Formal Interpretations

***Guidelines for Design and Construction of Hospitals*, 2022 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 (AHJs) 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 https://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:* **2022 Hospital** Guidelines *reference:* **2.1-2.4.3**

We recently had a question in our office regarding the 2018 and 2022 FGI standards for hospitals and the quantity of seclusion rooms required in a facility. Currently, we are in the design phase for two acute psychiatric hospitals, with 144 beds and 152 beds respectively, split among six patient care units in each hospital.

Question 1: Based on the information below, the facility with 144 beds appears to require 6 seclusion rooms (144 beds divided by 24 = 6). The facility with 152 beds, based on the language in Section 2.1-2.4.3.1, appears to require the same number of seclusion rooms. Since the difference in bed quantities between the facilities is only 8 (152 – 144 = 8), that would not be an increase of a "major fraction," which we understand to be 12 or more beds. If the project were to increase to 156 beds, we take this requirement to then require a total of 7 seclusion rooms (since the additional 12 is a "major fraction" increase over the original 144 bed quantity). Is this understanding of total required quantities for seclusion rooms correct?

Response: Yes, our calculation also yields 6 seclusion rooms per facility (144 divided by 24 = 6 and 152 divided by 24 = 6.33; a major fraction is one half or more).

Question 2: Additionally, we understand that Section 2.1-2.4.3.1 (2)(c) permits seclusion rooms to be grouped together and both their location and quantity is a function of the total size (bed capacity) of the hospital. We have typically grouped the spaces together so that a single seclusion suite (comprised of multiple seclusion rooms) is shared between multiple patient care units. We do not typically prefer to have a single seclusion suite provided for each and every patient care unit, since that would take up more space and cause higher project costs. Is this correct?

Response: Yes, organizing the required number of seclusion rooms into a seclusion suite meets the intent of the requirement. However, we would encourage you to conduct a behavioral and mental health risk assessment to assure that co-locating the seclusion rooms in one location rather than having one seclusion room in each unit supports patient and staff safety.

Further Comments

Senior architect specializing in behavioral and mental health facilities: The rooms can be grouped together if accessible to all units. The total number of seclusion rooms has to be equal to one for each unit, and if a unit is more than 24 beds there must be one for every 24 beds or [major] fraction thereof.

Senior architect specializing in behavioral and mental health hospitals: I have no issue with the understanding that the seclusion rooms can be grouped together if accessible to all patient care units. However, with the development of a single grouped seclusion suite (comprised of multiple seclusion rooms). attention should be paid to the associated support spaces.

Senior clinical design adviser with a behavioral health specialty: I concur with the previous comments and second the concern for adequate support spaces for the single seclusion suite. The *Guidelines* are being applied correctly by the inquirer, and thus I would state that the requirements are clearly written for 2022.

Senior architect specializing in behavioral and mental health hospitals: I do think the requirement potentially reads like it is for the number and not the specific location of the seclusion rooms. I have always interpreted this that the plan could have two or more seclusion rooms adjacent if it had more than 24 beds in adjacent units, for instance, in a common area (where the clinical support areas, including nurse station, consult, group activity areas, etc., are located) at the intersection of two nursing units on the same floor.

For most of the hospital designs I have been involved in, the patient care units were broken down into smaller pods for safety and other architectural reasons. My concern is that anyone needing to go into seclusion is under great distress and is aggressively acting out. Transporting that patient to another floor or even a far distance on the same floor can be dangerous for both staff and the patient; therefore, the rooms should be dispersed accordingly.

Engineer specializing in health care codes and design: The inquirer's solution appears sound as long as patient access to the seclusion suite is not hindered because of its location and the authority having jurisdiction agrees.

REQUEST

Guidelines *edition:* **2022 Hospital** Guidelines *reference:* **2.1-7.2.3.1 (7)(a)**

Question: Is it the intent of *Guidelines* Section 2.1-7.2.3.1 (7)(a)(vii) (Floor and wall base assemblies) to require the toilet room associated with an AII room to have the same flooring type as the patient room?

Response: Yes, the intent of the *Guidelines* is to require the toilet room associated with an AII or a protective environment (PE) room to have floor and wall base assemblies that are monolithic and have an integral coved wall base that is carried up the wall a minimum of 6 inches (150 mm) and is tightly sealed to the wall.

Further Comments

Health care facility manager/owner: By its very nature and its adjacency to the AII room, this bathroom increases the risk of potential infection if it is not kept just as clean as the patient room it serves.

Health care architect: I think the coved base is a requirement because of the amount of cleaning and sanitizing needed for the listed spaces. Since the patient toilet room is a part of the patient room and serves the same patient, the cleanability requirement for the AII or PE room should extend to the associated patient toilet room.

Authority having jurisdiction: The requirement for a monolithic flooring material with an integral wall base is to provide for efficient cleaning and sterilization of the room. Because the toilet room is attached to the patient room, open to the patient room, and used by the same room occupant, the rooms are basically one and the same and would require the same level of cleaning and care; thus, the floor throughout both rooms is intended to be monolithic with an integral base.

Health care architect/owner: In my opinion, it is reasonable that the AII patient bathroom carry the same flooring requirement as the AII room based on the requirement in Section 2.1-2.2.6.1 (Patient Toilet Room: General), which states "each patient shall have access to a toilet room *without having to enter a corridor*." [Italics added.]

"Without having to enter a corridor" means the toilet room is contiguous with the patient room. Since this is so, it would logically follow that the material requirements would also follow through. I do not see it as practical to meet the monolithic floor requirement in Section 2.1-7.2.3.1 if a different material is used in the adjacent/contiguous patient toilet room.

It would have been helpful to include the toilet room as an explicit requirement as the anteroom (although where provided) was, but that further strengthens my belief that the toilet room should have the same flooring requirement (why would a monolithic floor and wall base assembly be required for the anteroom and AII room but not for the bathroom?).

Compliance officer/owner: The toilet room is an extension of the patient care room and must have a monolithic floor with an integral coved base that has a minimum height of not less than 6 inches. The

flooring material may change so it is technically not “the same” material, but the floor is monolithic with an integral base.

Infection preventionist: The patient toilet room is an extension of the AII room and, therefore, the same minimum requirements apply.