

What's going on: FGI, DCA, the 2022 *Guidelines*, Emergency Conditions Project and 2026 ?

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**Health Facilities Management
Society of New Jersey**

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Introduction



A quick Intro to *FGI* and the *Guidelines*

DCA

2022 FGI Guidelines Quick Review

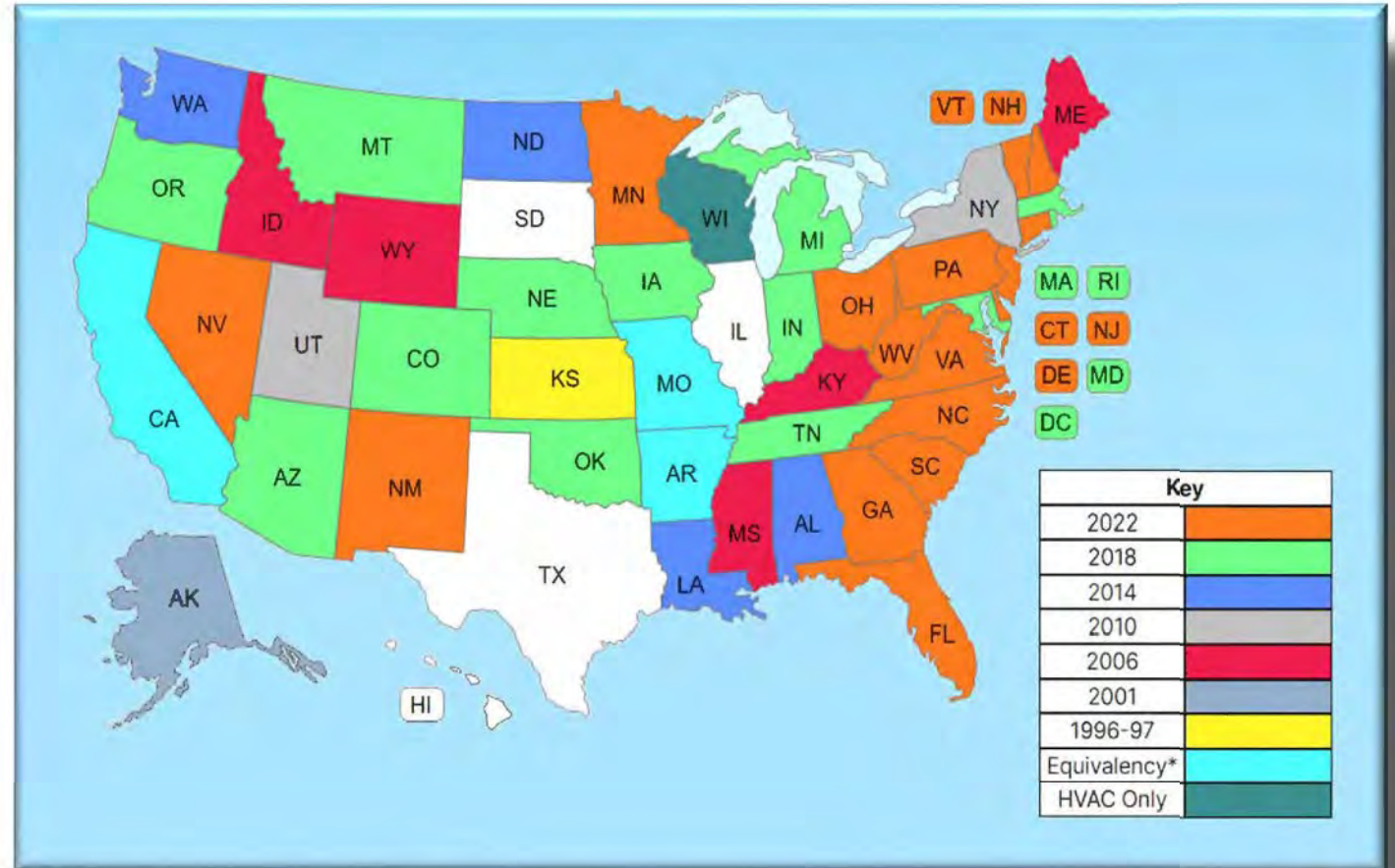
The Emergency Conditions Project

What happens next? *2026*



Who is FGI ?

