



Washington State Department of Health

Report on Proposals to modify chapter 246-320 WAC (Construction Standards only)

Department of Health contacts:

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Staff liaisons:

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Summary:

This document serves as compiled report of all discussions to change the initial draft of revisions to [Chapter 246-320 WAC](#). This initial draft was published August 15, 2014. This includes proposals received during the write-in period, as well as general discussion heard during the first public meeting, as described below:

Public Workshop Meeting 1 – Review Proposals

Date: September 26, 2014

Start Time: 10 a.m.
Break: 12:40 p.m. to 1:10 p.m.
End Time: 3:10 p.m.

This meeting was convened to review each proposal submitted during the proposal period. Attendees had an opportunity to speak on any proposal and discuss possible options.

Attending: John Williams, Marlei' LaChance, Susan Upton, Steve Pennington, Matthew Campbell, John Hilger, Linda Glaeser, Albert Spencer, Christine Kiefer, Stephen Chapel, Deborah Gates, Brian Goldstein

Next Steps:

Any interested party may submit a comment on one of the previously submitted proposals. A Rule Comment Form to use for making a public comment is in the rules development section of the CRS website at: <http://www.doh.wa.gov/crs>.

Comments on these proposals are due by November 10, 2014. These comments will serve as the agenda for Public Workshop Meeting #2.

Public Workshop Meeting 2 – Review Comments

Date: November 17, 2014

Time: 10 a.m. to 3 p.m.

Location: Point Plaza East, Room 152/153, 310 Israel Rd. S.E., Tumwater, WA 98501

Proposal 001:

Submitter: John Williams

Section: FGI Guideline 2.1-4.3.1.3

Proposal: Revise text as follows:

Construction, Equipment, and installation of food and nutrition service facilities in a hospital shall comply with the requirements of:

- (1) U.S. Food and Drug Administration (FDA)
- (2) U.S. Department of Agriculture (USDA)
- (3) Underwriters Laboratories, Inc (UL)
- (4) NSF International
- (5) WAC 246-215 The Washington State Retail Food Code

Statement of Problem and Substantiation: “This change is intended to provide clarity for designers and facilities. The Washington State Food Code (Chapter 246-215 WAC) is applicable for hospital based food establishments. Providing a reference here directs the design team to consider the requirements in this section. In case of conflicts between the items on this list, it is the intent of CRS that the more specific requirements in chapter 246-215 WAC take precedence.”

Cost Impacts: “This change will have no impact on construction cost. Since these requirements are already in effect, this additional reference will have no impact. No operating cost impact.”

Benefits: “Coordination with other rules.”

Discussion Notes: Adding a reference to the Washington Food Code as a reminder of state-specific rules.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 002:

Submitter: Janet Smoot

Section: FGI Guideline 2.1-7.2.3.1(6)

Proposal: Revise text as follows:

The following rooms shall 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:

- (a) Operating rooms
- (b) Interventional Imaging rooms, including cardiac catheterization labs
- (c) Cesarean Delivery rooms
- (d) Cystoscopy, urology, and minor surgical procedure rooms

- (e) Endoscopy procedure rooms
- (f) Endoscopy instrument processing rooms
- (g) IV and chemotherapy preparation rooms
- (h) Airborne infection isolation (AII) rooms
- (i) Protective environment (PE) rooms
- (j) Anterooms to AII and PE rooms, where provided
- (k) Central Processing rooms
- (l) Sterile Processing rooms

Statement of Problem and Substantiation: “Walls and wall protection, FGI section 2.1-7.2.3.2 (1)(c) calls for wall finishes in the sterile processing room to be free of fissures, open joints, or crevices that may retain or permit passage of dirt particles.

Rationale: The floor should have the same requirements for being free of fissures, open joints, or crevices that may retain or permit passage of dirt particles. Integral covered base meets this requirement. It is impossible to clean under the toe of rubber base where dust, dirt and contaminants build up over time. In order to continue limiting the amount of contaminants in these area integral covered base should be required.”

Cost Impacts: “This change will increase construction cost. Installed rubber base is \$1.50 per lineal foot. Installed covered base is \$6.50 per lineal foot. No operating cost impact.”

Benefits: “Infection prevention measure.”

Discussion Notes: When the FGI converted this section to a laundry list of rooms, it appears that the rooms added were missed. The added rooms have similar function; therefore they should follow the same standard.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 003:

Submitter: Janet Smoot

Section: FGI 3.1-7.2.3.1(5)

Proposal: Revise text as follows:

The following rooms shall have floor and wall base assemblies that are monolithic and have an integral covered wall base that is carried up the wall a minimum of 6 inches (150 mm) and is tightly sealed to the wall:

- (a) Operating rooms
- (b) Interventional Imaging rooms, including cardiac catheterization labs
- (c) Cystoscopy, urology, and minor surgical procedure rooms
- (d) Endoscopy procedure rooms

- (e) Endoscopy instrument processing rooms
- (f) IV and chemotherapy preparation rooms
- (g) Airborne infection isolation (AII) rooms
- (h) Anterooms to AII and PE rooms, where provided
- (i) Sterile Processing Rooms

Statement of Problem and Substantiation: “Walls and wall protection, section 3.1-7.2.3.2 (b) calls for wall finishes in the sterile processing room to be free of fissures, open joints, or crevices that may retain or permit passage of dirt particles.

Rationale: The floor should have the same requirements for being free of fissures, open joints, or crevices that may retain or permit passage of dirt particles. Integral coved base meets this requirement. It is impossible to clean under the toe of rubber base where dust, dirt and contaminants build up over time. In order to continue limiting the amount of contaminants in these area integral coved base should be required.

The FGI published a white paper on ‘Sterile Processing in the Surgical Suite’ (Sept 15, 2014) which stated, “Sterile processing areas in the surgical suite should be designed to be functionally equivalent to Sterile processing areas in the central sterile processing department.

Central Sterile processing is where all cracks and crevices are sealed to address cleanability for this important sterile function so integral coved base should be installed here.”

Cost Impacts: “This change will increase construction cost. Installed rubber base is \$1.50 per lineal foot. Installed coved base is \$6.50 per lineal foot. No operating cost impact.”

Benefits: “Infection prevention measure.”

Discussion Notes: When the FGI converted this section to a laundry list of rooms, it appears that the rooms added were missed. The added rooms have similar function; therefore they should follow the same standard.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 004:

Submitter: Janet Smoot

Section: FGI Guideline 2.2-3.5.2

Proposal: Revise text as follows:

2.2-3.5.2 Interventional Imaging Procedure Room

2.2-3.5.2.1 Space requirements. The procedure room shall be large enough to accommodate required equipment and clearances in accordance with the manufacturer’s technical specifications.

- (1) The procedure room shall have a minimum clear dimension of 18 feet (5.49 meters).

(2) The procedure room shall be sized to allow a minimum clearance of 4 feet (122 centimeters) on all sides of the gantry assembly or table.

2.2-3.5.2.2 Ceilings Ceilings in interventional imaging procedure rooms shall be designed as semi-restricted, see 2.1-7.2.3.3(3) for finishes.

Statement of Problem and Substantiation: “2.2-3.4.1.4(2)(b) refers the reader to interventional radiology room requirements for ceiling assemblies. There is no reference to ceiling assembly requirements in this section. A reference needs to be added for the type of ceiling designation and refer the reader back to the finish section.”

Cost Impacts: “This change will have no impact on construction. No operating cost impact.”

Benefits: “This is a coordination issue; provides reference to correct section.”

Discussion Notes: There is a broken link in the current FGI that refers to this section. Nothing in this section describes the types of ceiling finish. The intent is to clarify which finish standards apply.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 005:

Submitter: John Williams

Section: FGI Guideline 2.1-1.1

Proposal: Revise text as follows:

2.4-1.1 Application This chapter is ~~intended to be used for the federal program for~~ contains specific requirements for small rural hospitals. The functional program for these facilities must clearly describe a scope of services that is appropriate for this chapter. The department may apply the requirements of other chapters of this standard to the portions of the facility that is not appropriate for this chapter. The term “critical access” when used in the scope of this chapter is to be used in the context of the actual function of each space. ~~critical access hospitals; however, the guidelines herein may be applied to any small facility with similar functional program requirements as approved by the authority having jurisdiction (AHJ). The AHJ shall determine the number of beds applicable to facilities using this chapter.~~

Statement of Problem and Substantiation: “The intent of these two changes is to clearly set the scope for the application of the chapter for critical access hospitals. We recognize the need for different minimum standards for small rural facilities, regardless of their participation in federal reimbursement programs. Physical environment standards should be determined by the actual scope of services provided, not reimbursement strategy. Therefore, I propose modifying the application section to highlight the importance of the functional program review to determine the most appropriate section of the standard to review.

The intended result is to allow this chapter to be used by small facilities whose scope of practice is limited. This would also allow the department to scale up the requirements as the small facility

chooses to perform procedures that are more significant than typically seen in these smaller facilities. For example, there are no specific requirements for interventional imaging in Chapter 2.4. If a small rural facility wishes to provide these services and has appropriate approvals, we would use Chapter 2.2, General Hospitals, to determine requirements for that portion of the work. Practically, this is how the review process works today – requirements are based on risk.”

