Humanizing Health Care Environments - 2018 Guidelines -

Today’s Speaker

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• CEO of the Facility Guidelines Institute

Disclaimer

The views and opinions expressed in this presentation are the opinion of the speaker and may not be the official position of FGI or the Health Guidelines Revision Committee.
Who was involved in development of the 2018 Guidelines?

2018 HGRC
100+ Multidisciplinary Committee
- 20% - Architects
- 18% - Medical professionals
- 16% - State AHJs
- 13% - Engineers
- 10% - HC administrators/HC org. reps
- 8% - Federal AHJs (IHS, CMS, HUD, VA)
- 7% - Infection control experts + NIH/CDC
- 4% - Construction professionals
- 4% - Interior designers

FGI Process Overview
Consensus-based process for Guidelines development using:
- Collective multidisciplinary experience
- Professional stakeholder consensus, including many AHJs (no manufacturers vote on proposals)
- Public review process
- Clinical and evidence-based research
- Continual improvement process

Every new edition of the FGI Guidelines is different and an “evolution” from previous editions.
This is not us...

FGI website: a way to keep current with FGI and Guidelines activities

fgiguilines.org
New electronic version available
madcad.com

See FGI website for information

- Design Guide for the Built Environment of Behavioral Health Facilities
- FGI Acoustics Working Group (AWG) 2011 white paper
- Articles by FGI HGRC members in peer-reviewed journals
- Articles elaborating on changes to the Guidelines

2014 Edition First Cost Impact Review
- HGRC Cost/Benefit Committee in conjunction with ASHE
- Review of Hospital/Outpatient document to identify the first cost impact of implementing the 2014 edition (approx. 2% increase in first cost with no credits for cost reductions)

2018 Edition Benefit-Cost Impact Review
- EVERY 2018 proposal for change was reviewed by the HGRC for clinical and operational benefit. The Benefit/Cost Committee also reviewing for benefit, first cost, and life cycle cost of major changes.
2014 Cost/Benefit Study Algorithm

Cost/Benefit Algorithm for 2018 Analysis

ASHE 2014 Study – Added up + first cost part of the algorithm only

FGI is using the entire algorithm vs. just first cost

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FGI is using the entire algorithm vs. just first cost
2018
Defining Minimum

Minimum is Difficult to Define

- Risk of being too minimal
  (creates opportunity for harm)
- Consider risk/benefit for new minimums
- The minimum benchmark changes over time
- Cost is a reality in determining Minimum Standards

Key to “Minimum”
Leadership point of view

A change is below a minimum standard if it does any of the following:
1. Compromises patient, staff, or visitor safety.
2. Increases the risk of any of the seven elements of the SRA.
3. Increases readmission rates.
4. Compromises privacy requirements.
5. Decreases the operational efficiency of the clinical space.
THE LOW ACUITY PATIENT POD

Happening Now

Low Acuity Patient Pod
History & Development
Low Acuity Patient Pod
History & Development

2014 – 2016
ACEP National Conventions
Chicago, Boston, Las Vegas

Low Acuity Patient Pod
Variations & Sizing

DIMENSIONAL CONTROL
Low Acuity Patient Pod
Dimensional Control

2018 Guidelines

An overview of major topics that were addressed and some of the proposed changes discussed

Hot Topics for 2018

- Design/clearances to accommodate patients of size
- Pre- and post-procedure patient care areas – flexibility to combine areas and correct ratios when doing so
- Procedure and operating room sizes that reflect space requirements for anesthesia team and equipment
Hot Topics for 2018

• Classification system for imaging rooms
• Guidance for when exam/treatment, procedure, and operating rooms are needed
  – Clearances and spatial relationships
  – Locations for procedure types

Hospital and Outpatient Guidelines
Additional Major Topics Addressed

• Design of telemedicine spaces
• Sterile processing facilities
• Mobile/transportable medical unit revisions
• Expanded sustainable design requirements
• Emergency preparedness

