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:* **2.1-3.5.1.3 (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~~.	**2.2-3.4.2 Imaging Rooms** **2.2-3.4.2.1 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 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.