



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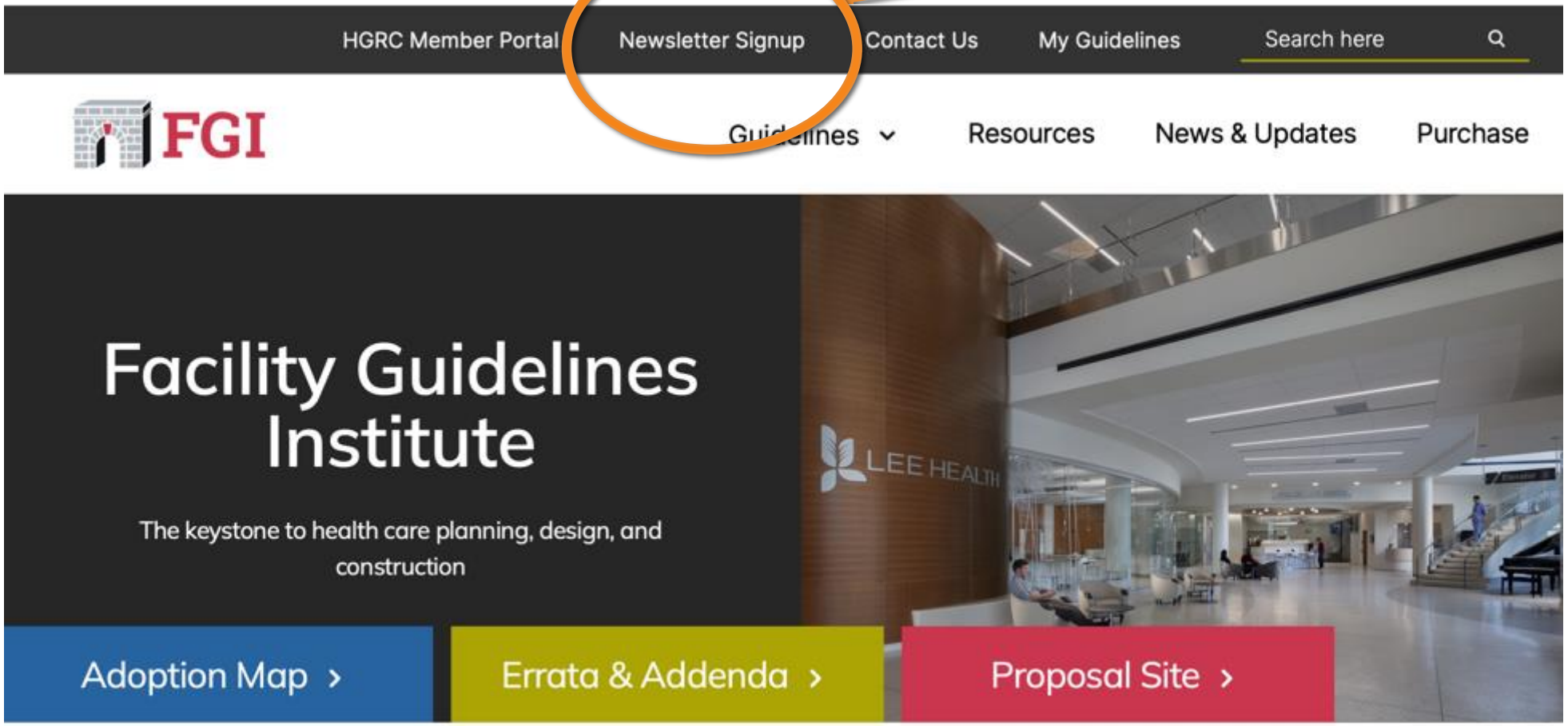
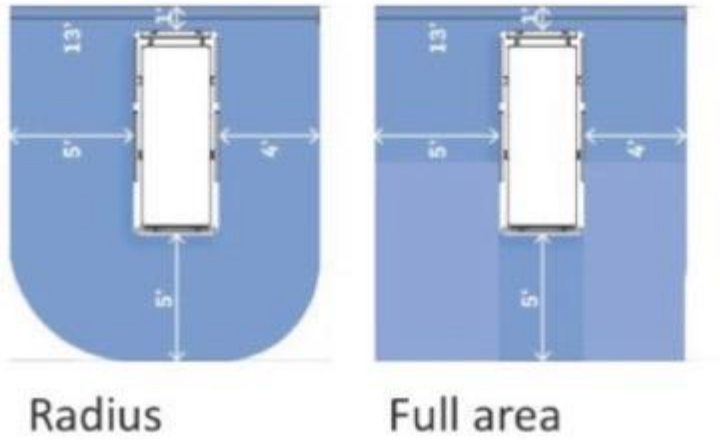
Sign up!



FGI Resources



Health Guidelines Revision Committee
A committee of the Facility Guidelines Institute

www.fgiguidelines.org
info@fgiguidelines.org

July 11, 2018

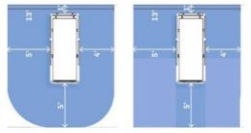
Richard Horeis, AIA
HDR, Inc.
Omaha, NE

Dear Mr. Horeis:

This letter is provided in response to your request for an interpretation of Section 2.2-2.6.2.2 (2) in the 2014 FGI Hospital/Outpatient *Guidelines*.

Question: In Section 2.2-2.6.2.2 (2), regarding clearances for critical care patient care stations, does the 5-foot clearance requirement at the foot of the bed only require clearance for the width of the bed itself, or is the clearance to be extended to include transfer side width (5 feet) and non-transfer side width (4 feet), such that the width of the clearance at the foot of the bed totals 14 feet?

Response: The clearance requirement at the foot of the bed is intended to create sufficient space for care of the patient. Space is needed around the corners of the bed to allow access and movement for equipment, staff, and family members. Staff must be able to easily move around the bed. As well, space is needed for IV and pain management systems, warmers, etc., and for use of patient lifts and gurneys. To accommodate these needs, the full dimension at the foot needs to be as wide as the clearances on the sides of the bed; however, the squared-off space this creates could be rounded off to accommodate structural or other non-movable encroachments. This response applies to all places in the *Guidelines* where clearance requirements are provided. The diagrams below may help clarify this response.



This correspondence is nether intended, nor should it be relied upon, to provide professional consultation or services.