Emergency Preparedness

• The design must provide space for resources needed to respond in an emergency.
• Design supports:
  – Sheltering in place
  – Continuance of service
• New appendix provides guidance on creating an emergency preparedness assessment, infrastructure assessment, and resiliency plan to absorb and recover from adverse events.
Sustainable Design

- Includes expanded information on waste minimization:
  - Requirements for mercury reduction and waste
  - Recommendations for developing a construction waste management plan
- Provides guidance on creating a measurement and verification plan for potable water and energy use
- Expands requirements to reduce water use from plumbing fixtures and fittings

Telemedicine Services

- Requires telemedicine space when clinical telemedicine services are provided
- May be a bay, cubicle, or room, permitted to be used for other purposes: e.g., patient room, physician’s office, conference room
- Appendix recommendations on:
  - Room features
  - Placement of cameras and microphones
- Addresses privacy, acoustics, lighting, site identification (for reimbursement and orientation)
Accommodations for Patients of Size

Determining “patient of size”:
- Patient’s weight
- Distribution of the patient’s weight throughout the body
- Patient’s height

In the Hospital document: Bariatric nursing unit removed from facility chapters and accommodations for patients of size added as a common element to address the need for serving patients of size throughout a health care facility.

Accommodations for patients of size also added to Outpatient and Residential documents.

Bariatric Patient Environment

Minimum Clearances Required for Bed to Wheelchair Transfer Using Floor-based Full Body Sling

Minimum Clearances Required for Bed to Chair Transfer Using Ceiling Lift
Pre- and Post-Procedure Patient Care Areas

• Direct access to the semi-restricted area without crossing unrestricted public corridors
• Ability to combine all patient care stations (pre-, Phase I, Phase II) in one area
    – Must meet the most restrictive requirements
    – Where combined into one area, at least two patient care stations per procedure, operating, or Class 2 or Class 3 imaging room

Pre- and Post-Procedure Patient Care Areas

Stations can be bays, cubicles, or single-patient rooms.

• Clearances
  — Bays (5 feet between gurneys, 3 feet between sides and adjacent walls, and 2 feet from foot of bed to the cubicle curtain)
  — Cubicles (3 feet between sides and adjacent walls, 2 feet from foot of bed to the cubicle curtain)
  — Where bays/cubicles face each other, need 8-foot aisle
  — Room (3 feet between sides and foot to the wall)

Pre- and Post-Procedure Patient Care Areas

• If separate pre-procedure room
  – Minimum of one patient care station per imaging, procedure, or operating room
• Phase I PACU
  – One per operating room (was 1.5)
• Phase II recovery room
  – Minimum of one per imaging, procedure, or operating room
Invasive Procedure Definition
A procedure that is performed in an aseptic surgical field and penetrates the protective surfaces of a patient’s body. May fall into one or more of the following categories:

- Requires entry into or opening a sterile body cavity
- Involves insertion of an indwelling foreign body
- Includes excision and grafting of burns that cover more than 20 percent of total body area
- Does not begin as an open procedure but has a risk, as determined by the physician, of requiring conversion to an open procedure

Why does it matter?

Operating Rooms
- Minimum clear floor area
  - Hospitals: Still 400 sq. ft. or 600 sq. ft. for special procedures
  - Outpatient: 255 sq. ft. unless general anesthesia administered, then 270 sq. ft.
Operating Rooms

- Clearances for 400-sq-ft OR:
  - 8 feet 6 inches on each side
  - 6 feet at the head
  - 7 feet at the foot
- Monolithic ceilings still required

Procedure Room Definition

- For procedures that do NOT meet the glossary definition of “invasive procedure”
  - Can be performed outside the restricted space of the surgery department or facility
  - May require use of sterile instruments or supplies
  - Requires some environmental controls but not OR-level environmental controls

  (Procedures performed in former Class A OR occur in procedure rooms.)