Cost Impacts: “This change will not increase construction cost. From the 2014 version of the code, the use of this chapter will reduce the cost of construction. The modification of scope; i.e., applying regulations based on function, is consistent with current practice. No operating cost impact.”

Benefits: “This change will clearly spell out the department’s intent on how to regulate the construction of small rural hospitals.”

Discussion Notes: The rule for small critical access hospitals was not available to be adopted in the previous version. This change would give the department the flexibility to review based on function, not on participation in federal programs.

The cost impact was questioned. Current practices within the department are consistent with the actions described above i.e., the review is based on the function of the space. This new chapter would lower the cost of construction, if the department didn’t take this approach. Since this is the current practice, the department lists this impact as no added cost from current operating procedure.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 006:

Submitter: Steve Pennington

Section: FGI Guideline 2.2-3.3.4.2(b)(ii)

Proposal: Revise text as follows:

Where bays are used, an aisle with a minimum clearance of ~~8~~ six (6) feet (2.44 meters) independent of the foot clearance between patient stations or other fixed objects shall be provided.

Statement of Problem and Substantiation: “Bays are defined in the FGI glossary as a space for human occupancy with one hard wall at the headwall and three soft walls (e.g., cubicle curtains or portable privacy screen). Eight foot clearances in corridors originated from in-patient hospitals minimum corridor width to allow for transportation of beds in both directions. The typical medical surgical patient bed is 40 inches wide and the typical recovery gurney width is 33 inches. Reducing the minimum clearance between bays to six feet would still allow two stretchers to pass without disturbing the curtains at the foot of the bays. If an emergency event occurs, where additional equipment or staff is needed, the curtains at the foot of the beds could be pushed back to allow for a total width of 12 feet. Requiring an eight foot clearance between bays is excessive as beds are not used for typical patient transport in the pre-operative area.”

Cost Impacts: “This change will not increase construction cost. Saves approximately \$2,000 per bay (8SF x \$250). No operating cost impact.”

Benefits: “Allows SF to be used for other areas within the facility.”

Discussion Notes: The rule as written could be interpreted to require an amount of space that isn’t functionally needed. The intent of this rule is to require a six foot clear aisle, outside of the patient care station (i.e., cubicle space), to allow for gurney traffic.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 007:

Submitter: Steve Pennington

Section: FGI 3.9-3.3.2.2(2)(b)

Proposal: Revise text as follows:

Where bays are used, an aisle with a minimum clearance of 8 6 feet (2.44 meters) independent of the foot clearance between patient stations or other fixed objects shall be provided.

Statement of Problem and Substantiation: “Bays are defined in the FGI glossary as a space for human occupancy with one hard wall at the headwall and three soft walls (e.g., cubicle curtains or portable privacy screen). Eight foot clearances in corridors originated from in-patient hospitals minimum corridor width to allow for transportation of beds in both directions. The typical medical surgical patient bed is 40 inches wide and the typical recovery gurney width is 33 inches. Reducing the minimum clearance between bays to 6 feet would still allow two stretchers to pass without disturbing the curtains at the foot of the bays. In an emergency event where additional equipment or staff is required the curtains at the foot of the bed could be pushed back to allow for a total width of 12 feet. Requiring 8 foot clearance between bays is excessive.”

Cost Impacts: “This change will not increase construction cost. This change will decrease cost by approximately \$2,000 per bay. No operating cost impact.”

Benefits: “n/a”

Discussion Notes: The rule as written could be interpreted to require an amount of space that isn’t functionally needed. The intent of this rule is to require a six-foot clear aisle, outside of the patient care station (i.e., cubicle space), to allow for gurney traffic.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 008:

Submitter: Susan Upton

Section: FGI Guideline 2.1-7.2.2.1

Proposal: Revise text as follows:

Corridor width. For corridor width requirements, see applicable building codes. In addition to building code requirements, in areas typically used for stretcher transport, minimum corridor or aisle width of six (6) feet shall be provided.

Statement of Problem and Substantiation: “Building codes establish minimum corridor widths for egress. IBC also recognizes the means of egress requirement for a minimum six foot wide corridors and areas serving gurney traffic for any occupancy where patients receive outpatient medical care per IBC Table 1018.2

FGI establishes minimum operational requirements. FGI 3.7-7.2.2.1 recognizes the operational need to set minimum corridor widths at outpatient surgical facilities with a minimum six foot wide corridor where patients are transported on stretchers.

Since both IBC and FGI recognize the operational need for a minimum six-foot wide corridor at outpatient occupancies where patients are transported on stretchers, it is consistent to require a minimum six foot wide corridor at hospitals where outpatients are transported on stretchers.”

Cost Impacts: “This change will have no impact on construction cost. No cost from 2010 FGI requirement. No operating cost impact.”

Benefits: “Maintain consistent minimum corridor widths based on operational use where patients are transported on stretchers.”

Discussion Notes: Consistent with proposal number 006 and 007, this change sets the minimum operational clearance needed for stretcher traffic in inpatient hospitals. The intent of this section is not for means of egress, but the operational area needed to maneuver a stretcher. This is intended to apply within suites where regular stretcher traffic is expected. These changes would promote consistency; this also aligns with the language in the outpatient surgery chapter.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 009:

Submitter: John Williams

Section: FGI Guideline Table 2.1-2

Proposal: Revise text as follows:

Staff lounge

Duty station is optional

Statement of Problem and Substantiation: “A report from a recent small hospital construction project where this was required stated that a significant cost was added to the ongoing operations of the hospital due to overtime pay of off-duty staff. The rules require nurse call alerts at staffed locations such as nurse stations, support area etc. Providing a nurse call in a staff lounge creates an unintended consequence and cost for small facilities.”

Cost Impacts: “This code reduces the cost of construction an ongoing staff costs.”

Benefits: “This code reduces the cost of construction an ongoing staff costs.”

Discussion Notes: This proposal also addresses concerns regarding the staff having uninterrupted breaks to allow appropriate down time. The 2014 FGI requires a centralized nurse call station where staff is “working.” One audience member stated that this would be better managed through policies and procedures. Generally, the audience was in support of making this an optional requirement.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 010

Submitter: Deborah W. Gates, JD, LLM, Attorney-at-Law

Section: FGI Guideline Table 2.1-2

Proposal: Add text as follows:

(add new table heading)

ALL INPATIENT HOSPITAL BUILDINGS

Patient, public, and staff hospital toilets

Bath station required at each toilet

Statement of Problem and Substantiation: “I am continuing to seek amendments to chapter 246-320 WAC that would require emergency assistance systems in all patient, public, and staff hospital toilets. I am proposing that this requirement apply prospectively only; I am not seeking retrofitting.

The WDOH adopted the 2006 Facility Guidelines Institute standard for hospital toilets following my formal comments submitted in March 2008; I wrote that my late husband, Stephen Gates, MD, had suffered a fatal heart attack in a hospital bathroom without an emergency call device. Dr. Gates had provided anesthesia for a late night emergency surgery on a toddler on Friday, July 21, 2006. The child did wonderfully and was discharged the following Monday. Shortly after the child's surgery, my husband had a fatal heart attack in a hospital bathroom without an emergency call device; his body was found about an hour after his death. He was 53 years old. My husband's colleagues told me that my husband might have had time to pull an emergency cord if one had been there and he might have had a chance. Or he might have died anyway, no one would ever know. Without an emergency call device in the bathroom, his chance of survival was zero.

I attach a copy of the February 18, 2010, letter submitted on behalf of the Washington State Nurses Association to the State of Washington Department of Health. Judith Huntington, MN, RN, Executive Director, WSNA, states as follows: Having emergency call devices in public and hospital

staff bathrooms will help save lives." Ms. Huntington explains that "many visitors, patients and staff who have serious illnesses or are health-compromised frequently use the rest rooms in the public and staff areas of our health care facilities. Our nurse members have reported incidents where family members and visitors have suffered severe and sometimes life-threatening events in public bathrooms. They also cite examples where hospital staff have become seriously ill in staff bathrooms." Prior to 2009, certain Washington hospitals had already voluntarily installed emergency call systems in patient, public and staff bathrooms. Such hospitals include Virginia Mason facilities and Harrison Medical Center in Silverdale, WA as well as the Seattle Cancer Care Alliance in Seattle, WA.

Hospitals should have emergency call devices in bathrooms throughout the hospital for the protection of patients, visitors, and staff. Hospitals, after all, are places where sick and injured people go for help, so the likelihood of people being ill, either as a patient or a potential patient, would seem to be high. And it would not be unusual for anyone feeling upset or otherwise unwell to use the bathroom. Syncope in bathrooms is a recognized medical phenomenon. With an emergency call device, someone suffering an episode of syncope in a hospital bathroom could receive prompt and potentially life-saving emergency medical care.

Hospitals are staffed 24/7 and off hours shifts have fewer personnel around. It is not unlikely that a staff member could feel badly, go to a staff bathroom, and then need assistance. Hospital staff are in the business of treating ill and injured people and thus hospital staff incur great stress during the performance of their duties. In the absence of an emergency call device in a bathroom, a member of the hospital staff (doctor, nurse, tech, etc.) could have a heart attack and die and no one would notice until it was too late.