Sincerely,

Douglas S. Erickson, FASHE, CHFM, HFDP, CHC
Chair, HGRC Interpretations Committee
314-800-7896
doug@fgiguidelines.org

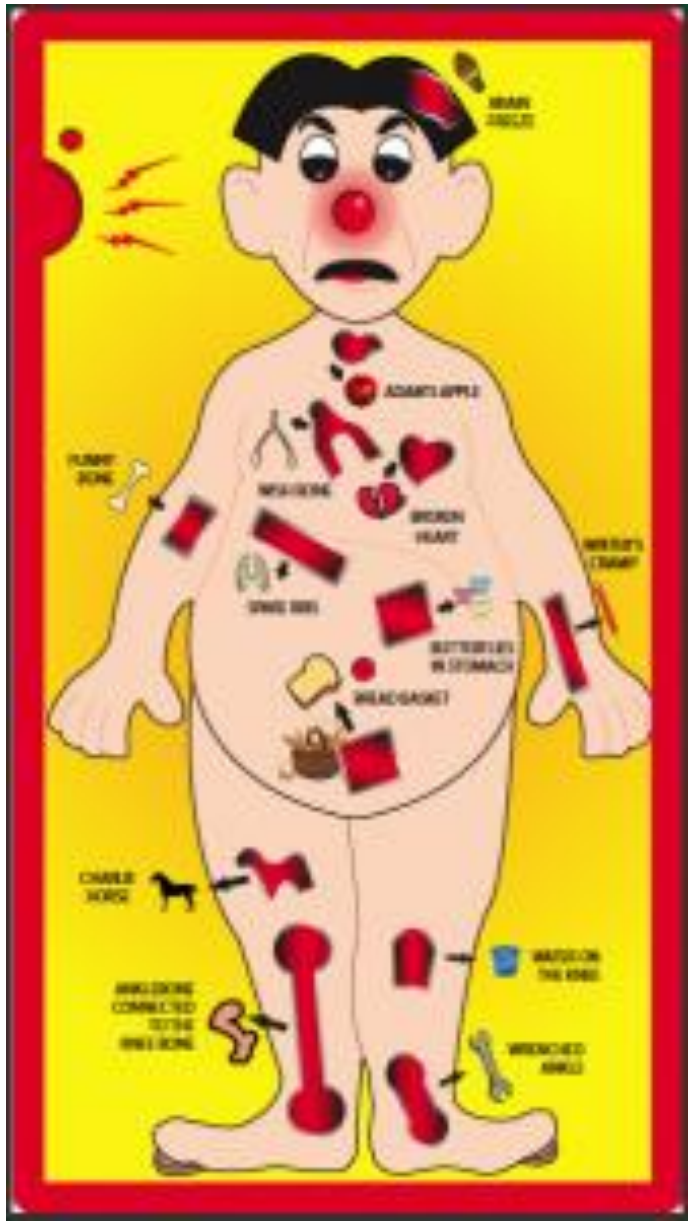
Major Updates

epic:

unusually long or great in size or scope.

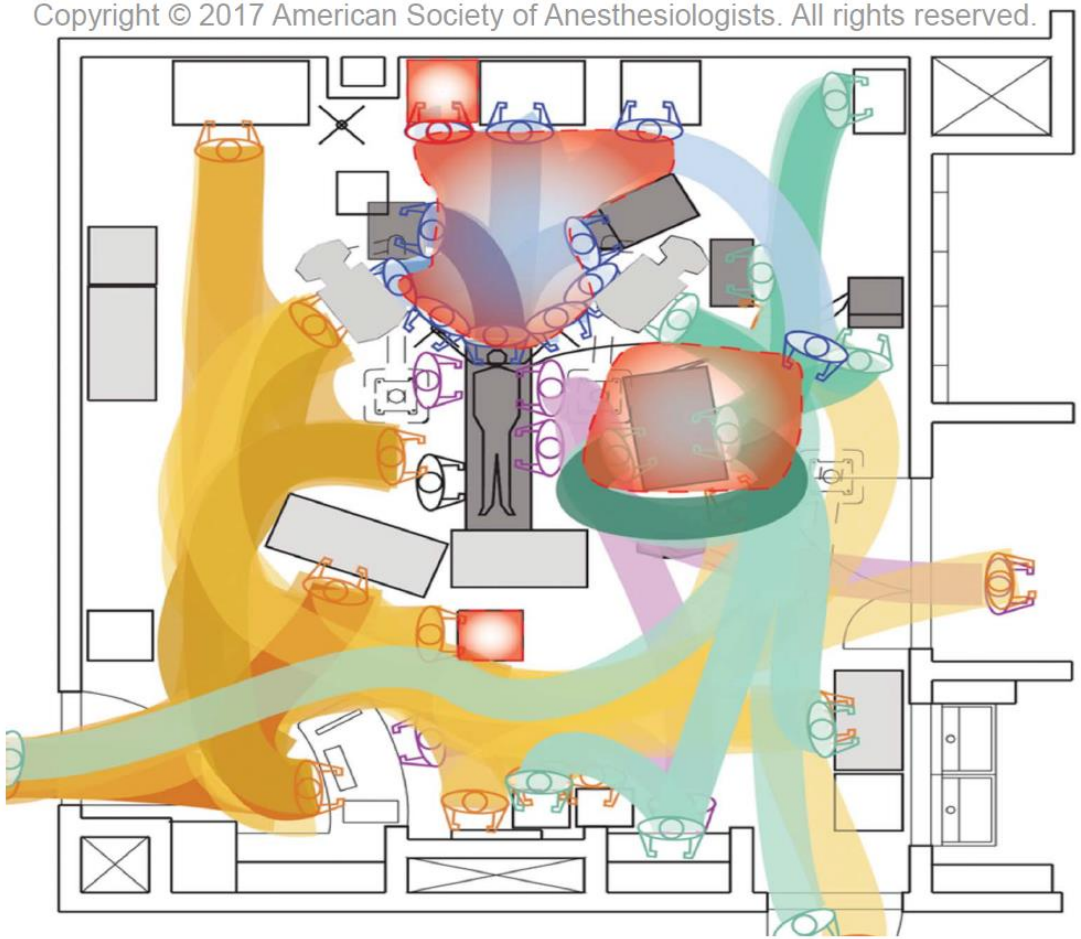
Procedure Room Debate

- What is the difference between an operation and a procedure?
- Where's the line between:
  - Exam room
  - Procedure room
  - Small operating room
  - Big operating room



