Washington State Department of Health

Workshop 2 - Agenda

Review comments on proposals to modify chapter 246-320 WAC (Construction Standards only)

DOH 505-124 October 2014

Department of Health contacts:

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Public Workshop Meeting 2 – Review Comments

Date: November 17, 2014
Time: 9 a.m. to 3 p.m.
Location: Point Plaza East, Room 152/153, 310 Israel Rd. S.E., Tumwater, WA 98501

This meeting is to review each comment submitted during the proposal period. The meeting order is as follows: attendees will have an opportunity to speak on any comment and make an advisory opinion to either support or not support each concept during the meeting. Following the review of comments, the floor will be open to any other comments.

After this meeting, DOH will publish the Report on Comments. The department will perform an internal review and generate the draft rule. We anticipate filing the draft rules in a CR-102 in February 2015. The next public meeting to review this revised draft will be in March 2015. The meeting date and location will be published on our website and announced via the construction review listserv.

CRS website: www.doh.wa.gov/crs
CRS main phone line: 360-236-2944

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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.

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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

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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.

Comment #1
Submitter: Elizabeth "Betsy" Braun, Architect
Position: Oppose
Section: FGI Guidelines Table 2.1-2

Statement of Problem and Substantiation for Comment: "I disagree with the requirement that nurse call devices be provided in all bathrooms in all inpatient hospital buildings for two reasons. The first is that many areas in hospitals are remote from facilities like nursing stations, where trained staff who are able to respond to calls are located. Providing appropriate staffing coverage for these areas from remote locations may be infeasible, and place an undue burden of care for those staff who need to leave their units to respond. Operationalizing coverage for these units will be difficult and costly. I also disagree with the concept that an untrained staff person should respond to calls as a cost-saving gesture. They would then need to summon trained staff, delaying appropriate care. Hospitals must respond to code calls of other types with appropriately trained personnel. I have serious concerns about the adequacy of this as an operational response.

Second, the risk that a person could have a medical incident in a bathroom is roughly equivalent to them having a medical incident in any other area of a hospital, on the campus or in the community. Nurse call stations are not provided in all locations in a medical center. Targeting bathrooms for special treatment does not fully mitigate this risk. Offices, sleep rooms, locker rooms, research laboratories and other areas are frequently occupied by only one staff at night."

Cost Impacts: "This change will increase construction cost. Nurse station systems are expensive to install and maintain. I do not know the cost per duty station of a system. The cost would increase the more remote an area is from the central station. The cost to cover the additional stations with appropriately trained personnel on all shifts in the areas where the bathrooms are located can be substantial."

Benefits: "This change adds cost for a poorly defined benefit, and creates significant operational challenges to realize. I recommend we not require these stations."

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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?

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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.

Comment #1
Submitter: Elizabeth "Betsy" Braun, Architect
Position: Oppose
Section: WAC 246-320-505(1)

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 for Comment: "I disagree with the requirement that consulting engineers must be used for all renovations. A diversity of delivery methods are now available. Local jurisdictions have differing, sometimes conflicting requirements on the level of professional required for various types of work. This should be left to the Owner and their local authorities having jurisdiction.
Also, when more people are involved in the design process, the cost of their coordination adds to the project costs. A design-builder can be more cost effective than a designer and a separate builder, due to reduced documentation and coordination requirements."

Cost Impacts: "This change will increase construction cost. This is hard to quantify. The cost to hire and negotiate a contract with an engineer can be substantial, especially for public hospitals, above and beyond the cost of the work."

Benefits: "I recommend leaving the current language as-is to provide flexibility in delivery of services."

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."

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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.

Comment #1
Submitter: John Williams
Position: Support
Section: FGI Guidelines 1.2-3.9 Construction Risks

The Safety Risk Assessment shall consider the impact of additional construction related risks, such as planned utility shutdowns, risk of noise or vibration from construction activity, as well as relocation and pathway disruptions.

(Modify Table 1.2-1 and A1.2-a as applicable.)

Statement of Problem and Substantiation for Comment: "The CRS team reviewed this proposal and felt that this was the appropriate section to locate a requirement. The team also agreed with the proponent's original substantiation."

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 faciltiy
- Minor Renovation: Renovations that are valued at less than 25% of the building, excluding land

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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.