For over twenty years, the State of Connecticut has required emergency call systems in all single occupancy bathrooms. (See Section 1109.2.3 in the Connecticut Supplement to the International Building Code.) When visiting family in Connecticut, I have personally observed emergency call devices in gas station bathrooms, in department store bathrooms, and in grocery store bathrooms.

In Europe, it is not uncommon to have emergency pull cords in bathrooms located in airports and train stations. The Connecticut Hospital Association and local Connecticut Health Departments tend to interpret the national AIA/FGI standards/Connecticut building code quite strictly. As new facilities have been constructed, the Yale New Haven Health System has installed emergency call devices in all bathrooms, including patient bathrooms, public bathrooms, and staff bathrooms. (Portions of the Yale New Haven Health System date back to the 1800s.)

Yale's fourteen-story cancer center has emergency call devices in every bathroom, whether patient, staff, or public bathroom. The newest cancer center has a nurse station on every floor and the emergency call devices for all bathrooms (including staff and public bathrooms) ring at the nurse station. My sister and her husband are Professors at Yale Medical School and they have observed emergency pull cords in the bathroom stalls of the patient, staff and public bathrooms at the main Yale New Haven Hospital. Washington's adoption of the 2014 FGI standards should ensure that using a bathroom in a hospital in Washington hospital is as safe as using a bathroom in a gas station in Connecticut. The public and our medical personnel deserve no less."

Cost Impacts: "A wireless device can cost \$195 per bathroom and a hard wire system can cost \$85 per pull cord. One dome light with buzzer costs \$36. Installation costs range between \$45 to \$195 for the wireless systems and up to \$540 (depending on length of cable, etc.) for the hard wire

system. By installing emergency call devices in all hospital bathrooms (patient, public, and staff) hospitals will limit liability in the form of money damages and penalties.”

Benefits: “The determination of the risk management benefits of installation of emergency call devices is a determination that is properly made by a lawyer familiar with hospital liability.”

Discussion Notes: This requirement is intended to provide emergency call devices for an inpatient hospital building only. The intent of the proposal is to add a pull station in every toilet within a hospital when renovating or in new construction. There is a question of whether this would apply to a particular occupancy group as defined by the State Building Code, or the more amorphous term “hospital.” The original proposal was written did not include outpatient clinics, although questions were raised about the application to outpatient clinics where sedation is performed.

The way that the proposal is currently written, this system would alarm at a clinical station. Concerns were expressed about pulling inpatient nurses off patient floors to respond to alarms in other buildings containing outpatient clinics, counseling, etc. Pulling clinical staff away to respond to nuisance alarms could result in less focus on critically ill patients. The proponent stated that the person who responds doesn’t necessarily need to be clinical staff, just someone who could call 911.

The proponent offered to get the department in contact with code officials from Connecticut, where this is a broad requirement. In cases where you have a single hospital based tenant in a multi-tenant building, does the hospital-based clinic then become responsible for monitoring and maintaining an emergency call for all non-hospital based tenants. There appeared to be general support for a call system to summon non-clinical personnel, provided that the scoping was limited to inpatient hospital buildings.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 011

Submitter: Deborah W. Gates, JD, LLM, Attorney-at-Law

Section: FGI Guideline Table 2.1-2

Proposal: *(In relation to previous proposal)* Add concept as follows:

Add a requirement that hospitals and outpatient facilities to report to one state agency all fatalities sustained within the four walls of a hospital or outpatient facility, with the exception of patient deaths associated with the sickness or injury that led the patient to seek medical care.

Statement of Problem and Substantiation: “In prior rulemakings, representatives of the hospital industry stated that no data existed regarding fatalities in bathrooms. I request that as part of this rulemaking, the department require hospitals and outpatient facilities to report to one state agency all fatalities sustained within the four walls of a hospital or outpatient facility, with the exception of patient deaths associated with the sickness or injury that led the patient to seek medical care. What is measured, matters.

I attach a copy of the February 18, 2010, letter submitted on behalf of the Washington State Nurses Association to the State of Washington Department of Health. Judith Huntington, MN, RN, Executive Director, WSNA, states as follows: Having emergency call devices in public and hospital staff bathrooms will help save lives." Ms. Huntington explains that "many visitors, patients and staff who have serious illnesses or are health-compromised frequently use the rest rooms in the public and staff areas of our health care facilities. Our nurse members have reported incidents where family members and visitors have suffered severe and sometimes life-threatening events in public bathrooms. They also cite examples where hospital staff have become seriously ill in staff bathrooms.

*see attachment 1”

Discussion Notes: This proposal was in direct response to the statement made last revision cycle that there was no data that tracked staff or public deaths in toilet facilities in hospitals. The proponent proposes that this data point would be useful for the public and for facilities. Furthermore, this collected information could be useful to risk management programs and rule development. The question was raised whether this was appropriate to the construction portion of the licensing rules. The department has opened the construction portion of the hospital licensing rules only. There is currently a type of adverse event reporting in the operational section of chapter 246-320 WAC. The department has reviewed this proposal and has determined that this proposal doesn't pertain to the portion of the rules that are currently open. If the proponent wishes, this could be a rule petition to the department.

Advisory opinion: Generally, there was not a clear consensus from the participants on what direction to move with this proposal.

Proposal 012:

Submitter: Stephen Chapel
Section: WAC 246-320-505(1)
Proposal: Revise text as follows:

The services of a consulting engineer registered under chapter 18.43 RCW ~~may~~ must be used for the various branches of work ~~where appropriate, excluding minor alterations.~~

Statement of Problem and Substantiation: “The purpose of hiring a design professional is to ensure that the life and safety of the occupants are protected. Modern building systems, not just those generally assigned within the purview of an architect, may adversely impact the life and/or safety of the occupants, especially in a healthcare setting. Professional engineers ensure that such life and safety concerns with respect to modern building systems is addressed in a manner that architects and/or vendors (building contractors and equipment providers) cannot.”

Cost Impacts: “This change will have no impact on construction cost. The cost of design of building systems will either be assigned to a consulting engineer or will to a vendor. The increased assignment to the engineer will be offset by a decrease to the vendor.

A well designed AND coordinated building system may actually cost less per year.”

Benefits: “A well designed system by a consulting engineer will likely produce better aseptic control of the space and produce better coordinated power systems, both resulting in increased patient outcomes.”

Discussion Notes: There is concern that an engineer should be consulted on every project to determine if their services are needed to ensure patient safety. There was concern that an architect would not be able to make all decisions on a substantial project. Adding significant capacity by adding breakers could adversely affect the system as a whole. There are projects that would not require an engineer, especially for smaller scopes of work or work in outpatient clinics.

There was concern over the deletion of the definition of “minor alteration.” This definition still exists within WAC 246-320-010 (3), and this portion of the rule is not open for revision. Local building departments and Labor and Industries (L&I) inspection would also be another possible check to ensure that the professional practice standards are being upheld. There was concern expressed that smaller rural jurisdictions would not make that check consistently. Some audience members were concerned that an absolute requirement would preclude some well-established practices, such as use of staff engineers and licensed workers who must also know the rules.

The rule states that a consulting engineer must be used, where appropriate. The professional practice rules give guidance on when the services of an architect or engineer are appropriate. The department will review these rules and report back at the next public meeting. One question that is unclear is: does this proposal intend to make a more stringent set of requirements than the practice rules in chapter 18.43 RCW and chapter 18.08 RCW?

Advisory opinion: Generally, there was not a clear consensus from the participants on what direction to move with this proposal. Participants were curious to see what guidance is provided by the professional practice rules.

Proposal 013:

Submitter: Daniel Swanson

Section: WAC 246-320-505(1)

Proposal: Revise text as follows:

- (1) Drawings and specifications for new construction, excluding minor alterations, must be prepared by or under the direction of, an architect registered under chapter 18.08 RCW. The services of a consulting engineer registered under chapter 18.43 RCW may be used for the various branches of work where appropriate. The services of a registered engineer may be used in lieu of the services of an architect if work is primarily an engineering project ~~involves engineering only~~.

Statement of Problem and Substantiation: “The word “only” is extremely limiting. Engineering projects may involve minimal modification to architectural elements. This would allow engineers to

prepare and submit projects that are primarily engineering, as governed by the RCWs that define practice rules.”

Cost Impacts: “No cost impacts”

Benefits: “Clarity and usability.”

Discussion Notes: Engineers are able to prepare projects that are primarily engineering in nature; change in wording is for clarification only. Currently, the department accepts minor architectural related work that is prepared by an engineer. The department will review the professional practice rules and report back at the next public meeting.

Advisory opinion: Generally, the opinion of the audience was mixed. Participants were curious to see what guidance is provided by the professional practice rules.

Proposal 014:

Submitter: Daniel Swanson

Section: WAC 246-320-500(3)(a)

Proposal: Revise text as follows:

(1) Standards for design and construction.