1990s	2000s	2010s	2020s
Room typology	Anesthesia level	“Invasive-ness”	Sterility, environmental controls, chart + classes

STUDY BY AMERICAN SOCIETY OF ANESTHESIOLOGISTS w/ CLEMSON
Operating Room Architectural Flow Diagram



Nurses
Anesthesiologists
Surgeons
Perfusionists

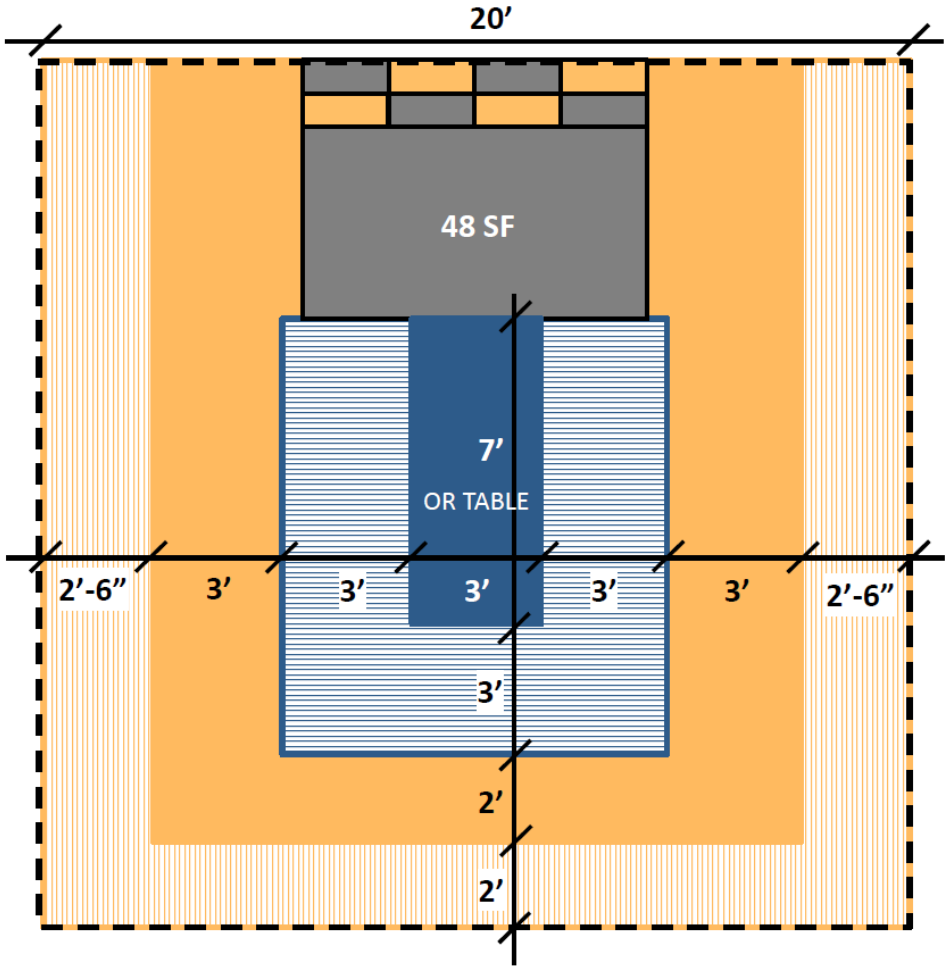
ANESTHESIOLOGY
The Journal of the American Society of Anesthesiologists, Inc.

Realizing Improved Patient Care through Human-centered Operating Room Design:

A Human Factors Methodology for Observing Flow Disruptions in the Cardiothoracic Operating Room

Anesthesiology. 2013;119(5):1066-1077.
doi:10.1097/ALN.0b013e31829f68cf

CLEARANCE ZONE DIAGRAM
OPERATING ROOM – INPATIENT

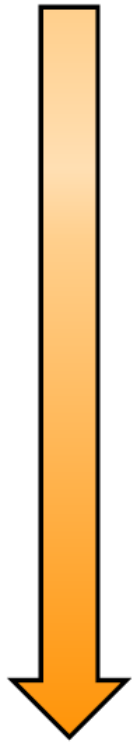


INPATIENT OPERATING ROOM

- Patient area
- Sterile field where scrub and physician work
- Circulation pathway where the circulator walks to perform duties. Cannot walk into sterile field.
- Movable equipment zone where the required movable equipment is stored and provides for door swing and opening of fixed drawers or opening of door and drawers on carts
- Anesthesia 6’ x 8’ work zone
- Gray and White area is 2’ area shared between anesthesia and circulator.
- CFA Clear Floor Area - 400 SF

3’ X 7’ Gurney for planning purposes
3’ at Sides & Foot – Sterile Field
3’ at Sides, 2’ at Foot – Circulation
2’-6” at Sides, 2’ at Foot – Equipment
20’ Minimum Width, 400 SF Minimum CFA

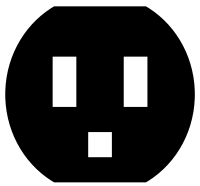
	Level of Invasiveness	Risk of Infection	Sterility of Environment	Infrastructure Room Finishes
1	Non Invasive	Low	Low, 4-6 ACH	Low
2	Limited		15 ACH	
3	Invasive, Any	High	High, 20 ACH	High



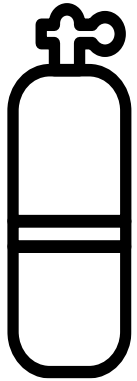
Is this an operating room?

2026

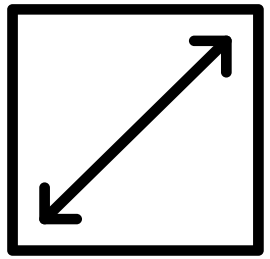
Y/N?