- 501(c)(3) not-for-profit
- A volunteer, multidisciplinary committee of Health Facility experts
- Develops and authors fundamental standards and best practice white papers
- Produces three *Guidelines*
- Referenced by 43 states and federal agencies
- Uses a public process for proposed changes and comments on changes

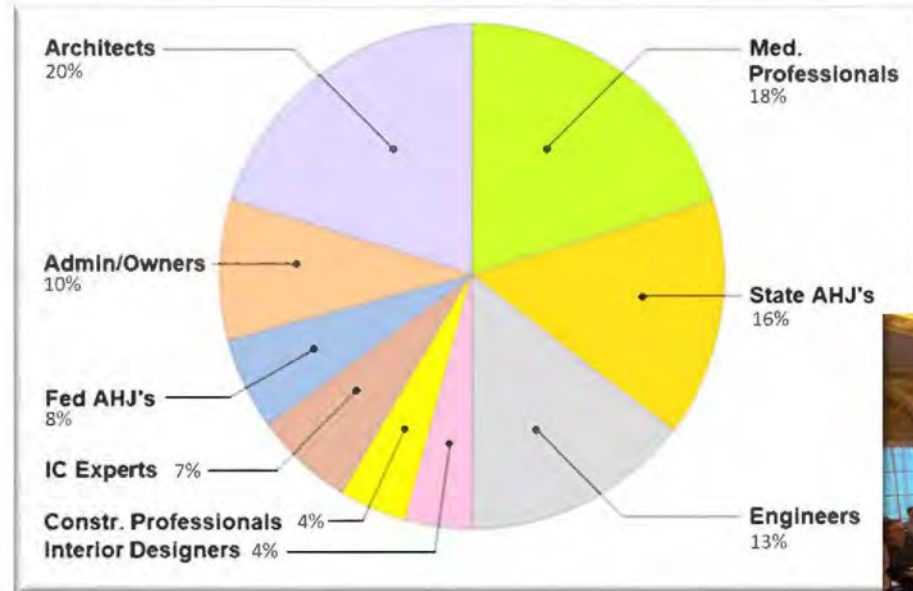


The Health Guidelines Revision Committee

- The **HGRC** is a select, multi-disciplinary, body of more than 130 professional volunteer representatives from across the nation

- The **HGRC** includes:

- Architects
- Medical professionals
- State AHJs
- Engineers
- HC administrators/HC org. reps
- Federal AHJs (IHS, CMS, HUD, VA)
- Infection control experts + NIH/CDC
- Construction professionals
- Interior designers



- **HGRC** members spend countless hours each cycle in subcommittees and focused task groups reviewing proposals for change, revising existing language and authoring new up-dated standards.

FGI Process Overview

Consensus-based process for *Guidelines* development that relies on:

- An experienced, multidisciplinary committee
- Professional stakeholder consensus, including many AHJs
- Manufacturers and vendors prohibited from voting on proposals
- Strong 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.

The “Guidelines”

- The original **General Standards** appeared in the *Federal Register* on February 14, 1947, as part of implementing regulations for the 1946 Hill-Burton Act.
- In 1974 the document was retitled **Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities** to emphasize that the requirements were minimum, not ideal standards.
- In 1984 the Department of Health and Human Services asked the American Institute of Architects to publish and distribute the **Guidelines**
- The **Facility Guidelines Institute** (FGI) was formed in 1998
- The 2022 edition is the latest in the 75 year history of the **Guidelines** and the 9th edition to be revised through a multidisciplinary consensus process supported by public input and review.



Guidelines for Design & Construction of Health Care Facilities

- The **Guidelines** are a consensus-based **minimum** standard that promote a level of building performance that will not detrimentally affect the health and safety of patients and staff when buildings are operated as designed.
- The **Guidelines** outline minimum program space, risk assessment, infection prevention, architectural details, and surface and furnishing needs for all clinical and support areas of hospitals, long term care, rehabilitation and ambulatory care facilities.
- The **Guidelines** also address minimum engineering design criteria for plumbing, electrical, and heating, ventilation and air-conditioning systems.
- When possible, the **Guidelines** standards are performance oriented to meet desired results. Prescriptive measures, when given, have been carefully considered relative to generally recognized standards.