Facilities constructed and intended for use under this chapter shall comply with:

- (a) The following chapter of the ~~2010~~ 2014 edition of the *Guidelines for Design and Construction of ~~Health-Care Facilities~~ Hospitals and Outpatient Facilities*, as developed by the Facilities Guidelines Institute, as published by the American Society for Healthcare Engineering of the American Hospital Association, 155 North Wacker Drive Chicago, IL 60606, as amended in WAC 246-320-600:

Statement of Problem and Substantiation: “Designers and facilities typical refer to this document as the “FGI Guidelines” adding the text here provide clarity.”

Cost Impacts: “No cost impacts.”

Benefits: “Clarity and usability.”

Discussion Notes: The phrase “as developed by the Facilities Guidelines Institute” is all that is added in this proposal. The intent is to add some context to increase name recognition of the proposed standard. Most people refer to this document as the “FGI Guidelines” even though the actual name of the document does not include acronym “FGI.” No technical change is intended.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 015:

Submitter: Daniel Swanson

Section: WAC 246-320-505(2)(c)

Proposal: Add new section as follows:

(c) The construction documents must include:

(iv) Verification of capacities and loads of infrastructure systems to accommodate planned load.

Statement of Problem and Substantiation: “Designers and planners often miss the need to verify that the capacity of infrastructure systems will meet the demand. These infrastructure systems include mechanical, electrical and plumbing. Especially during renovation, designers should provide due diligence to ensure that the systems will support the new plan.”

Cost Impacts: “Typical I have seen 30 power models cost \$1,000 to \$1,500 to set up recording meters. Plumbing and medical gases and vacuum systems is a function of connected fixtures and a basic calculation based on design practice, so no real additional cost. Mechanical load calculation will be a requirement to select any equipment and therefore no additional cost.”

Benefits: “Facilities will have the infrastructure to function as planned.”

Discussion Notes: The intent is to ensure that an infrastructure system assessment is performed to accurately determine if the systems support the new scope of work. Many facilities do this as part of their regular planning process. There is a concern that some facilities aren’t doing this. The concern was also that the owner gets to decide how much due diligence an engineer is paid to do. The proposal is written very broadly and if adopted as written would probably be interpreted broadly. The engineering narratives in functional program would be the place that documents this assessment. There are various points during a typical review process to catch issues, such as: the department, local AHJ and the Department of Labor and Industries (L&I).

Advisory opinion: There were some participants in favor of recommending this proposal, the majority didn’t record an opinion.

Proposal 016:

Submitter: Daniel Swanson

Section: WAC 246-320-505(2)(c)(i)(c)

Proposal: Revise text as follows:

(C) An infection control risk assessment indicating appropriate infection control measures, keeping the surrounding area free of dust and fumes, and ensuring rooms or areas are well ventilated, unoccupied, and unavailable for use until free of volatile fumes and odors, ensure a clear pathway for construction waste and debris;

Statement of Problem and Substantiation: “This would require facilities to identify paths and locations where construction debris, waste containers and associated demolition material must travel to get out of the building. This is sometimes missed during the infection control planning process.”

Cost Impacts: “No cost impact, this is planning function and does not take up resources.”

Benefits: “Better protection of patient during construction activities.”

Discussion Notes: Added language to clearly define a pathway that the construction debris and materials travel through the facility to get to a dumpster. This would be a good tool for the architect in planning; the department doesn’t think the language harms anything.

Advisory opinion: The audience members didn’t provide any specific opinions on this particular proposal.

Proposal 017

Submitter: Sandra Miller

Section: FGI Guideline 1.2-3.2.3

Proposal: This section was not completed by submitter.

Statement of Problem and Substantiation: “The Infection control risk mitigation recommendations have crossed over to incorporate other construction risks and are not necessarily related to risk of infections such as planned utility shutdowns, risk of noise or vibration from construction activity and pathway disruptions. This information is not typically addressed or managed by infection preventionist and may be overlooked. A pre-construction risk assessment that includes the ICRMR, ILSM, and identification of all other risks and associated mitigation should be in place prior to construction start. Development of the overall plan should be reviewed and approved by the team in table A1.2-a.”

Cost Impacts: “This change will have no impact on construction cost.”

Benefits: “Documentation of a process to address non- infection risks to patients and staff during the construction phase of a project.”

Discussion Notes: It appears that the intent of the proposal is to require facilities to consider operational issues as part of a pre-construction assessment, similar to the current infection control risk assessment (ICRA) process. Such items include: utility shut downs, noise and vibration kind of issues and other impacts to continuing patient care. It’s unclear what this would look like or what we would call it, but it could be part of the Safety Risk Assessment. If there are other systemic concerns in addition to the ones listed above, the department would be interested to hear what those are.

Advisory opinion: The audience members did not provide any specific opinions on this particular proposal. There were too many questions about what the actual language would look like.

Proposal 018:

Submitter: Sandra Miller

Section: FGI Guideline 1.2-3.1.3.1

Proposal: Revise text as follows:

The safety risk assessment shall be initiated and managed by a team or individual as appointed by the governing body during the planning phase of the project.

Statement of Problem and Substantiation: “As identified in the glossary the governing body is at too high of a level to initiate manage the process of the SRA. In many larger institutions that is equivalent to the board of directors or CEO. The SRA would be much more effective lead and approved by a team or individual that engages in the design work often as part of a standard practice that would then report up to the governing body on a quarterly basis. Most institutions have a designated safety officer or director of facility planning that should be leading these efforts. This change would require modification at all locations in the section referring to governing body.”

Cost Impacts: “This change will have no impact on construction cost. No operating cost impact.”

Benefits: “The intent of the code is to put in place a process to ensure risks are considered and mitigated and is most efficiently done at the work group level.”

Discussion Notes: Page #40, Table 1.2-A has language about the makeup of the safety risk assessment team which is a broad range of people in the organization. There was general concurrence that there is value in having a large number operational staff involved versus staff that is higher in the organization’s hierarchy.

Advisory opinion: The audience members didn’t provide any specific opinions on this particular proposal.

Proposal 019:

Submitter: Christine Kiefer

Section: FGI Guideline 1.2-3 Safety Risk Assessment (SRA) Table 1.2-1

Proposal: Revise text as follows:

Please include an SRA template in the tables.

Statement of Problem and Substantiation: “During the initiation of the ICRA and ILSM many institutions did not understand how to create a program to meet the intent of the guidelines and to document it per the requirements. It was not until templates of ICRA’s were fully implemented the intent of the ICRA. Please include a template of an SRA in the FGI for reference. Table 1.2-1 is not sufficient for this purpose.”

Cost Impacts: Not completed by submitter.

Benefits: Not completed by submitter.

Discussion Notes: A consistent template would be beneficial for facilities and application of the rule. The Center for Healthcare Design is putting together a tool kit that may be comparable to the current toolkit used for Infection Control Risk Assessments. The department will monitor what is being developed but is cautious of creating a single template in rule and requiring everyone to follow it. There could be many approaches to successfully completing a Safety Risk Assessment.

Advisory opinion: There was some support of the concept, but the majority of the audience didn't register an opinion.

Proposal 020:

Submitter: Christine Kiefer

Section: FGI Guideline Glossary

Proposal: Add the following text:

Construction:

- New construction: Constructon that requires site preparation for, and construction of, entirely new structures and/or significant extensions to existing structures. These projects would require compliance with the Guidelines
- Major Renovation: 25% the value of the building, excluding land and involves major HVAC infrastructure upgrades, significant envelope upgrades and major interior rehabilitation. Construction work that is so extensive that normal operations are vacated from the facility
- Minor Renovation: Renovations that are valued at less than 25% of the building, excluding land

Statement of Problem and Substantiation: “The guidelines definitions and compliance requirements do not define major renovation projects and leave ambiguity to the applicability of the Code.”

Cost Impacts: Not completed by submitter.

Benefits: “This proposal decreases the ambiguity for the application of the code and helps to define which projects have what parts of the code apply.”

Discussion Notes: It's unclear if some section of the code applies to existing facilities because the definitions of major and minor were removed from the glossary. These definition are contained in Chapter 246-320 WAC. There was concern that this rule, as written, would remove a significant of oversight and create patient safety issues. One audience member stated that it would be helpful if the language could be a little more definitive. The proponent's intent was not to remove requirements,

but rather have a predictable level of application of the rules. There didn't seem to be much opposition to the application of scope the way that it is currently applied by the department.

Advisory opinion: Generally, the reactions of the participants were mixed. There was an agreement that clarity is needed – but there was general discomfort with the proposal as it was written.

Proposal 021:

Submitter: Christine Kiefer

Section: FGI Guideline 1.1-3.1.2(c), (h)

Proposal: Revise/add text as follows:

FGI 1.1-3.1.2(c) Minor changes to the configuration of an existing space including equipment replacements, functional reconfigurations and minor renovations shall not require upgrade of the entire space.

FGI 1.1-3.1.2(h) Minor renovations

Statement of Problem and Substantiation: “In many existing facilities the new clearances and functions of the code cannot be met in the existing square footage and facility configuration. However, the proposed minor renovations will add clinical and patient benefit meeting the intent of the code even if the specific requirements cannot be met. The department should be given the authority to permit minor renovations that cannot comply with the 2014 FGI.”