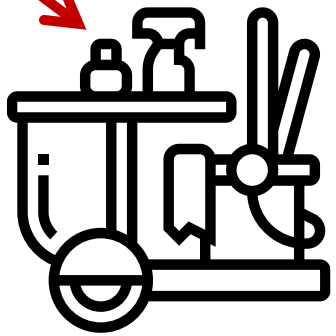
Electrical



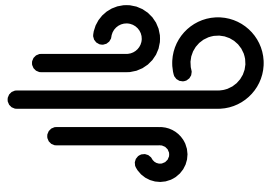
Gas



Room Size



Cleanability

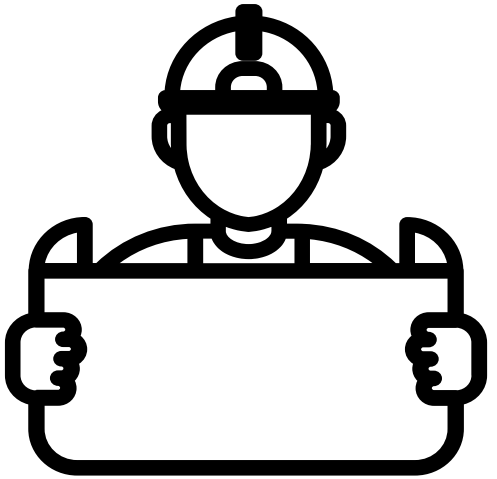


HVAC

2026

CLINICAL DECISIONS

PLANNING DECISIONS



ENGINEERING DECISIONS

Ceilings in ORs & Class 3 imaging

- Modular or prefabricated laminar flow ceiling systems if:
  - Seams / access doors gasketed
  - Structurally rated assembly
  - Access for maintenance
  - Diffuser compliant with ASHRAE 170
  - Devices and controls UL/ETL labeled

Ceilings in restricted areas

- Remain monolithic

Emergency Department

Requires **video surveillance** at public entrances to emergency facilities and **a duress alarm** where entrances may be locked.

Trauma room

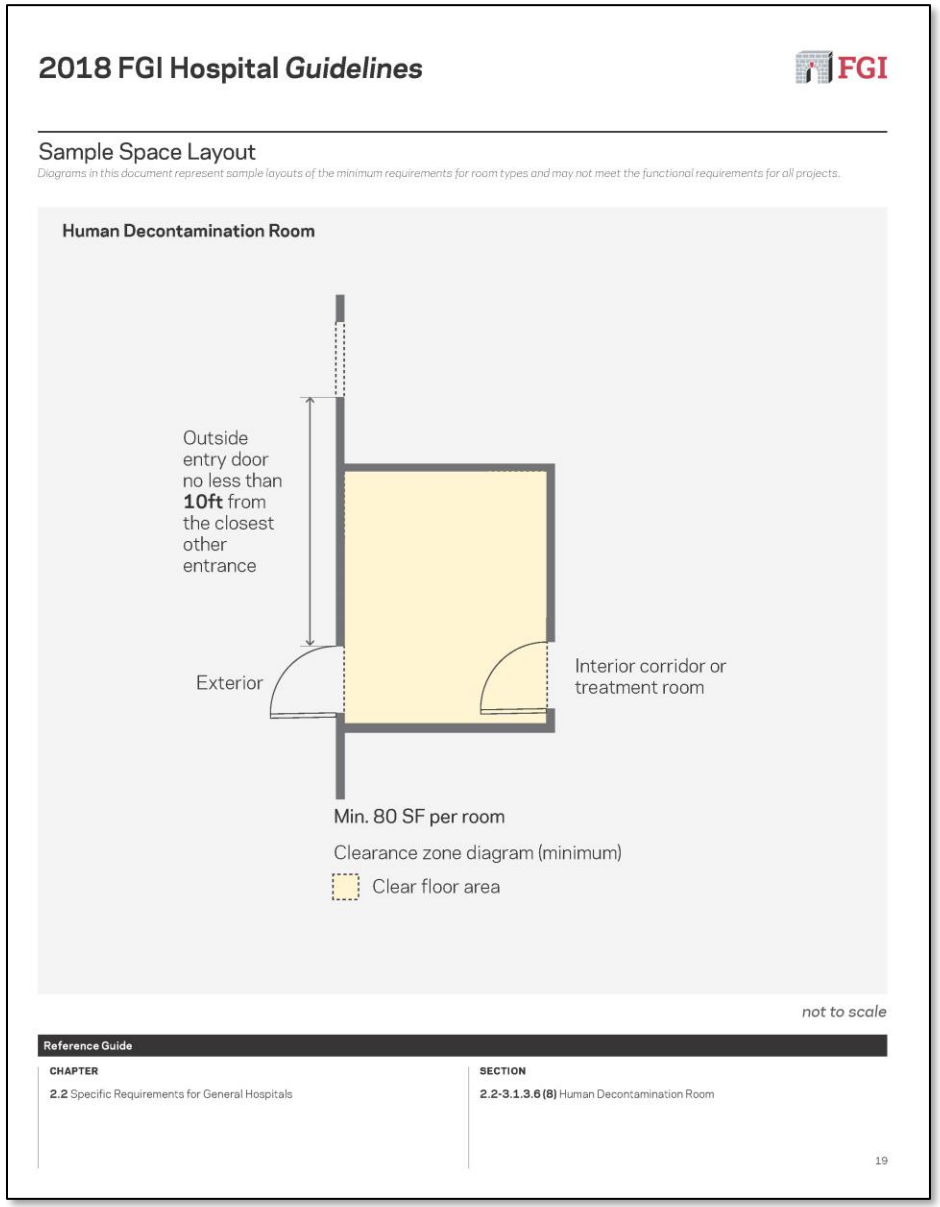
When not in use for a trauma patient, this room shall be **permitted to be:**

- **Subdivided** to provide multiple patient care stations
- **Used for individuals of size** providing it meets requirements for treatment room for individuals of size

The physical space and operational plan **must accommodate quick conversion back** to a trauma room when needed, and each resulting patient care station must meet the requirements for the service to be provided.

@ HOK

@ HOK



Emergency decontamination

Revisions of significance:

- Increased minimum size from ~~80 SF~~ to **100 SF**
- Shall be designed as a **wet location**
- Rinsate shall be prevented from leaving the room

Included are minimum requirements for exterior decontamination structures, where provided.