Update on DCA

- Employees most often working from the office, although occasionally remotely
- Submittals are running close to normal (*15 to 20 new & 50 to 70 overall per month*) at this time
- Currently operating with 60 total employees. (20 field, 8 clerical, 32 reviewers) (*down from 126 in 2015*)
- They have only 3 full time health care reviewers (*down from 15 in 2015*)
- *They slowly beginning to add additional employees, but not necessarily those with healthcare experience*
- The remainder of reviewers are pulled from other units as needed
- Currently holding close to the normal 20 Day / 7 Day review schedule
- E-mail is still the best way to contact the reviewers, but phones are available



Update on DCA : Self Certification

Self-certification shall be available for repair, renovation, alteration, and reconstruction projects, as defined by the State Uniform Construction Code, in the following use groups with the square footage limitations: *Business, Factory, Mercantile, Residential & Storage*

To participate in the self-certification program design professionals will be required to meet the following, including, but not be limited to:

- Current licensure as a design professional;
- Current licensure by DCA to inspect high-rise and hazardous structures (HHS) for the applicable State Uniform Construction Code subcode jurisdiction;



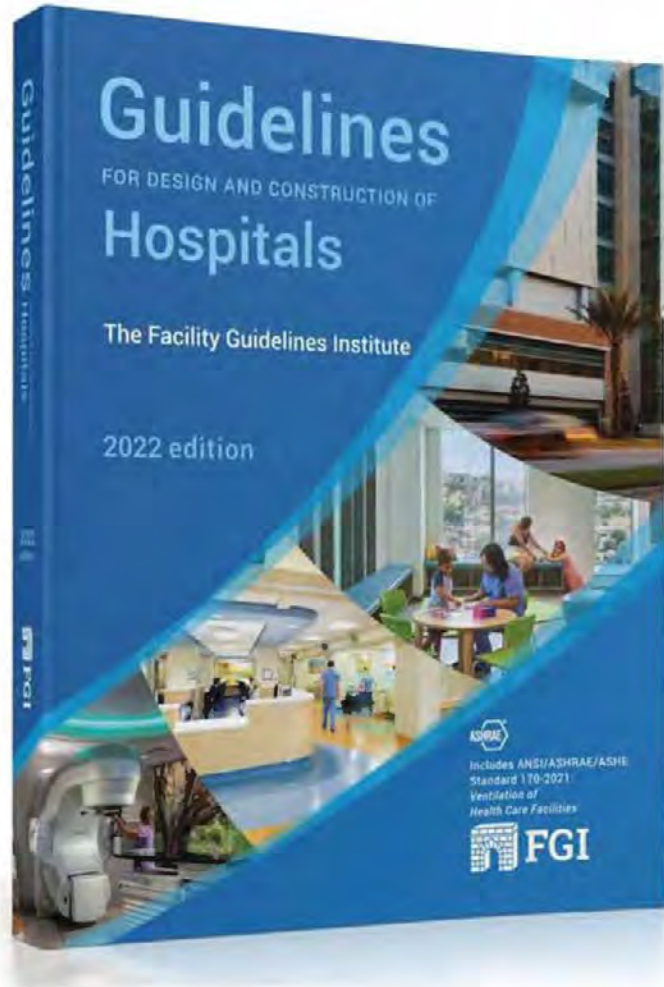
Self-certification ***shall not be available*** for projects where plan review is reserved solely to the Department of Community Affairs

Overview of FGI 2022



Changing to Keep
Pace with Clinical
Practices

Hospital Guidelines Major Revisions



- Common Elements
- Burn Trauma Care
- Hospice Patient care
- ER Low Acuity Treatment
- Neonatal Care
- Behavioral Health

Common Elements

Functional Program

- Guidance on project purpose & expectations for delivery of care

Acoustics for telemedicine rooms

- 0.25 noise reduction coefficient
- Interior noise (building system) 25 NC and 30 dBA
- Speech privacy requirement added

Emergency Site Access

- Video surveillance system for public entrances
- Duress alarm systems where entrances are **locked (Laura's Law)**

Airborne Infection Isolation Rooms

- Analysis of number required in the hospital is based on the ICRA

All Anterooms

- Whether an anteroom is required shall be determined by the ICRA
- Added space in the anteroom for doffing PPE before leaving

Call (nurse) systems

- Clarified use of wireless systems
- Clarified use of radiofrequency systems
- **Getting rid of “station” and going to “device”**