Cost Impacts: Not completed by submitter.

Benefits: “This proposal would allow existing spaces to be upgraded to meet patient and clinical demands allowing for better access and clinical care.”

Discussion Notes: The intent was to add some clarification to the definition of “configuration of an existing space.” The scope of renovation needs clarification.

Advisory opinion: Generally, the participants were opposed to recommending proposal.

Proposal 022:

Submitter: Christine Kiefer

Section: FGI Guideline 2.2.1.16.9.1(4)

Proposal: Add the following text:

FGI 2.2.1.16.9.1(4) In renovated areas, the Authority with Jurisdiction may provide exception for the requirement to provide 54” clear width and door openings for path of travel and access to spaces in the facility. Additionally, this requirement may not be feasible in the renovation of a bariatric unit or designated room.

Statement of Problem and Substantiation: “Existing facilities did not anticipate the requirement for a 54” clear opening for bariatric room and units. Many out swinging doors if replaced to 54” would impede the egress path, not meeting code. Additionally, replacing doors in egress stairs to accommodate a 54” opening would decrease the required stair width and may not be feasible in existing facilities. It is cost and space prohibitive to have a 54” clear opening in all areas required by 2.2-2.16.9.1.”

Cost Impacts: “If the requirement for clear opening in the special design elements for the bariatric population is not modified, the doors and frames in many locations would need to be replaced.”

Benefits: “This change would allow existing facilities to renovate to meet the needs of the population without remodeling the entire facility.”

Discussion Notes: Creating a new bariatric unit in an existing facility may not be possible without some allowances for existing conditions. Facilities try to make every effort to serve patients in the highest quality possible, however, the requirements may prohibit some existing facilities from providing bariatric units. The example that was given of a concrete stair core or shear wall that could not be altered. It was noted that the reference section in the proposal may be incorrect.

Advisory opinion: There was some support the concept, but the majority of the audience didn’t register an opinion.

Proposal 023:

Submitter: Christine Kiefer

Section: FGI Guideline 1.2-3 and 1.2-5.4.2.2

Proposal: Add the following text:

FGI 1.2-3 and 1.2-5.4.2.2 In renovated areas, the Authority with Jurisdiction may provide exceptions for remodeled areas that cannot meet the requirements in association with bariatric accommodations including the associated path of egress to reach these areas.

Statement of Problem and Substantiation: “Existing facilities did not anticipate the requirement for a 54” clear opening for bariatric room and units. Many out swinging doors if replaced to 54” would impede the egress path, not meeting code. Additionally, replacing doors in egress stairs to accommodate a 54” opening would decrease the required stair width and may not be feasible in existing facilities. It is cost and space prohibitive to have a 54” clear opening in all areas required by 2.2-2.16.9.1.”

Cost Impacts: “If the requirement for clear opening in the special design elements for the bariatric population is not modified, the doors and frames in many locations would need to be replaced.”

Benefits: “This change would allow existing facilities to renovate to meet the needs of the population without remodeling the entire facility.”

Discussion Notes: Same concept as in proposal number 022.

Advisory opinion: There was some support the concept, but the majority of the audience didn't register an opinion.

Proposal 024:

Submitter: Christine Kiefer

Section: FGI Guideline 2.1-7.2.2.10(1)

Proposal: Revise text as follows:

Where the functional plan determines that handrails are needed for the patient population, handrails shall be installed on both sides of patient use corridors.

Statement of Problem and Substantiation: “The needs of patients vary widely, and there are areas where ambulation is not recommended. The use of handrails should be based upon the patient population.”

Cost Impacts: Not completed by submitter.

Benefits: “Decreased falls for specific patient populations.”

Discussion Notes: There are areas in the facility where patients are dizzy and confused and we would not want to give them the impression that they can get up and walk by themselves. If handrails are placed on both walls with multiple breaks between the handrails, are we encouraging patients to use them? Will this result in a higher prevalence of falls in areas like neurology areas? There was concern over removing the requirement as a whole, and only providing it when described by the functional program. Suggestion was made to leave the requirement, and allow the safety risk assessment to limit the handrails to one side of the corridor only. One suggestion was to change the proposed language to “Unless the safety risk assessment determines that handrails are necessary only on one side of the corridor, provide handrails on both sides of the corridor.”

Advisory opinion: The participants were not in favor of recommending this proposal as written, there appeared to be more support with the language in the discussion notes.

Proposal 025:

Submitter: Christine Kiefer

Section: FGI Guideline 2.1-2.6.6.1(2)(a), (b), (c)

Proposal: Revise text as follows:

FGI 2.1-2.6.6.1(2)(a) Medication safety zones shall be located out of circulation paths or within alcoves to minimize the potential for distraction and interruption.

FGI 2.1-2.6.6.1(2)(b) If required by the functional program, work space organization for medication safety zones shall be designed so staff can access information and perform required tasks.

FGI 2.1-2.6.6.1(2)(c) If required by the functional program, work counter shall provide space to perform tasks referenced in paragraph (b).

Statement of Problem and Substantiation: “In many facilities, units are designed to decrease distances by bringing services, such as, medications closer to the patient bed side. For instance automated medication – dispensing units are dispersed throughout the unit and distribution of medications is located in locked and secure areas in each patient room. Automated medication – dispensing units functions often occur in alcoves. By adding alcove to (a) it clarifies that an alcove is considered to be out of the circulation path. In both examples above, the distribution system may not have direct access to work counters or IT support. Requiring (b) & (c) without modification will ultimately create greater travel distances for nursing and reduce the amount of time spent at the patient bed side.”

Cost Impacts: Not completed by submitter.

Benefits: “Increased nursing time at patient bed side.”

Discussion Notes: There was concern expressed over how the new requirements would impact current practices, specifically the use of automated medication dispensing units and medication “alcoves” near the patient bed. It was noted that the new FGI specifically allows for automated dispensing units in Section 2.1-2.6.6.1. There was also some general agreement around the concept that some alcoves would be sufficient, others would not. For example a six (6) inch deep alcove off of a major public thoroughfare would be too distracting and not acceptable. However, 4’x’4 alcove off of a staff only corridor could be acceptable. The current language allows a degree of flexibility to consider and approve the alcove. Clearer language defining exactly what an acceptable alcove look like might help with facility planning. However, a more prescriptive approach could restrict flexibility for existing buildings and unique situations.

Advisory opinion: The audience members didn’t provide any specific opinions on this particular proposal.

Proposal 026:

Submitter: Christine Kiefer

Section: FGI Guideline 3.1-2.6.6.1(2)(a), (b), (c)

Proposal: Revise text as follows:

FGI 3.1-2.6.6.1(2)(a) Medication safety zones shall be located out of circulation paths or within alcoves to minimize the potential for distraction and interruption.

FGI 3.1-2.6.6.1(2)(b) If required by the functional program, work space organization for medication safety zones shall be designed so staff can access information and perform required tasks.

FGI 3.1-2.6.6.1(2)(c) If required by the functional program, work counter shall provide space to perform tasks referenced in paragraph (b).

Statement of Problem and Substantiation: “In many facilities, clinics are designed to decrease distances by bringing services, such as, medications closer to the patient. For instance automated medication – dispensing units are dispersed throughout the clinic. Automated medication – dispensing units functions often occur in alcoves. By adding alcove to (a) it clarifies that an alcove is considered to be out of the circulation path. In both examples above, the distribution system may not have direct access to work counters or IT support. Requiring (b) & (c) without modification will ultimately create greater travel distances for nursing and reduce the amount of time with the patient.”

Cost Impacts: Not completed by submitter.

Benefits: “Increased nursing time with patient.”

Discussion Notes: Same discussion as proposal number 025.

Advisory opinion: The audience members didn’t provide any specific opinions on this particular proposal.

Proposal 027:

Submitter: Christine Kiefer

Section: FGI Guideline 3.1-3.2.3.2(2)(a), (c)

Proposal: Revise/add text as follows:

FGI 3.1-3.2.3.2(2)(a) Room size shall permit a room arrangement with a minimum clearance of 2 feet 8 inches ~~3 feet 6 inches~~ at the side(s), head or foot of the examination table, bed or chair that corresponds with the care provider(s) expected work position(s).

FGI 3.1-3.2.3.2(2)(c) A room arrangement in which an examination table, recliner, bed or chair is placed at an angle, closer to one wall than another or against a wall to accommodate the type of patient being served shall be permitted.

Statement of Problem and Substantiation: “The proposal addresses room layout for specialty clinics where the preferred location for the patient bed, table, exam, chair, etc differs from the required clearances. The preferred layout is due to the patient population seen in the clinic and the need to address patient safety and falls.”

Cost Impacts: Not completed by submitter.

Benefits: “This proposal allows equipment to be laid out in examination rooms to address patient safety concerns.”

Discussion Notes: This section refers to outpatient settings for special purpose exam rooms; currently the section on general exam rooms already has similar language. What is the reason for the modification from 3’-6” to 2’-8””? The code should consider where the care provider is and where the activity is, which is the primary reason for having the clearance there.

Advisory opinion: The audience members didn’t provide any specific opinions on this particular proposal.