Emergency severity index

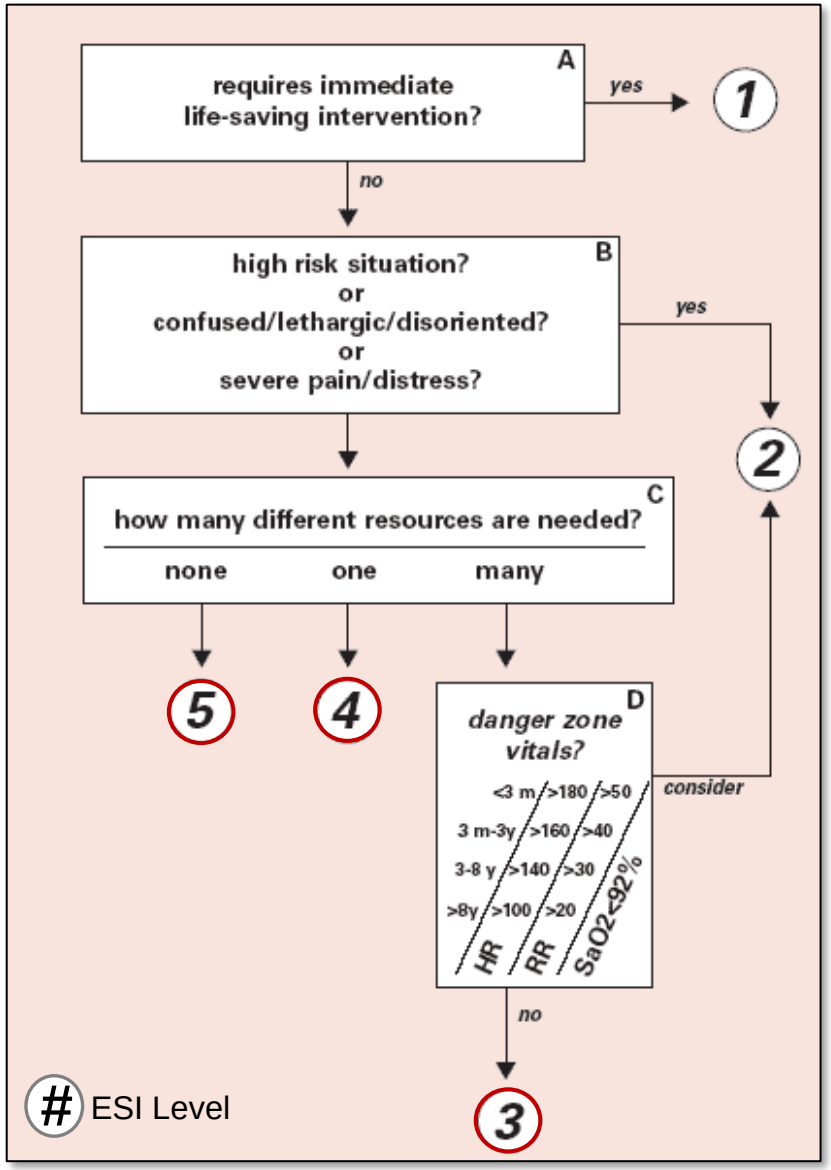
Patients generally not requiring horizontal care:

Emergency Severity Index (ESI) and physically able to sit in chair

- **Levels 4 & 5**
- **Some portion of Level 3** (estimated at ≤ 50% of patients)
- **Results waiting**

Flow RN/tech directs the patient by determining if the patient:

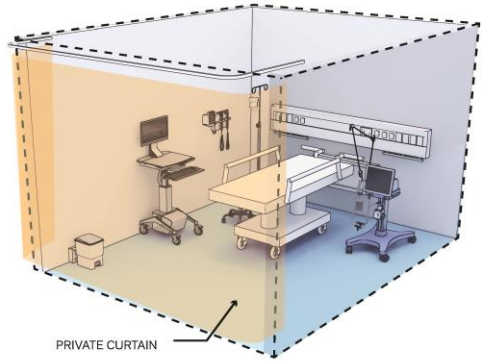
- **Needs resuscitation**
- **Is disoriented or in severe distress**
- **Is sick and need stretcher**

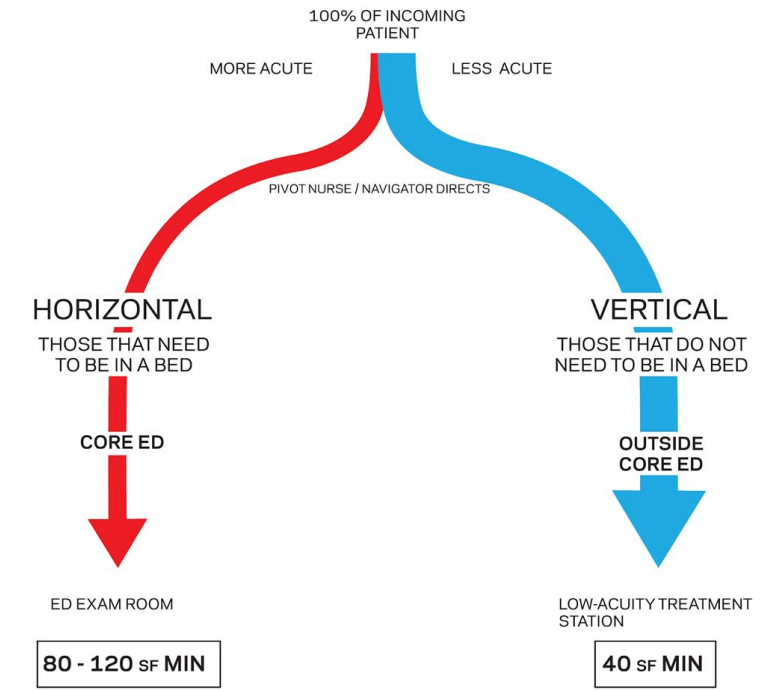


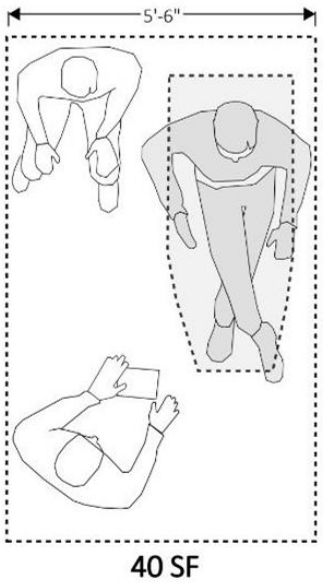
Current state

Aside from specialty rooms/areas (i.e., trauma, fast-track, individuals of size), there are two types of spaces for treatment of patients in the ED:

