



# FGI

**Formal Interpretations**  
*Guidelines for Design and Construction of*  
*Hospitals, 2018 edition*

Decisions published here were rendered after a multi-person panel of Health Guidelines Revision Committee (HGRC) members reviewed the request and consensus was achieved. These decisions are considered formal interpretations of the HGRC, but they are not binding for states that reference the *Guidelines*. Rather, they are advisory in nature and are intended to help users and adopting authorities having jurisdiction (AHJ) maximize the value of the *Guidelines*.

Further comments from members of the Interpretations Committee have been added to some interpretations. These comments are intended as explanatory information for users of the *Guidelines* and are not to be considered part of the formal interpretation.

Formal interpretations are rendered on the text of the requested edition of the *Guidelines*. However, any interpretation issued shall apply to all editions in which the text is identical, except when deemed inappropriate by the HGRC.

**In all cases, it is important to remember that the ultimate interpretation of information contained in the *Guidelines* is the responsibility of the authority having jurisdiction.**

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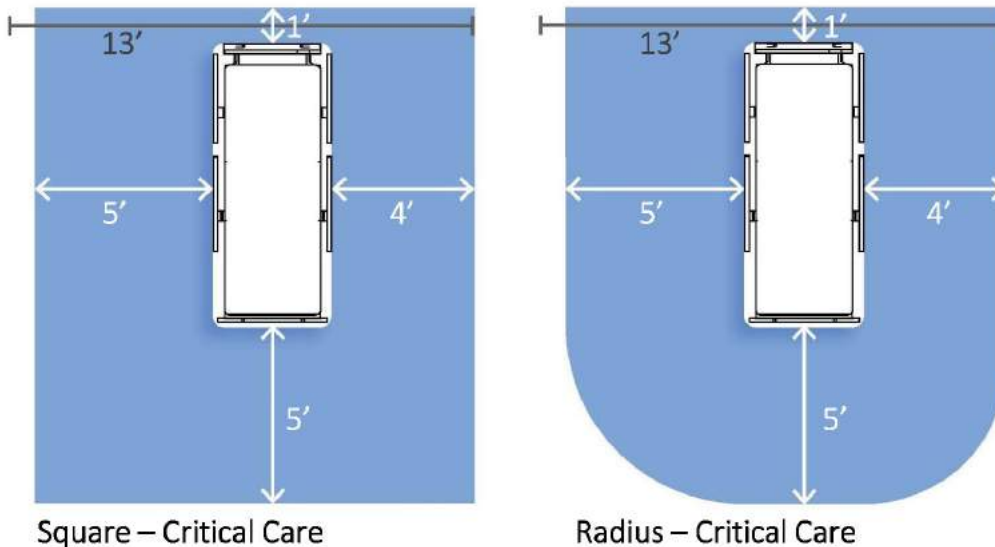
## REQUEST

*Guidelines edition:* **2018 Hospital**

*Paragraph reference:* **2.2-2.6.2.2 (2)**

**Question:** In Section 2.2-2.6.2.2 (2), regarding clearances for critical care patient care stations, does the 5-foot clearance requirement at the foot of the bed only require clearance for the width of the bed itself, or is the clearance to be extended to include transfer side width (5 feet) and non-transfer side width (4 feet), such that the width of the clearance at the foot of the bed totals 14 feet?

**Response:** The clearance requirement at the foot of the bed is intended to create sufficient space for care of the patient. Space is needed around the corners of the bed to allow access and movement for equipment, staff, and family members. Staff must be able to easily move around the bed. As well, space is needed for IV and pain management systems, warmers, etc., and for use of patient lifts and gurneys. To accommodate these needs, the full dimension at the foot needs to be as wide as the clearances on the sides of the bed; however, the squared-off space this creates could be rounded off to accommodate structural or other non-movable encroachments. This response applies to all places in the *Guidelines* where clearance requirements are provided. The diagrams below may help clarify this response.



## REQUEST

*Guidelines edition:* **2018 Hospital**

*Paragraph references:* **2.2-3.1.3.6 (2) and 2.2-3.1.4.3**

**Question:** Is it permissible for a single room in a hospital or freestanding emergency facility to be used as both a secure holding room and an emergency department (ED) exam/treatment room? If so, what would be needed to make it possible for this room to meet the requirements of both a single-patient treatment room and a secure holding room? That is, how would such a room be made safe for patients who need a secure holding room? When FGI is adopted as state law, AHJs are very careful not to be flexible to avoid inconsistency. Clarifying this would be appreciated for *Guidelines* users and for the real need of such rooms.