Proposal 028:

Submitter: Christine Kiefer

Section: FGI Guideline 2.2-3.3.3.2(2)(2)

Proposal: Revise text as follows:

FGI 2.2-3.3.3.2(2)(2) The room shall be physically separated from the hybrid operating room with walls ~~and a door~~.

Statement of Problem and Substantiation: “A door decreases the ability to communicate between those in the OR and control room.”

Cost Impacts: Not completed by submitter.

Benefits: “This proposal will allow clinical practice in OR’s to proceed in a safe manner.”

Discussion Notes: A door could inhibit communication (both walking and talking) such as nurses documenting what is happening in the room. There was some discussion over the intent of this rule. There seemed to be some consensus over the idea that if the control room is constructed and controlled exactly like the operating room, the door could be removed. If not, the door should remain. “Constructed and controlled” was described to mean the finishes, air changes, staff protocol, gowning procedures etc.

Advisory opinion: The audience members didn’t provide any specific opinions on this particular proposal.

Proposal 029:

Submitter: Christine Kiefer

Section: FGI Guideline 2.2-3.4.2.1(1)(b)

Proposal: Revise text as follows:

CT scanner rooms(s) shall be sized to allow a minimum clearance of 4 feet ~~all sides of the gantry or table on patient transfer and foot and 3 feet clear on non-transfer side of the table.~~

Statement of Problem and Substantiation: “Patient care does not require access on all sides of the gantry but does require clearance around the table. The 4”-0” clear is not required for patient care behind the gantry and is greater than the required service area from manufacturers. In fact, several CT technologies do not recommend accessing behind the gantry during normal operations due to the increased speed of the CT.”

Cost Impacts: “\$350 / sf shell and core”

Benefits: “Increases required clearances at the table where needed for patient care but does not require clearances in areas that would be dangerous to staff or unused in patient care.”

Discussion Notes: The manufacturers don’t recommend a lot of clearances on the back side of the gantry because they don’t like to see people behind the gantry.

Advisory opinion: The audience member was in support of recommending this particular proposal.

Proposal 030:

Submitter: Christine Kiefer

Section: FGI Guideline 2.2-3.4.4(2)

Proposal: Revise text as follows:

The MRI scanner room shall have a minimum clearance of 4 feet on all sides of the gantry assembly or table, transfer side and foot of the table and 3 feet clearance on the non-transfer side of the table and the door swing shall not interfere with the patient transfer. The door swing shall not encroach on these minimum clearances.

Statement of Problem and Substantiation: “Patient care does not require access on all sides of the gantry but does require clearance around the table. The 4”-0” clear is not required for patient care behind the gantry and is greater than the required service area from manufacturers.”

Cost Impacts: “\$3.50 / sf for shell and core”

Benefits: “Proposal increases required clearances at the table where needed, but does not require increased clearances at areas that do not affect patient care.”

Discussion Notes: The door swing should not interfere with the patient transfer.

Advisory opinion: The audience member was in support of recommending this particular proposal.

Proposal 031:

Submitter: Christine Kiefer

Section: FGI Guideline 3.1-7.2.2.2(2)

Proposal: Delete text as follows:

~~In radiography, procedure and operating rooms and other rooms with ceiling-mounted equipment or fixtures in the stowed position, the minimum height from the lowest protruding element of the equipment or fixture when it is in the stowed position shall be no less than 7 feet.~~

Statement of Problem and Substantiation: “Many boom mounted shelves for cauterization equipment, etc have three shelves. It is not possible to have this system be stowed above 7’-0” and reach the location where it is needed for patient care.”

Cost Impacts: Not completed by submitter.

Benefits: “This proposal will allow clinical practice in ORs to proceed in a safe manner.”

Discussion Notes: Even when booms are docked out of the way, they don’t meet the clearance requirements per manufacturing standards. Are there other specific conditions that are unable to meet this requirement?

Advisory opinion: The audience members didn’t provide any specific opinions on this particular proposal.

Proposal 032:

Submitter: Christine Kiefer

Section: FGI Guideline 2.2-3.3.4.3(1)(b)

Proposal: Revise text as follows:

FGI 2.2-3.3.4.3(1)(b) A minimum of 1.5 post-anesthesia patient care station or as determined by the functional program per operating room shall be provided.

Statement of Problem and Substantiation: “Depending upon the type of surgery, duration of surgery and patient flow, institutions may need fewer post-anesthesia patient care stations.”

Cost Impacts: “Not completed by submitter.”

Benefits: “Allows institutions to determine what is the appropriate ratio between ORs and PACU based upon their specific patient population.”

Discussion Notes: The department historically hasn’t put a requirement on the number of post anesthesia care (PACU) spaces; rather it has relied on the facility to set a number based on

operational need. It was recommended that an anesthesiologist be consulted. The question was asked whether the number of spaces could safely be limited down to zero, depending on the procedure type.

Advisory opinion: The audience members didn't provide any specific opinions on this particular proposal.

Proposal 033:

Submitter: John Williams

Section: FGI Guideline 3.5-1.1

Proposal: Revise text as follows:

This chapter applies to facilities that provide urgent care to the public but are not freestanding emergency departments, ~~or do not provide care on a 24 hour day, seven day per week basis.~~ The functional program for these facilities must clearly describe a scope of services that are appropriate for urgent care, as determined by the department.

Statement of Problem and Substantiation: “The intent of these two changes is to adopt the chapter of the FGI for urgent care facilities. The technical change eliminates the condition that these facilities cannot provide care for twenty four (24) hour, seven day per week basis. In this case, the application of a particular set of physical standards should be based on the type and duration of the care provided. Restricting the hours of operation in this case is an artificial limiter. The scope of services provided should be the sole determiner of whether this chapter can be used or not. To clarify this, I propose to add a sentence that provides a more heightened attention to the importance of the functional program review.

My intent that services traditionally performed in an urgent care setting be allowed to use this chapter. Buildings that plan to provide more acute services traditionally associated with an emergency room setting must be done in either a hospital based emergency room or a free-standing emergency room.”

Cost Impacts: “This change will not increase construction cost. Previously the department has considered these free standing EDs or allowed the use of this chapter as an alternative method. This change will either decrease or have no impact on cost. No operating cost impact.”

Benefits: “This change will clearly spell out the department's intent of how urgent care facilities should be reviewed.”

Discussion Notes: The intent is to apply this chapter based on services provided (under the scope of an urgent care) as described in the functional program, not how many hours it is open.

Advisory opinion: The audience members were generally in support of recommending this proposal.

Proposal 034:

Submitter: Kevin A. Scarlett

Section: FGI Guideline 2.1-8.3.4.3

Proposal: Add the following text:

(7) Uplight fixtures or troughs in patient care areas that create ledges or troughs that collect dust shall be provided with a lens on the top of the fixture to facilitate cleaning.

Statement of Problem and Substantiation: “The departments CRS staff field observation has identified the increasingly frequent use of up-light or trough fixtures in patient care areas which create ledges or troughs that collect dust. These up-light or trough fixtures are basic wall mounted light fixtures (usually indirect fluorescent type) with no lense (open on top with exposed light tube/bulb). With no lens, dust/dirt/bacteria collect inside the fixture, which cannot be readily cleaned as part of the regular housekeeping routine (Maintenance Staff would need to remove the bulbs for cleaning of the fixture). Housekeeping staff have no realistic option to clean the fixture without removing the light tube/bulb. This is a designated function for Maintenance staff, not Housekeeping staff. The 2014 FGI 2.1-7.2.3.2(3)(c) requires a wall surface finish ‘that facilitates cleaning’. The 2014 FGI 2.1-7.2.3.3 has disallowed ceilings ‘that create ledges/crevices and that cannot be cleaned with routine housekeeping equipment’. Currently we have been suggesting or requesting this lense addition. Thus far facilities have agreed that the fixtures would be difficult and potentially unsafe for housekeeping staff to routinely clean and have provided fixtures with lenses, with no further discussion or push-back on the issue. In speaking with Architects familiar with specifying light fixtures located in healthcare environments, they’ve stated that top lensed up-light fixtures are very standard and that lenses are readily available (come standard at no up charge with Hospital Grade fixtures).

FGI 2014 Patient Room Wall & Ceiling Requirements - refer to substantiation above for referenced text excerpts;

Walls Ref; 2014 FGI 2.1-7.2.3.2(1)(a) & (3)(c)

Ceilings Ref; 2014 FGI 2.1-7.2.3.3(1)(a&b)”

Cost Impacts: “This change will increase construction cost. Zero to \$40 per fixture. Most (to all) Hospital Grade fixtures already come supplied w/ these up-light lenses with no additional cost.”

Benefits: “Allows staff to readily clean up-lights, without the added burden of removing bulbs prior. Guides Design staff to specify Hospital Grade fixtures which already come supplied w/ these up-light lenses.”

Discussion Notes: Lighting in patient care areas need to have a “manufactured” lens to facilitate with cleaning. A couple of available fixtures have been identified.

Advisory opinion: The audience members were generally in support of recommending this proposal.