Comment #1
Submitter: Christine Keifer
Position: Support w/modifications
Section: FGI Guidelines Glossary

Construction:

- New construction: Construction that requires site preparation or changes the demising walls of areas to create useable square footage.
- Major renovation: Renovation that changes the function or operation of an area, HVAC replacement, or increases the overall square footage of a department.
- Minor renovation: Renovation or maintenance that maintains the existing function but does not change the demising walls of an area. Minor changes to the configuration of an existing space within existing demising walls, equipment replacement or those projects that fall under finish only plan review.

Statement of Problem and Substantiation for Comment: "The intent of this proposal is to add clarity and predictability for all parties involved on the application of the Guidelines, not to limit the Department of Health's oversight or authority. The definitions of major and minor were removed from the glossary in this addition. Specifically, the goal would be to define when the Guideline is applied to construction projects: new construction and major renovation. However, in areas where the space and function remain the same it may not be feasible to apply the new Guidelines. For instance, if a CT scanner is replaced in an existing room and the demising walls are not changing location then it likely is not feasible to meet the clearances as stated in the Guidelines. However, the original CT installation met the requirements at the original time of design."

Benefits: "Clarifies the applicability of the code for all parties."

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Comment #2
Submitter: Susan Upton
Position: Support w/modifications
Section: FGI Guidelines 1.1-6-3

1.1-6.3 Authorities adopting these standards as codes may approve plans and specifications that contain deviations if it is determined that the applicable intent or objective has been met.

Statement of Problem and Substantiation for Comment: "The proposal author submitted several proposals (reference proposals 020, 021, 022 and 023) relating to existing conditions, renovation projects and the authority having jurisdiction having the ability to deviate from guideline requirements when in the judgment of the AHJ the intent or objective of the guidelines have been met.

Rather than amending multiple specific sections of the guidelines this comment would add a general section that guides the AHJ authority to deviate from the guidelines, where deemed appropriate by the AHJ. The comment text was taken from the 2010 FGI section 1.1-1.3.5. Adding this text back into the 2014 guidelines is consistent with CRS policy for using judgment while reviewing existing conditions and renovation projects.

Ref: 2010 FGI 1.1-1.3.5"

Cost Impacts: "This change will have no impact on construction cost. No impact since it is CRS policy to use judgement to deviate from guideline requirements when reviewing existing conditions."

Benefits: "Codifies CRS policy."

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."

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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.

Comment #1
Submitter: Christine Keifer
Position: Support w/modifications
Section: FGI Guidelines 2.1-7.2.2.10(1)

Handrails shall be installed on both sides of patient use corridors unless, based upon the Safety Risk Assessment, handrails could cause a fall risk to the patients being served.

Statement of Problem and Substantiation for Comment: "For specific patient populations who are dizzy or confused, the use of handrails may increase the fall risk. The proposal allows a diverse team to assess the risk using the safety risk assessment and make a recommendation for a specific patient population."

Benefits: "Allows multidisiplanary team to asses fall risks to patients using the Safety Risk Analysis."

Comment #2
Submitter: Elizabeth "Betsy" Braun, Architect
Position: Support
Section: FGI Guidelines 2.1-7.2.2.10(1)

Statement of Problem and Substantiation for Comment: "I support Ms. Kiefer's recommendation that handrail requirements be defined by the functional program, and by the pragmatic concern that in many patient care facilities, sliding doors, pass-throughs and other interruptions of the wall surface make the installation of meaningful handrails to support ambulation impractical. Handrails should be provided where needed to support the patient activities planned for the area."

Cost Impacts: "This change will not increase construction cost. Handrails are costly. I do not have precise figures. They should be installed where needed."

Benefits: "Avoiding overbuilding building elements that are unused or create unsafe conditions."

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Comment #3
Submitter: John Williams
Position: Oppose
Section: FGI Guidelines 2.1-7.2.2.10(1)

Handrails shall be installed on both sides of patient use corridors, 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.

Statement of Problem and Substantiation for Comment: "The CRS team reviewed this proposal and felt that language that would allow the SRA limit the handrails to one side of the corridor was appropriate for most conditions. Given special cases, eliminating the handrails on both sides of the corridor could be done, however we felt that this should be reviewed on a case by case basis as an exemption or alternative methods request."

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.