- Single-exam room at 120 SF CFA
- Bay or cubicle at 80 SF CFA







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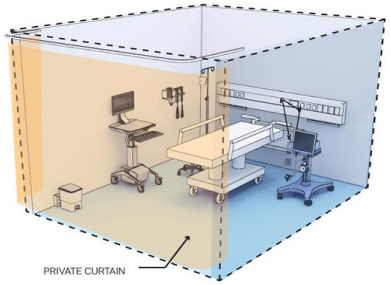
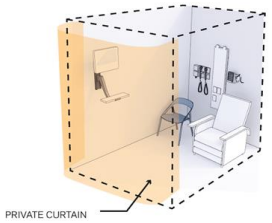




© NBBJ

Low-acuity spaces

New section

- **40 SF** minimum clear floor area
- **5’ 6”** minimum clear dimension
- **3’ at the side(s), head, or foot** of the patient chair that corresponds with the care provider’s expected work position(s)
- **Nurse call, 4 outlets, no gas**

Rural Emergency Hospitals (REH)

- New CMS provider type
- Began Jan. 2023
- No inpatients*
- 365/24/7
- Ambulatory health care occupancy
- Can convert back to hospital

Behavioral health crisis unit

This **dedicated emergency services unit.**

Physical environment controlled to help **alleviate stressors** for patients and staff.

- Open design
- Staff are imbedded in room
- Fully self-contained unit

Behavioral health crisis unit requirements

- Nurse station, medication safety zone, consultation area, exam rooms, soiled, clean, nourishment, patient and staff toilets.
- Readily accessible to the emergency dept.
- Single-patient observation room
  - Single patient room 100 sq. ft.
  - 10 ft. clear dimension
- Multiple-patient room
  - 80 sq. ft. per person (total open area)
  - 4’ between recliners
  - 3’ clearance from recliner to walls

Outpatient crisis unit

2026

- Medically cleared crisis patients
- Immediate patient evaluation
- Constant observation and re-evaluation
- Wellness and recovery-oriented approach

ED rooms serving behavioral health patients

FGI *Guidelines* 2022 edition now includes 4 types of spaces:

1. Secure holding room
2. Flexible secure treatment room
3. Behavioral and mental health treatment room
4. Seclusion room

*** Safety risk assessment** shall determine the **types and number of rooms provided.**

Behavioral and mental health hospitals

- Added requirements for a geriatric patient care unit
- Added transcranial magnetic stimulation (TMS) room
- Added intensive outpatient and partial hospitalization program (IOP/PHP)

New Space Types

Changes to the Hospital *Guidelines*: Burn trauma intensive care unit

Meet ICU criteria → Available OR with temp of 95° → Maximum of one patient per room

Protective Environment (PE) → Radiant heat panels over bed → Direct access to a patient toilet room

New OP hyperbaric section

- Multiplace facilities
- Monoplace facilities
- Pre-procedure area
- Support areas for staff
- Support areas for patients

Hospice and/or palliative care room

- 153 SF clear floor area
- Minimum 10’ at head of patient bed
- CFA includes 33 SF for family support zone; provides space for overnight stay
- In renovation - 120 SF

Emerging Ideas

Nurse call

Call (nurse) systems

- Eliminated “optional” devices
- Staff assist can be by “other electronic means”
- Ancillary systems don’t have to be 1069 complaint
- Clarified use of radiofrequency systems

Nurse call and telecom

2026

Eliminate reference to UL 1069?

Offsite monitoring stations

- Telemetry
- Nurse call

Emergency conditions

Consolidated DEVA

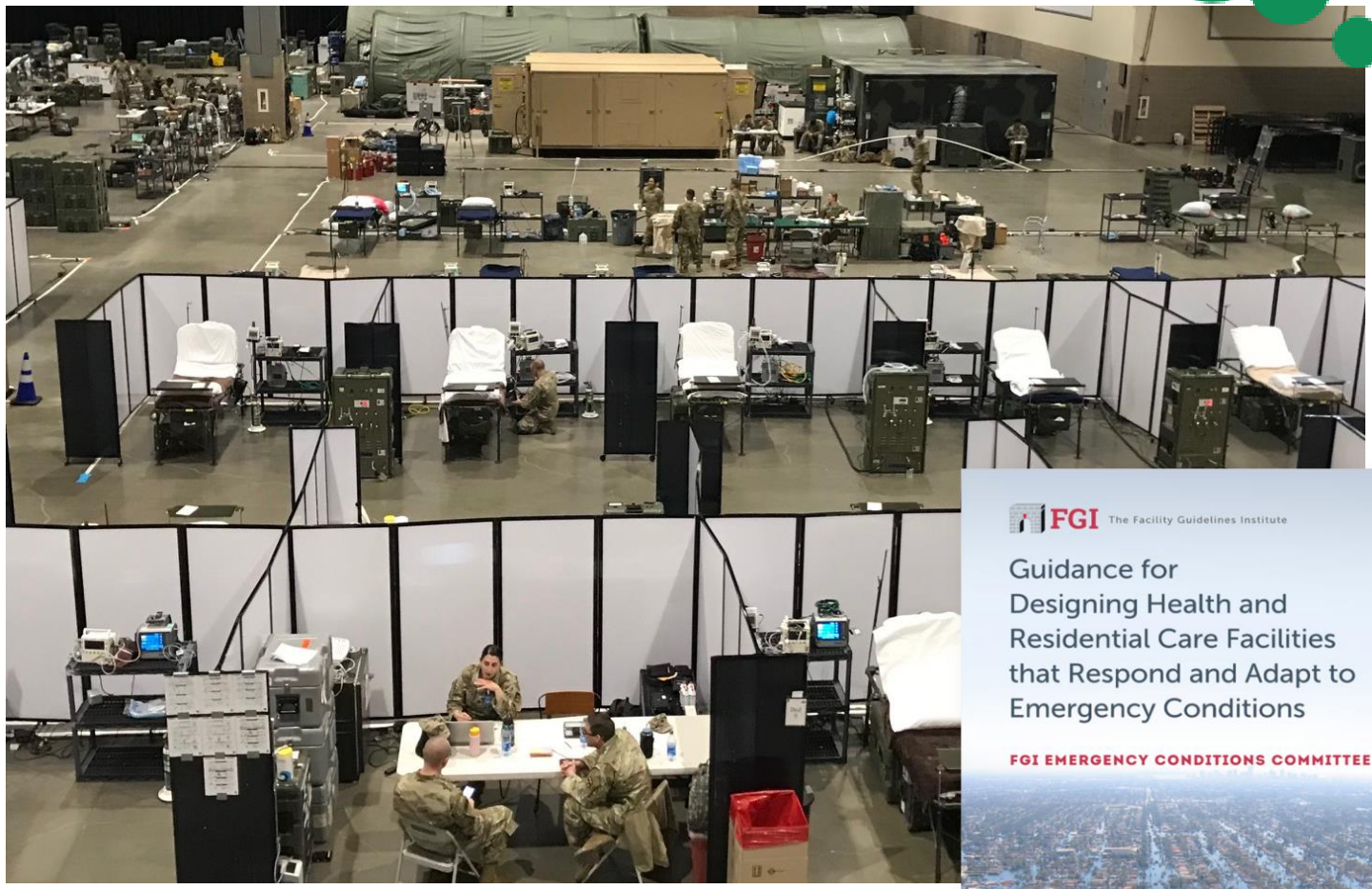
Added audio & visual means of communication in/out of AII rooms