Proposal 035:

Submitter: Matthew Campbell

Section: FGI Guideline 3.7-3.6.13.4

Proposal: Add the following text:

3.7-3.6.13.4 The HVAC for the sterile processing room shall comply with part 4 of this document, with all of the following additional requirements:

- (1) HVAC design shall provide a “clean to dirty” airflow within the space with supply air provided over the clean area and exhaust air drawn from the soiled area.
- (2) This room shall be positive to adjacent spaces with exception to Operating or Procedure rooms.
- (3) Two outside air and six total air changes per hour shall be provided.
- (4) Two filter banks shall be required: The primary filter shall be MERV 7, the final filter shall be MERV 14.
- (5) Room air should be exhausted to the exterior.

Statement of Problem and Substantiation: “This proposal addresses a known oversight in the 2014 FGI. The ASHRAE 170 development process is separate from the FGI development process. The new concept of sterile processing rooms for immediate use sterilization is not addressed in the published version of ASHRAE 170. This proposal represents our mechanical ventilation expectations for this room. We anticipate that this issue will be addressed by the ASHRAE 170 committee within the next few months. Our intent is to keep a close eye on the ASHRAE 170 process and coordinate our rule with their final standard.”

Cost Impacts: “This change will have no impact on construction cost. No cost impact from 2010 FGI requirement. No operating cost impact from 2010 FGI requirement.”

Benefits: “Ensures consistent and appropriate interpretation of a new concept in the FGI according to the purposes set forth by the FGI committee.”

Discussion Notes: Outlines mechanical requirements for the sterile processing room; this is a new room type and the ASHRAE 170 committee currently has it on its agenda to discuss. The intent is for the department to match what the committee decides.

Advisory opinion: The audience members were generally in support of recommending this proposal.

Proposal 036:

Submitter: Matthew Campbell

Section: FGI Guideline 3.7-5.1.2

Proposal: Revise text as follows:

When sterilization occurs on site, one of the following conditions shall apply:

- (2) Outpatient surgical facilities with 3 or fewer operating and/or procedure rooms ~~W~~where immediate use sterilization occurs on-site, the requirements in Section 3.7-3.6.13 (Sterile Processing Room) shall be met.

Outpatient surgical facilities with 4 or more operating and/or procedure rooms, or facilities which do not use immediate use sterilization, decontamination and sterilization shall meet the requirements of 2.1-5.1.

Statement of Problem and Substantiation: “This particular design option is a new option in the 2014 version of the code. Preliminary investigation and discussion with FGI workgroup indicates that single room decontamination and sterile processing is not practical for large volumes. Therefore, we are proposing changes to define the scope and applicability of this new language.

We added the phrase ‘immediate use sterilization’ to establish that this design is acceptable for a very specific type of sterilization process. More traditional sterilization methods will require traditional layouts. We also set a threshold for large volumes at four or more operating rooms. There is no particular reason for arriving at this number, it is proposed as a point of discussion for the healthcare community. We commit to continue to research this concept and update this proposal as new information is discovered.”

Cost Impacts: “This change will have no impact on construction cost. No cost impact from 2010 FGI requirement. No operating cost impact from 2010 FGI requirement”

Benefits: “Ensures consistent and appropriate interpretation of a new concept in the FGI according to the purposes set forth by the FGI committee.”

Discussion Notes: This proposal discusses the requirement to develop scoping requirements for when facilities can use certain types of sterilization procedures as described in the document. The department realizes that not everybody uses this particular method and will further develop this proposal.

Advisory opinion: There was some support for recommending this proposal; however the majority of the audience didn’t register an opinion.

Proposal 037:

Submitter: Matthew Campbell

Section: FGI Guideline 3.7-3.6.13.1(2)

Proposal: Revise text as follows:

The sterile processing room shall be designed to provide a one-way traffic pattern of contaminated materials/instruments to clean materials/instruments to the sterilizer equipment. Two remotely located doors shall be provided as follows:

(rest of section to remain unchanged)

Statement of Problem and Substantiation: “The purpose of this section is to clarify that two doors are required for this particular room. The current directs you to do this, however we feel the added language would be clearer. We have confirmed this is the intent with the FGI focus group chair. It is also described this way in the FGI white paper on the subject, as well as the new practice guidelines.

This modification provides clarification.”

Cost Impacts: “This change will have no impact on construction cost. No cost impact, this is for clarification purposes. This section is an alternative way of providing sterilization facilities, the method in the 2010 FGI is still acceptable, so there is no cost impact. No operating cost impact from 2010 requirement.”

Benefits: “Ensures consistent and appropriate interpretation of a new concept in the FGI according to the purposes set forth by the FGI committee.”

Discussion Notes: Proposal seeks to clarify the requirement for two (2) doors. The FGI guidance document talks about two (2) doors. The department recognizes that there are existing conditions which affect the design of a room.

Advisory opinion: The audience members were generally in support of recommending this proposal.

Proposal 038:

Submitter: Sandra Miller

Section: FGI Guideline 1.2-3.2.3

Proposal: Revise/add text as follows:

Add section under 2.7:

All entries to a Children’s hospital shall be controlled, or each specific unit within the hospital shall be controlled. The check in and registration areas shall be clearly identified. The check in and registration area shall permit visual observation and contact with all traffic entering the unit. All staff entries shall have an access control system and be observed by camera.

When an NICU is part of a free standing Children’s hospital, then 2.2-2.10.1.2 should be waived as the security is at the level of overall building.

Statement of Problem and Substantiation: “As in an NICU environment, a children’s hospital possess the same risks for abduction. Depending on the diagnoses a patient could be either in the NICU or the Cardiac Pediatric ICU for example. Or a patient graduating from the NICU to an acute care unit for follow up does not have the same level of protection. Extending the requirement to the overall facility protects all vulnerable patients.

Removing the requirement for a add protection at the NICU allows foe better workflow between NICU and other ICU’s. The location of the NICU should remain in an area that does not require through traffic.”

Cost Impacts: “This change will have no impact on construction cost. No operating cost impact.”

Benefits: “Provide security to reduce risk of abduction of all patients in a children's hospital, not just NICU patients.”

Discussion Notes: The submitter wasn’t available for discussion. It appears that the intent of proposal is to have a minimum requirement for security to be handled at each building level entrance or at each specific unit entrance. Concerns were raised that removing individual securities of a NICU in a freestanding children’s hospital may increase risk and raises issues/concerns from risk management perspective. The department currently can allow alternative methods based on particular projects and facilities, provided that the facility can demonstrate that the intent of the rule is meet. The word “should” was of concern as it unclear. The word “shall” or “may” is clearer.

Advisory opinion: The audience members didn’t provide any specific opinions on this particular proposal.

Proposal 039:

Submitter: Sandra Miller

Section: FGI Guideline 2.1-2.4.3

Proposal: Revise text as follows:

Where required by the functional program, a seclusion Room for short term occupancy shall be provided.

Statement of Problem and Substantiation: “The current wording does not support a restraint free approach to the care of psychiatric patients. Institutions which have a model of care which supports restraint free therapy, should be allowed to provide other means of protection for those patients and be able to describe the process in which the safety of those patients and staff are protected.”

Cost Impacts: “This change will not increase construction cost. No operating cost impact.”

Benefits: “Where a successful model of care exists, promote a restraint free environment for psychiatric patients.”

Discussion Notes: The submitter wasn’t available for discussion. This eliminates the absolute requirement that a seclusion room is required in a psychiatric area of a general hospital. It was noted that the FGI guidelines are moving away from blanket reliance on the functional program and focusing on minimum standards. This may not be compatible with certain facilities where involuntary holds are placed on patients.

Advisory opinion: The audience members didn’t provide any specific opinions on this particular proposal.

Proposal 040

Submitter: Cory Hamilton

Section: FGI Guideline 4-7.2.3(c)

Proposal: Revise text as follows:

7.2.3 Combination Airborne Infectious Isolation/Protective Environment (AII/PE) Rooms.

Ventilation for AII/PE rooms shall meet the following requirements:

- a. Supply air diffusers shall be located above patient bed.
- b. Exhaust grilles or registers shall be located near the patient room door.
- c. The pressure relationship to adjacent areas for the required anteroom shall be ~~one of the~~ following:
 1. The anteroom shall be at a positive pressure with respect to both the AII/PE room and the corridor or common space.
 2. ~~The anteroom shall be at a negative pressure with respect to both the AII/PE room and the corridor or common space.~~

Statement of Problem and Substantiation: “The principles of infection prevention would dictate that the anteroom, the location where PPE are donned and stored, be POSITIVE to the patient room, to protect the healthcare worker from airborne infectious illness while putting on and taking off PPE. Hence statement 7.2.3.c.1 is the only safe pressure relationship.”

Cost Impacts: “This change will have no impact on construction cost. No operating cost impact.”

Benefits: “The positive anteroom keeps the healthcare worker and corridor safe from the AII patient and the AII/PE patient safe from the corridor.”

Discussion Notes: The submitter wasn’t available for discussion. There exist two options in the current rule: one to make the anteroom positive, one to make it negative. The proponent wants to make the ante room positive only to eliminate risks to staff. It would be beneficial to have input from other facilities.

Advisory opinion: The audience members didn’t provide any specific opinions on this particular proposal.