Ceilings in ORs & Class 3 imaging

- Modular or prefabricated laminar flow ceiling systems if:
 - Seams/access doors gasketed
 - Structurally rated assembly
 - Diffuser compliant w/ASHRAE 170

Ceilings in restricted areas

- Remain monolithic

Burn Trauma Critical Care Unit (New)

- Meet ICU criteria
- Available OR with temp of 95 degrees
- Maximum of one patient per room
- Patient room designed as Protective Environment (PE) room
- Radiant heat panels over bed
- Direct access to a patient toilet room





Hospice Patient Care Unit

- Minimum clear floor area of 153 sf with a min wall width at the head of the bed of 10 ft
- Family support zone with a minimum clear floor area of at least 33 sf
- Movable seating with a minimum of one seat for a family member or visitor and one seat for the individual receiving care
- At least one chair for long-term sitting
- Space for family member overnight stay
- Patient Toilet Room) shall be provided.

ER Low Acuity Treatment Area (New)

- Low-acuity patient treatment stations are intended to complement single- and multiple-patient treatment rooms and fast-track areas.
- The size and ratio of low acuity treatment bays or cubicles provided in an emergency department should depend on the expected patient acuity mix and planned use of the facility.
- Low-acuity patient treatment stations shall not be permitted to replace other emergency department treatment room types in their entirety.
- Each patient care station shall have a minimum clear floor area of 40 square feet with a minimum clear dimension of 5 feet 6 inches
- Each bay or cubicle shall accommodate a minimum clearance of 3 feet at the side(s), head, or foot of the patient chair that **corresponds with the care provider's expected work position(s).**



Neonatal Couplet Room (New)

- This room accommodates a hospitalized mother and a NICU patient to be cared for in the same room.
- 300 sf min. clear area, including 150 square feet for the infant care station and **150 square feet for the mother's bed.**
- Clearances for the adult bed shall meet the requirements for Care of Individuals of Size
- Clearances for the infant care station shall meet the requirements in Section 2.2-2.8.2.2





Behavioral Health Crisis Unit (New)

- A dedicated emergency services unit to respond to behavioral health patients presenting in a state of crisis
- The unit shall be in or readily accessible to the emergency department.
- Where in or readily accessible to the emergency department, shared services shall be permitted when located and configured to accommodate programmatic requirements for safety, security, and other clinical considerations
- Means for visual observation of unit corridors and patient care areas shall be provided.
 - Electronic surveillance shall be permitted but shall not be the only means of visual observation.
- An examination/treatment room shall be provided for medical assessment or triage of patients in the unit.
- The number of observation rooms in the behavioral health crisis unit shall be determined by the health care organization during the planning phase. The maximum number of beds per room shall be one.