Incident Command Center

Non-refrigerated body holding room in Residential

Single-resident rooms proposed for Residential

2026



Plumbing changes

- Restriction of low-flow fixtures
- Focus on water age
- Treated water at sterile processing
- Review of medical gas counts, including elimination of N20 systems

2026

Consolidated tables

Most information in one table (like ASHRAE 170):

- Medical gas
- Electrical receptacles
- Nurse call

Will appear in 2026 draft

2026

Sleep disorders center

2026

New chapter proposed on sleep study labs

Addresses requirements for:

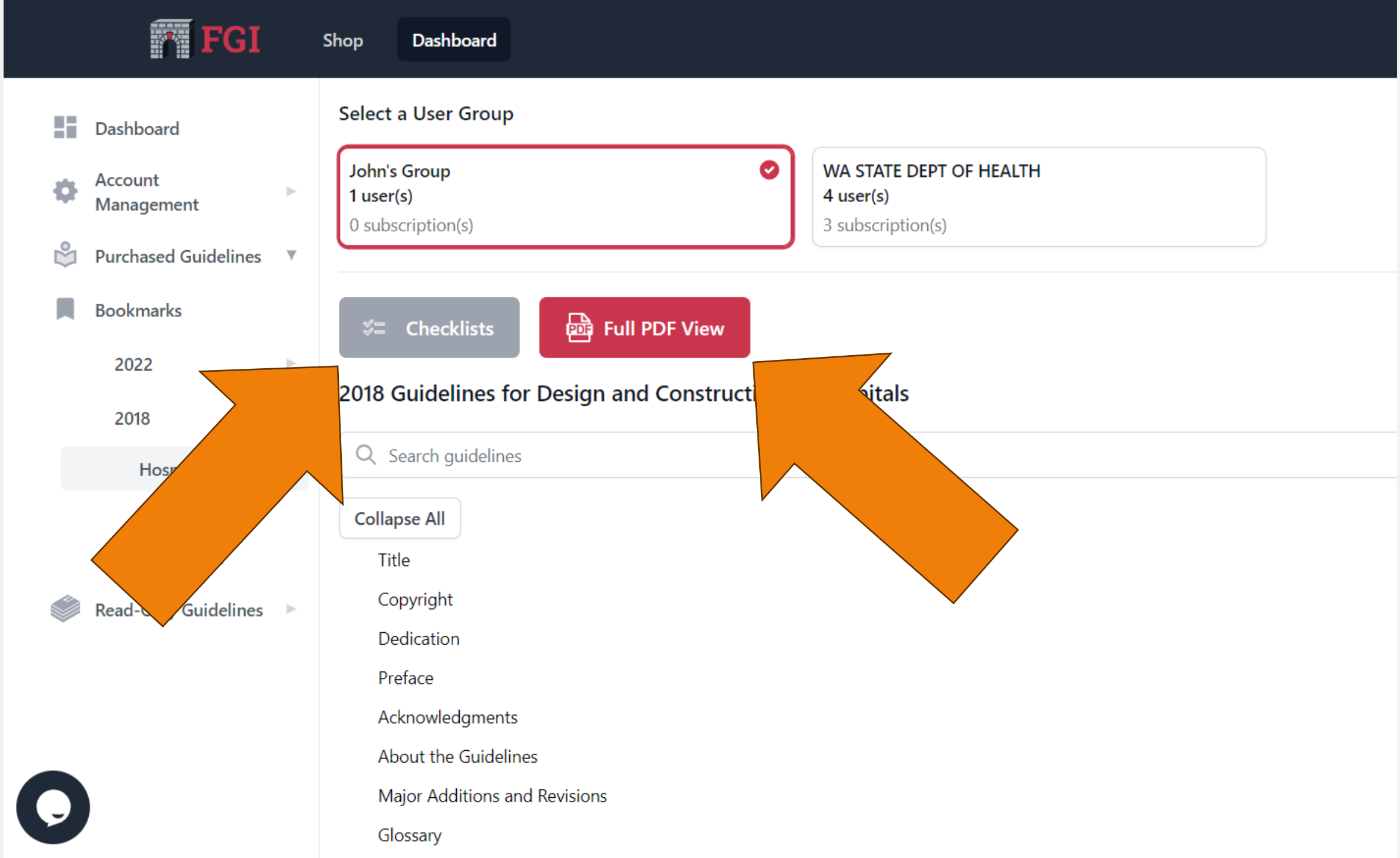
- Sleep testing rooms
- Patient toilet room and shower
- Control room for patient observation