Comment #1
Submitter: John Williams
Position: Oppose
Section: FGI Guidelines 2.2-3.3.3.2(2)(2)

The room shall be physically separated from the hybrid operating room with walls and a door. A door separating the control room is not required when the control room is built, maintained, and controlled exactly the same as the OR.

Statement of Problem and Substantiation for Comment: "We support the concept, but oppose the language as written. As discussed in the first public meeting we prefer language that would govern the design content and operation of the control room. This should include the design of walls, floors, HVAC; operational controls like garb, scrubbing, etc.; and maintenance of the area."

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.

Comment #1
Submitter: Christine Keifer
Position: Support w/modifications
Section: FGI Guidelines 2.1-7.2.2.10(1)

2.2-3.3.4.3(1)(b) A minimum of 1.5 post-anesthesia patient care stations per operating room shall be provided unless the functional program and safety risk assessment demonstrate that a lower number of post-anesthesia patient care stations is appropriate.

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Statement of Problem and Substantiation for Comment: "The intent of this proposal is to allow hospitals to determine the patient flow and functionality between the ORs, PACU, ambulatory surgery and inpatient units. The prescriptive number assumes that all institutions operate PACUs and related units in the same manner. However, the types of procedures can vary wildly between institutions. Information should be provided to the Department of Health in the functional program and safety risk assessment on space and patient flow to help determine the appropriate PACU requirements."

Cost Impacts: "This change will increase construction cost. Each PACU station requires approximately 450 sf in direct patient care areas and support at $350 per square foot. Each PACU station is appx. $157,500."

Benefits: "Allows institutions to manage patient flow and efficiency."

Comment #2
Submitter: Elizabeth "Betsy" Braun, Architect
Position: Not specified by submitter
Section: FGI Guideline 2.2-3.3.4.3(1)(b)

*(b) PACU size. ~~A minimum of 1.5 post-~~The quantity of post anesthesia patient care stations per operating room shall be provided based on the functional program.

Statement of Problem and Substantiation for Comment: "Patient recovery, length of case, staff efficiencies, recovery in the OR, or inpatient units and other variables can significantly vary the need from one hospital to another for PACU and Phase 2 recovery bays. The prescriptive standard expressed in the FGI does not reflect the diversity of need.

I support Ms. Kiefer's concerns about a diversity of population, and propose alternate language above."

Cost Impacts: "This change will not increase construction cost. Current costs of high acuity hospital construction can range in the $1,200/SF range fully equipped. By allowing the hospital to rightsize their demand and therefore capacity, they don't overbuild. Additional PACU bays that are underutilized still require maintenance and staffing."

Benefits: "As healthcare corporations use Lean techniques to reduce the waste in their processes, one of the net benefits is faster turn times, and the need to rightsize their capacity."

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.

Comment #1
Submitter: Matthew Campbell
Position: Support w/modifications
Section: FGI Guideline 3.7-3.6.13.4, Part 4 – ASHRAE 170

~~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:~~

(Amend Part 4 of the 2014 FGI to include the following requirements for Sterile processing rooms in Table 7.1 of ASHRAE 170)

(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) Not less than ~~T~~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 for Comment: "Revised language clarifies that 2 outside and 6 total air changes per hour is a minimum; more air changes per hour is acceptable. The intent is still to follow the direction of the ASHRAE 170 committee as they investigate appropriate requirements for this new type of room.

Placing the new language in Part 4 of the FGI ensures consistent physical environment standards for sterile processing rooms within hospitals and ambulatory care facilities. Table 7.1 is the logical place that a mechanical designer would go to for guidance. Placing the text in the 3.7 may lead to confusion."

Cost Impacts: "This change will have no impact on construction cost. No 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."

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.

Comment #1
Submitter: Elizabeth "Betsy" Braun, Architect
Position: Oppose
Section: FGI Guideline 7.2.3

Statement of Problem and Substantiation for Comment: "The anteroom for rooms that are used for both AII/PE should be positive to the patient room and positive to the corridor to prevent staff who may be donning or doffing apparel in the anteroom from being exposed to airborne agents. If the anteroom is negative, it may draw contaminated air into the anteroom, exposing the staff. The room can then be used safely for either neutropenic patients or airborne infectious isolation patients."

Cost Impacts: "This change will not increase construction cost. Reduction, as rooms can serve a greater diversity of patients."

Benefits: "I am not an infection prevention specialist, and would defer to other experts in this issue."

DRAFT