**Response:** The *Guidelines* does not prohibit the use of a single room as both a secure holding room and an ED treatment room as long as the room meets the *Guidelines* requirements for both space types. The room design must be able to provide safety for both functions—accessibility to electrical and medical gas requirements, a hand-washing station, etc. for the treatment room and the ability to secure these services behind a closed door or panel (e.g., a rolling shutter or similar retractable panel) to meet the provisions for the secure holding room.

## Further Comments

**Architect:** I have designed flexible rooms within the ED setting for secure holding rooms and typical treatment rooms with the gases and electrical outlets behind a secure overhead door. This design required coordination and waivers with the local AHJ to provide the flexibility typically required within EDs that cannot afford the space for dedicated secure holding rooms and/or seclusion rooms.

**Behavioral health expert:** An ED secure holding room is not limited to use by a behavioral health patient and can often be used to hold an agitated or not yet fully stabilized patient until a more appropriate and staffed bed is available. When these rooms will be used as both an ED treatment room and a secure holding room, they must be designed to provide safety for both functions (i.e.,

exam accessibility to electrical and medical gas requirements and hiding these services behind a closed door or access panel for secure holding).

But the room should also meet expectations for limiting ligature attachment (i.e., a solid ceiling or ceiling with glued or clipped-in-place tiles, impact-resistant lighting, ligature-resistant HVAC grilles, and tamper-resistant electrical outlets protected by GFCI and a remote master switch. The door to the room should have ligature-resistant hardware and, to foil attempts at barricade, swing outward or be double-acting. Lastly, any glazing material, including that in a mirror or picture frame, should be shatter-resistant and, any operable window should be limited to an opening of 4 inches.

**Authority having jurisdiction:** The *Guidelines* is silent on the use of an ED secure holding room (defined by Section 2.2-3.1.4.3) for any other purpose. However, if the room in question meets the requirements for both uses then, logically, the room is compliant with the *Guidelines*.

I have seen rooms provided with temporary doors, grilles, or shutters that allow the room to meet requirements for both an ED treatment room and a secure holding room. With the temporary doors down, it meets the room dimension requirements and is devoid of outlets, accessories, objects, etc. I also have approved, through the exception or equivalency concepts in *Guidelines* Section 1.1, alternate designs that have larger minimum dimensions than 11'-0". The value added by providing an additional exam room, including shorter wait times and increased access to care, warrants the increase of the maximum dimension. An ED is typically a highly observed location. If someone is secluded, a staff person is watching them and can intervene with other means if necessary.

The original question stated that AHJs are careful not to be flexible to avoid inconsistency. If an AHJ consistently follows an equivalency or exception process that purposefully weighs the intent of the rule and the risks and the benefits of a design, then they are being consistent; the *Guidelines* permit this approach. If an AHJ determines that an exemption or equivalency is valid, then the room meets the requirements of the *Guidelines*.

**Architect:** A secure holding room can be used as an ED treatment room as long as all the requirements and appendix guidance are followed. The existing *Guidelines* language should allow for this dual use; however, the essence of how a secure holding room works may not be met when the two room uses are combined unless attention is paid to the location of the room. ED treatment rooms are often located on the "front lines" in the emergency department close to the triage area, but it is recommended secure holding rooms be in a more discreet location. Can these two functions work for the operations of the ED? In small settings, such as critical access hospitals, you can easily accomplish both the frontline position and discreet location for a dual-purpose or transformative room combining secure holding and examination. In larger emergency departments, accomplishing this may not be so successful.

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## REQUEST

*Guidelines* edition: **2018 Hospital**      Paragraph references: **2.2-3.3.4.3 (2) and 2.2-3.4.1.3 (1)(d)**

**Question:** There is a conflict between the control room door requirements for hybrid ORs and Class 2 and 3 imaging rooms in the 2018 Hospital *Guidelines* (see explanation just following). Should the exception to omit the control room door permitted for the hybrid OR also be permitted for imaging rooms?

**Walls and a door required between control room and OR or imaging room:** Section 2.2-3.3.4.3 ([Hybrid OR:] Control room) and Section 2.2-3.4.1.3 (1) ([Imaging Services: General] Shielded control alcove or room) require walls and a door between a control room and a hybrid OR or Class 2 or 3 imaging room.

**Exception to omit door for hybrid OR:** Section 2.2-3.3.4.3 (2) permits this exception: “The door shall not be required where the control room serves only one operating room and is built, maintained, and controlled the same as the operating room.” This exception does not appear in the imaging section.

**Response:** It is acceptable to omit a door between the control room and a single Class 2 or Class 3 imaging room when the entire space is maintained at the same ventilation standards. It appears the HGRC missed the opportunity to coordinate this issue when updating the imaging requirements for 2018, but it is the task group’s view that the intent was the same for a control room serving a single OR and for a control room serving a single imaging room.