Outpatient Guidelines Revisions

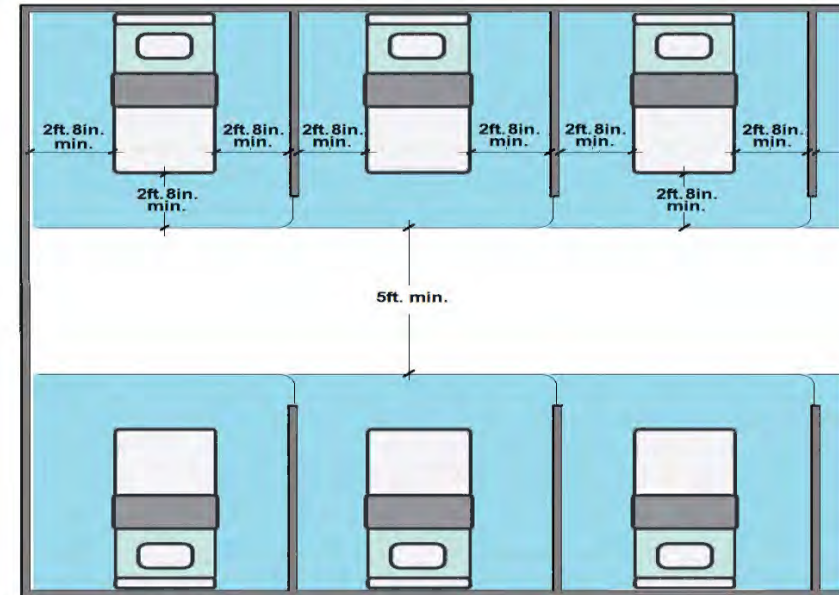
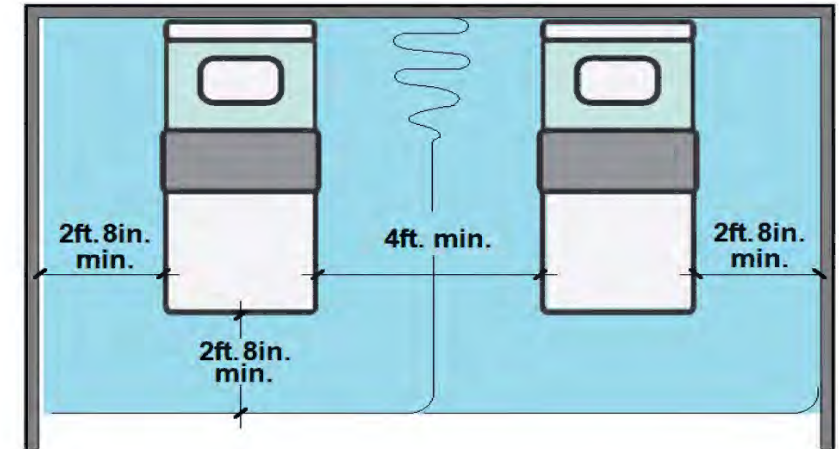


- Freestanding ED requirements now appear in Outpatient Guidelines only
- Removal of clear floor area requirements for several patient care stations, with clearances determining their size
- Birthing rooms **reduced** from 200 to 120 square feet
- Multiple-patient exam room added to the urgent care center chapter
- Added Language for Sexual Assault Forensic Exam Room
- New chapter for extended stay centers affiliated with outpatient surgery and freestanding emergency facilities put on hold for closer review

Multiple Patient Exam Room

Where an exam room with multiple-patient care stations is provided, it shall meet the following requirements:

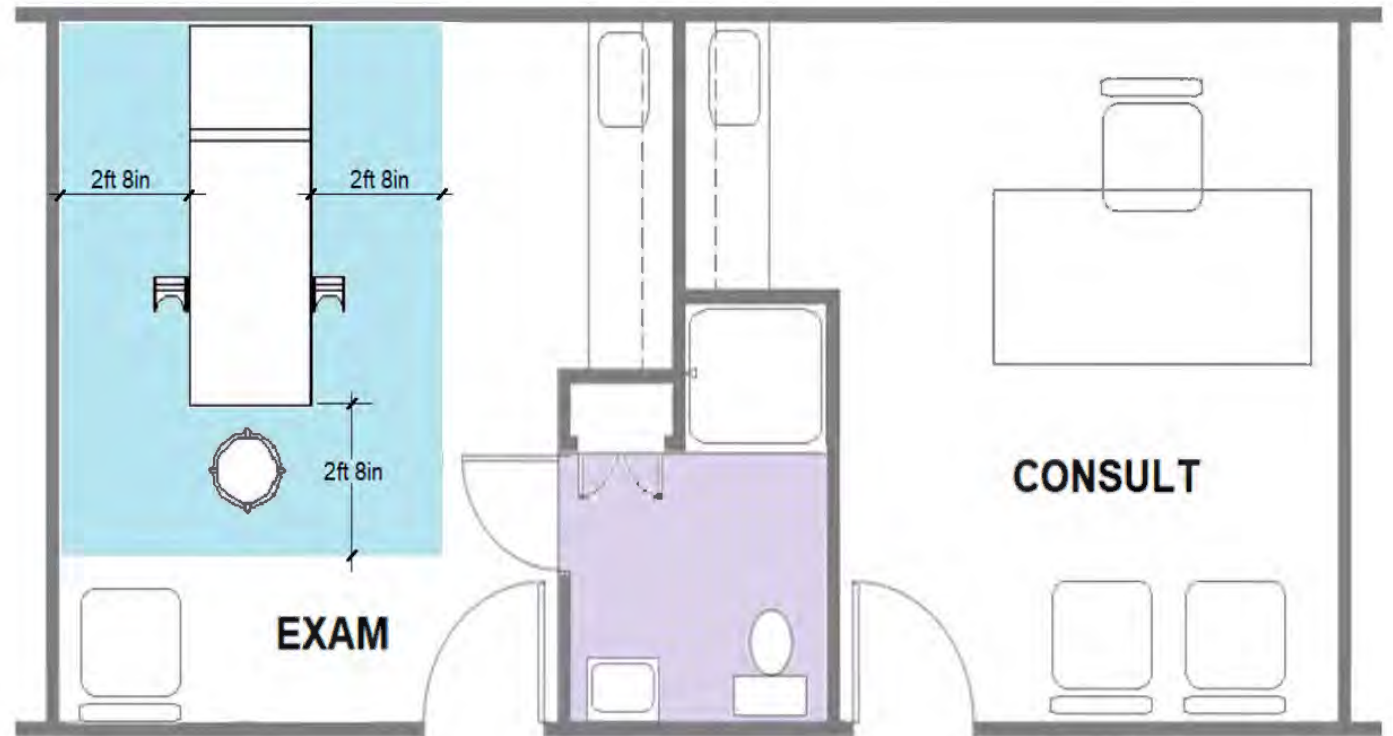
- Clearances shall be measured from the extended lounge chair/gurney position.
- Where bays are used, 4 feet shall be provided between the sides of gurneys/lounge chairs
- 2 feet 8 inches between the sides of gurneys/lounge chairs and adjacent walls or partitions
- 2 feet 8 inches between the foot of gurneys/lounge chairs and the cubicle curtain
- Where cubicles are used, a minimum clearance of 2 feet 8 inches shall be provided between the sides and of gurneys/lounge chairs and adjacent walls, partitions, or cubicle curtains.
- Where bays or cubicles face each other, an aisle with a min clearance of 5 ft independent of the foot clearance between patient care stations or other fixed objects shall be provided.