LOOKING AHEAD

REVIEWING USABILITY/NAVIGATION

DEVELOPING A HANDBOOK/COMMENTARY COMPANION

LAUNCHING A PODCAST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Shop
Dashboard
Dashboard
Account Management
Purchased Guidelines
Bookmarks
2022
2018
Read-
Guidelines
Select a User Group
John's Group
1 user(s)
0 subscription(s)
WA STATE DEPT OF HEALTH
4 user(s)
3 subscription(s)
Checklists
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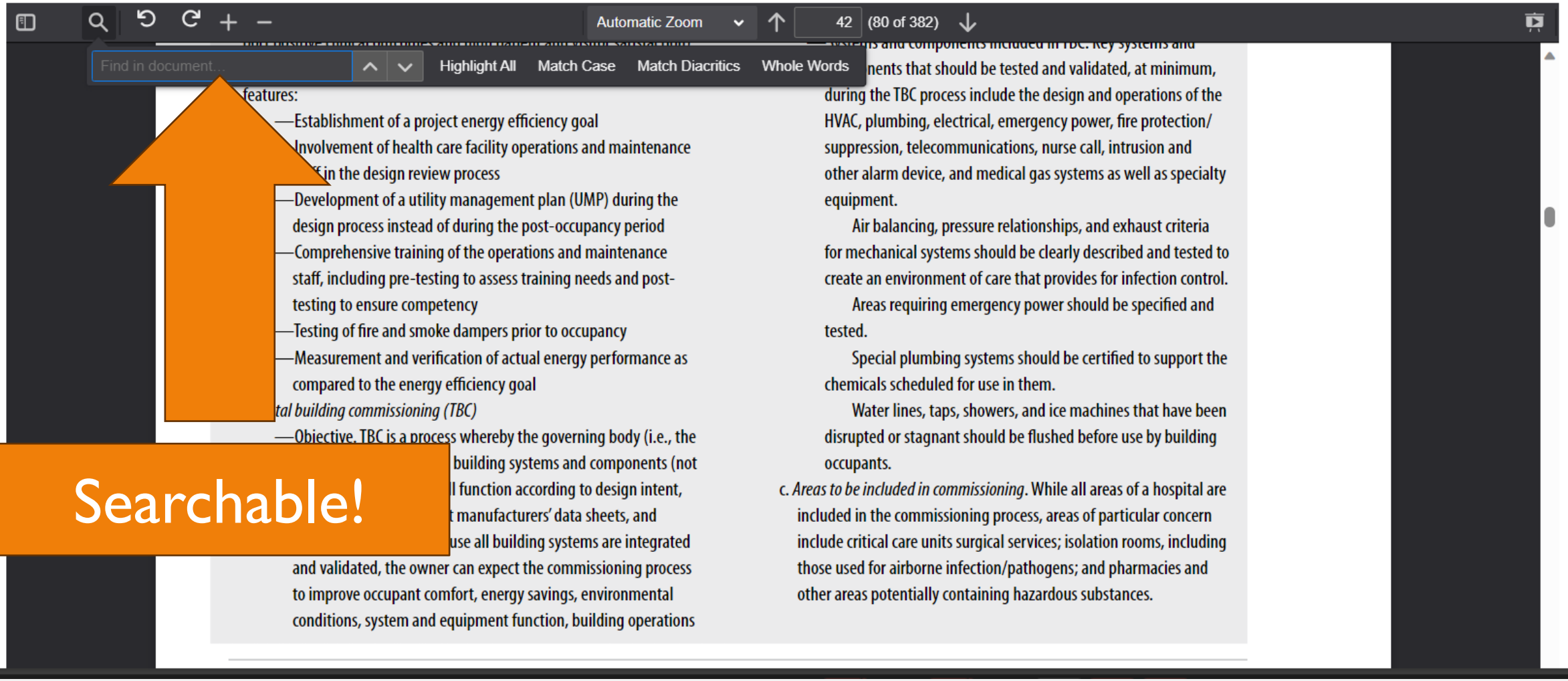
2018 Guidelines for Design and Construction of Hospitals



features:

—Establishment of a project energy efficiency goal

Involvement of health care facility operations and maintenance
f in the design review process

—Development of a utility management plan (UMP) during the design process instead of during the post-occupancy period

—Comprehensive training of the operations and maintenance staff, including pre-testing to assess training needs and post-testing to ensure competency

—Testing of fire and smoke dampers prior to occupancy

—Measurement and verification of actual energy performance as compared to the energy efficiency goal

tal building commissioning (TBC)

—Objective. TBC is a process whereby the governing body (i.e., the
building systems and components (not
l function according to design intent,
t manufacturers' data sheets, and
use all building systems are integrated and validated, the owner can expect the commissioning process to improve occupant comfort, energy savings, environmental conditions, system and equipment function, building operations

nents that should be tested and validated, at minimum, during the TBC process include the design and operations of the HVAC, plumbing, electrical, emergency power, fire protection/suppression, telecommunications, nurse call, intrusion and other alarm device, and medical gas systems as well as specialty equipment.

Air balancing, pressure relationships, and exhaust criteria for mechanical systems should be clearly described and tested to create an environment of care that provides for infection control.

Areas requiring emergency power should be specified and tested.

Special plumbing systems should be certified to support the chemicals scheduled for use in them.

Water lines, taps, showers, and ice machines that have been disrupted or stagnant should be flushed before use by building occupants.

c. *Areas to be included in commissioning*. While all areas of a hospital are included in the commissioning process, areas of particular concern include critical care units surgical services; isolation rooms, including those used for airborne infection/pathogens; and pharmacies and other areas potentially containing hazardous substances.

Patient Room for Patients of Size

Where accommodations for care of patients of size are provided, they shall meet the requirements in Section 2.1-2.3 (Accommodations for Care of Patients of Size). [Source: 2.2-2.1.3]

2.1-2.3.2 Patient Room for Patients of Size

2.1-2.3.2.1 General

2.1-2.3.2.1 (1) ☐ Single-patient room

Patient lift system

2.1-2.3.1.3 ☐ To accommodate patient handling, movement, and mobilization, lift for maximum patient weight defined during planning phase
- ☐ Fixed (ceiling- or wall-mounted) lift
- ☐ Mobile (floor-based) lift

2.1-2.3.2.1 (2) ☐ For rooms designated for patients weighing ≥ 600 pounds, lift system to move patient from bed to toilet
- ☐ Fixed (ceiling- or wall-mounted) lift to accommodate individual of ≥ 600 pounds
- ☐ Mobile (floor-based) lift to accommodate individual of ≥ 600 pounds

2.1-2.3.2.2 Space requirements

2.1-2.3.2.2 (2) Clearances
- ☐ At foot of patient bed: 5 feet
- ☐ Non-transfer side: 5 feet 6 inches from edge of patient bed

Transfer side:
- ☐ Room with fixed lifts—Rectangular clear floor area parallel to the bed with the following dimensions:
  - ☐ 10 feet 6 inches long, beginning 2 feet from headwall
  - ☐ 5 feet 6 inches wide, measured from edge of patient bed
- ☐ Room with mobile lifts—Rectangular clear floor area parallel to the bed with the following dimensions:
  - ☐ 10 feet 6 inches long, beginning 2 feet from headwall

Questions?

john@fgiguidelines.org

Questions?