Proposal 041:

Submitter: Daniel Swanson
Section: FGI 2.1-2.2.6.7.4
Proposal: Revise text as follows:

Nourishment function may be combined with a clean utility without duplication of sinks and work counters. If Nourishment is combined with Clean utility, storage of soiled food service implements must be in a separate enclosed cart or room and clean linen must be stored within the room must be covered.

Statement of Problem and Substantiation:“If food preparation is performed in a clean room, clean linen should be protected from splash and splatter from those activities.”

Cost Impacts: “No cost, linen is transported covered under current practice, just need to maintain that cover when carts are parked within nourishment stations.”

Benefits: “Clean linens will be kept clean from accidental spills.”

Discussion Notes: Covering the clean linen would protect it from possible contamination during food preparation. The group discussed that this was an operational requirement, possibly better controlled by surveyors at the operational level.

Advisory opinion: The audience members didn’t provide any specific opinions on this particular proposal.

Proposal 042:

Submitter: Daniel Swanson
Section: WAC 246-320-600
Proposal: Delete state amendment as follows:

Part 6

~~**ANSI/ASHRAE/ASHE Standard 170-2008: Ventilation of Health Care Facilities**~~

~~**Table 7-1 – Design Parameters**~~

Function of Space	RH (k), %
Class B and C operating rooms (m)(n)(o)	max 60
Operating/surgical cystoscopy (m)(n)(o)	max 60

Function of Space	RH (k), %
Delivery room (Caesarean) (m)(n)(o)	max 60
Treatment room (p)	max 60
Trauma room (crisis or shock) (c)	max 60
Laser eye room	max 60
Class A Operating/Procedure room (o)(d)	max 60
Endoscopy	max 60

Statement of Problem and Substantiation: “This proposal deletes the state amendment and reverts back to language in the ASHRAE 170 document. There have been many discussions about humidity over the past 10 years. The low range of humidity has been deleted from the newer version of NFPA 99. CMS has recently provided direction to state agencies to allow the lower (20%) humidity ranges in the ASHRAE 170 document. This change coordinates the requirements between state and federal agencies.”

Cost Impacts: “No cost impact – this is consistent with current guidance from the Centers for Medicaid and Medicare Services.”

Benefits: “Consistency between state and federal agencies.”

Discussion Notes: The submitter wasn’t available for discussion. It appears the submitter wants to default back to the old ASHRAE 170 language. General discussion was that consistency with the national standards is a good thing. This has been a question/point of confusion for other facilities.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 043:

Submitter: John Williams

Section: WAC 246-320-600

Proposal: Delete state amendment as follows:

3.1-8.2.43 HVAC Air Distribution

~~3.1-8.2.3.34.1 Return air systems. For patient care areas where invasive applications or procedures are performed and rooms containing materials used in these applications and procedures, return air shall be via ducted systems.~~

Statement of Problem and Substantiation: “This proposal deletes the previous state amendment to require ducted returns only in specific locations. The purpose at that point in time was to address concerns from the ASHRAE 170 committee that ducted return requirements were not properly scoped in their document. Several revision cycles have passed for ASHRAE 170, and we propose reverting back to the language established by the national standard.”

Cost Impacts: “Add fifteen (15) percent to the mechanical system design for certain outpatient clinics.”

Benefits: “Cleaner air, allows for possible heat recovery and energy savings.”

Discussion Notes: The intent is to let ASHRAE 170 direct the location of ducted returns, and therefore be consistent with the national standard. The previous change was intended to address a perceived failure in aligning scope between the two documents. This has been resolved between the organizations. Hard ducted returns will be required in all of the places where there is a pressurization requirement.

A question was raised as to how this might impact changes of function inside of an existing facility. Currently when similar questions arise, the department reviews scope of the work along with how significantly the function of the space changed to determine if ducting are necessary. For example, changing a conference room to an operating room would require ducted returns.

Advisory opinion: Generally the participants were in favor of recommending this proposal.

Proposal 044:

Submitter: John Williams

Section: WAC 246-320-505

Proposal: Revise text as follows:

WAC 246-320-505 (2) A hospital will meet the following requirements:

- (a) **Preconstruction.** Request and attend a presubmission conference for projects with a construction value of two hundred fifty thousand dollars or more. The presubmission conference shall be scheduled to occur for the review of construction documents that are no less than fifty percent complete.
- (b) **Construction Document Review.** Submit construction documents for proposed new construction to the department for review within ten days of submission to the local authorities. Compliance with these standards and regulations does not relieve the hospital of the need to comply with applicable state and local building and zoning codes.
 - (e) The construction documents must include:
 - (i) A written program containing, but not limited to the following:
 - (A) Information concerning services to be provided and operational methods to be used;

- (B) An interim life safety measures plan to ensure the health and safety of occupants during construction and installation of finishes.
- (C) An infection control risk assessment indicating appropriate infection control measures, keeping the surrounding area free of dust and fumes, and ensuring rooms or areas are well ventilated, unoccupied, and unavailable for use until free of volatile fumes and odors;
- (ii) Drawings and specifications to include coordinated architectural, mechanical, and electrical work. Each room, area, and item of fixed equipment and major movable equipment must be identified on all drawings to demonstrate that the required facilities for each function are provided; and
- (iii) Floor plan of the existing building showing the alterations and additions, and indicating location of any service or support areas; and
- (iv) Required paths of exit serving the alterations or additions.
- (~~dc~~) **Resubmittals.** ~~The hospital will r~~Respond in writing when the department requests additional or corrected construction documents;
- (~~ed~~) **Construction.** Comply with the following requirements during the construction phase.
 - (i) The hospital will not begin construction until all of the following items are complete:
 - (A) The department has approved construction documents or granted authorization to begin construction; and
 - (B) The local jurisdictions have issued a building permit; and
 - (C) The hospital has ~~Notify~~-notified the department in writing when construction has commenced;
 - (ii) The department will issue an "authorization to begin construction" when the construction documents have been reviewed to the department's satisfaction, or, when all of the following items have been provided and approved:
 - (~~fA~~) Provide the department with a signed form acknowledging the risks if starting construction before the plan review has been completed. The acknowledgment of risks form shall be signed by the:
 - (i) Architect; and
 - (ii) Hospital CEO, COO or designee; and
 - (iii) Hospital facilities director.
 - (B) The infection control risk assessment;
 - (C) The interim life safety plan;
 - (D) A presubmission conference has occurred.
 - (~~giii~~) Submit to the department for review any addenda or modifications to the construction documents;
 - (~~hiv~~) Assure construction is completed in compliance with the final "department approved" documents. Compliance with these standards and regulations does not relieve the hospital of the need to comply with applicable state and local building and zoning codes. Where differences in interpretations occur, the hospital will follow the most stringent requirement.

- (iv) The hospital will allow any necessary inspections for the verification of compliance with the construction document, addenda, and modifications.
- (je) **Project Closeout.** ~~Notify the department in writing when construction is completed and include a copy of the local jurisdiction's approval for occupancy.~~
- (3) The hospital will not begin construction or use any new or remodeled areas until:**
 - (a) ~~The infection control risk assessment has been approved by the department;~~
 - (b) ~~The interim life safety plan has been approved by the department;~~
 - (c) ~~An acknowledgment of risk form has been submitted to the department as required by subsection (2)(f) of this section;~~
 - (di) The department has approved construction documents; and The department has approved construction documents or granted authorization to begin construction; and
 - (eii) The local jurisdictions have completed all required inspections and approvals issued a building permit, when applicable or given approval to occupy; and.
 - (iii) The facility notifies the department in writing when construction is completed and includes a copy of the local jurisdiction's approval for occupancy.
- (4) ~~The department will issue an "authorization to begin construction" when subsection (3)(a), (b), and (c) are approved and the presubmission conference is concluded.~~**

Statement of Problem and Substantiation: “This proposal attempts to clarify the submission, review, closeout and approval requirements for submitting project to Construction Review. No technical changes to the requirements are being made. This section has evolved over many decades, with additions and subtracts resulting language that could be clearer.

I do not intend to add any requirement, only to rearrange the requirements based on the natural progression of the projects. My goal is a clearer understanding for designers and facilities personnel that are new to interacting with CRS. Indentation and bolded letters have been added for emphasis only.”

Cost Impacts: “No cost impact due to no technical changes being made.”

Benefits: “Rules that are more clear and straightforward.”

Discussion Notes: The intent is to make the section more user friendly. No technical changes have been made.

A question was raised in reference to the final dollar amount submitted on the notification of completion (NOC.) This cost may not be available until months after construction is complete. This poses a potential conflict with occupancy if the NOC can't be completed. CRS staff discussed our policy for resolving this case. A possible public comment to this proposal is to clarify that it is acceptable to provide the best final cost estimate at project completion, with the understanding that a change to that number can be submitted at a later date if necessary.

A suggestion was made to add additional language to require that designers and facilities provide prompt response to plan review comments. Often the facility or architect will not respond timely (or at all) which creates adverse impacts for the project. Discussion centered around what an acceptable

amount of time would be for responses. This would probably vary significantly based on the scope of the project.

Advisory opinion: Generally the participants were in favor of recommending this proposal.