Procedure Room

- Semi-restricted area that is accessed from either semi-restricted or unrestricted corridor
- Space requirements
  - Clear floor area: reduced to 130 square feet
  - Clearances: 3 feet 6 inches on sides of table and 3 feet at head and foot of table
  - EXCEPTIONS where general anesthesia administered:
    - Clear floor area: 160 square feet
    - Clearances: 6 feet at head
Endoscopy

• Endoscopy procedure rooms shall meet the requirements for procedure rooms...except as follows:
  – Minimum clear floor area of 180 sq. ft. (reduced from 200)
  – Clearance of 5 feet at each side
  – Clearance of 3 feet 6 inches at head and foot
• Endoscope processing room is a semi-restricted area
  – Both decontamination and clean work areas with one-way traffic flow
  – Entrance and exit permitted to be from the procedure room

Classification of Imaging Room Types

• Class 1 imaging room
  – Diagnostic in nature (CT, MRI, fluoroscopy)
  – Services that utilize natural orifice entry
  – Accessed from an unrestricted area
  – Basic environmental controls (ventilation, surfaces)

Classification of Imaging Room Types

• Class 2 Imaging room
  – Procedures:
    • Diagnostic and therapeutic
    • Electrophysiology
    • Endoscopic
  – Accessed from an unrestricted or semi-restricted area
  – Some environmental controls for procedures such as cardiac cath
Classification of Imaging Room Types

- Class 3 imaging room and operating room
  - Invasive procedures
  - Any Class 2 procedure the physician identifies with a risk of needing conversion to an open procedure
  - Accessed from a semi-restricted area
  - Environmental controls of an operating room

Sterile Processing

Facilities outside a sterile processing department shall comply with all requirements for two-room sterile processing areas unless the equipment is limited to a table-top or similar-sized sterilizer, in which case a single room is acceptable.

Sterile Processing

- Sterile processing areas shall:
  - Be a semi-restricted area
  - Support a one-way traffic pattern
  - Have at least two entrances
  - Consist of a decontamination room and a clean workroom, separated by a wall with a door or pass-through
One-Way Flow

Clean Work

Traffic Flow
Decontam

Clean Core

Hospital Guidelines
Other Notable Changes

• Single-bed CCU rooms
• Sexual assault forensic exam room
• Geriatric treatment room in ED
• Technology distribution room size

Critical Care Unit

• Each patient care station shall be a single-patient room.
• In renovation, cubicles would be permitted.
**Sexual Assault Forensic Exam Room**

If provided, must meet the requirements of a single-patient exam room. SANE room contains:
- Pelvic examination bed/table
- Lockable storage area for forensic collection kits
- Private toilet and shower
- Readily accessible consultation room

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**Geriatric Treatment Room in ED**

Focus on reducing risk of patient falls

Provides brief guidance on:
- Surfaces & furnishings
- Flooring and furniture

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**Technology Distribution Room Size**

All TDRs shall provide a minimum 3-foot clearance on all sides of the equipment rack(s).
**Outpatient Guidelines**

to be a separate book

Part 1: Introduction

Part 2: Outpatient Facility Types

Chapter 2.1: Common Elements for OP Facilities

Facility type chapters:

- Will include chapter on freestanding emergency departments from Hospital book
- Mobile/transportable units will also be included in the Hospital book

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**Outpatient Guidelines**

Common Elements

- Patient care and diagnostic areas (clinical rooms, telemedicine, imaging, etc.)
- Patient support areas (pharmacy, lab, linen, sterile processing)
- Building support areas (environmental services, waste management, materials management)
- Public and administrative areas
- Architectural details, surfaces, and furnishings
- Building systems
- Acoustic tables tailored for outpatient facilities

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**Outpatient Guidelines**

Other Notable Changes

- Two approaches to applying requirements to facility projects
- Attention to flexibility for small projects
- Acknowledgment some facilities may be part of larger buildings owned by others
- Adjustments to building system requirements
- Consistent waiting room requirements for outpatient facilities
- Mobile/transportable medical unit revisions
Moving Forward…..

Onward to 2018…and multiple documents

- Hospitals
- Outpatient Facilities
- Residential Health, Care, and Support Facilities
- Sound & Vibration 3.0
- Beyond Fundamentals

Q & A

Thank you for joining us today!