The task group agreed this discrepancy should be addressed by adding the second sentence currently in the hybrid OR text at 2.2-3.3.4.3 (2) to the imaging text in 2.2-3.4.1.3 (1)(d), as shown below.

As a result of this change, the task group found the language in paragraph (1)(e) confusing and unnecessary as paragraph 2.2-3.4.1.3 (1)(d) now addresses the issue of room pressurization, stating that the control room and imaging room will be “maintained” and “controlled the same.”

### 2.2-3.3 Surgical Services

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#### \*2.2-3.3.4 Hybrid Operating Room

...

**2.2-3.3.4.3 Control room.** Where required, a control room shall be provided that accommodates the imaging system control equipment.

...

- (2) The control room shall be physically separated from the hybrid operating room with walls and a door. The door shall not be required where the control room serves only one operating room and is built, maintained, and controlled the same as the operating room.

#### \*2.2-3.4 Imaging Services

##### \*2.2-3.4.1 General

...

##### \*2.2-3.4.1.3 Radiation protection....

- (1) Shielded control alcove or room....

...

- (d) The control room shall be physically separated from the Class 2 or Class 3 imaging room with walls and a door. The door shall not be required where the control room serves only one imaging room and is built, maintained, and controlled the same as the imaging room.

- ~~(e) Where an imaging room requires positive (or negative) pressure, a door shall be provided between the control room and the imaging room.~~

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## REQUEST

*Guidelines edition:* **2018 Hospital**

*Paragraph references:* **2.5-2.2.8.12**

**Question:** Chapter 2.5, Specific Requirements for Psychiatric Hospitals, requires a soiled workroom for the patient care [nursing] unit. Our client uses a linen service so would like to have a soiled holding room rather than a soiled workroom. The language in Section 2.5-2.2.812 (Soiled

workroom) does not appear to permit this. Shouldn't use of a soiled holding room be permitted for a psychiatric hospital patient care unit, where the patients are not being treated for medical issues that would require a soiled workroom?

**Response:** The HGRC Interpretations Task Group agreed that provision of a soiled holding room rather than a soiled workroom should be an option permitted for a patient care unit in a psychiatric hospital. To accomplish this change, the group recommended adding to the subhead in Section 2.5-2.2.8.12 as shown below. This interpretation can be applied to earlier editions of the *Guidelines*.

#### **2.5-2.2.8 Support Areas for the Psychiatric Patient Care Unit**

**2.5-2.2.8.12 Soiled workroom or soiled holding room.** See Section 2.1- 2.8.12 (Soiled Workroom or Soiled Holding Room) for requirements.

CROSS-REFERENCED COMMON ELEMENT TEXT:

#### **\*2.1-2.8.12 Soiled Workroom or Soiled Holding Room**

**2.1-2.8.12.1 General.** Soiled workrooms and soiled holding rooms shall be separate from and have no direct connection with either clean workrooms or clean supply rooms.

#### **2.1-2.8.12.2 Soiled workroom**

(1) This room shall contain the following:

- (a) Hand-washing station
- (b) Flushing-rim clinical service sink with a bedpan-rinsing device or equivalent flushing-rim fixture
- (c) Work counter
- (d) Space for separate covered containers for waste and soiled linen

(2) Where a fluid management system is used, the following shall be provided:

- (a) Electrical and plumbing connections that meet manufacturer requirements
- (b) Space for the docking station(s)

**2.1-2.8.12.3 Soiled holding room.** This room shall contain the following:

- (1) Hand-washing station or hand sanitation station
- (2) Space for separate covered containers for waste and soiled linen

### **Further Comments**

**Behavioral health design expert:** In behavioral health, either a soiled workroom or a soiled holding should be acceptable if the unit is being used for behavioral health patients without a medical comorbidity.

**Health care system design and construction VP:** In our system, we don't use bedpans or need a fluid management system, so a soiled holding room where both red bag hazardous waste and/or soiled linen can be placed is acceptable and generally what we build.

**Nurse:** Provision of a soiled holding room should be permitted if a soiled workroom is not required by the functional program.

**Health care project manager:** I find that freestanding behavioral health facilities rarely use the soiled workrooms. When picking up linens or waste they use a cart. If the cart is lockable once material has been deposited, a soiled room is not used. If the cart is not locked and materials can be

removed from it, a locked soiled holding room is mandatory because an event could arise when staff are picking up linens or wastes, causing them to leave the linens or trash open to patients who might remove something that presents a potential risk on the unit.

A soiled holding room is okay in lieu of a soiled workroom based on the acuity of the population. On a general hospital-based psych unit where bedpans may be required, a workroom with clinical sink is necessary. In a freestanding behavioral health facility where patient acuity does not require bedpans, a soiled holding room is acceptable.