Sexual Assault Forensic Exam Room

If provided, must meet the requirements of a single patient exam room. *SAFE* room contains:

- 80sf. min. clear floor area
- Pelvic examination bed/table
- Lockable storage area for forensic collection kits
- Private toilet and shower
- Readily accessible Consultation room



Hyperbaric Oxygen Therapy Facilities (New)

- The hyperbaric treatment area shall meet the requirements of the “Hyperbaric Facilities” chapter in NFPA 99: Health Care Facilities Code.
- Requirements for :
 - Multi-place (Class A chamber) facilities
 - Mono-place (Class B chamber) facilities
- The support areas in Section 2.6-3.8 (Support Areas for the Infusion Center) shall be provided for the hyperbaric facility

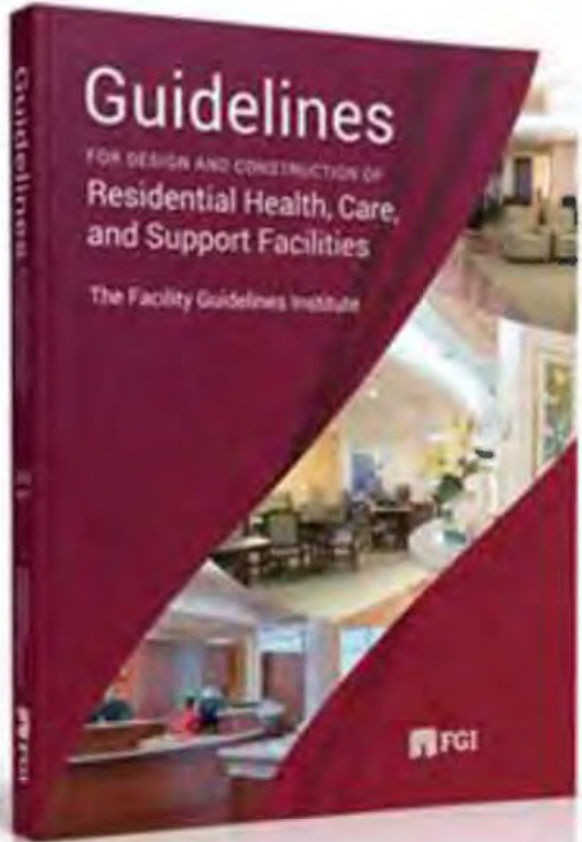


Extended Stay Centers

- This proposed chapter of the Guidelines was intended to apply to extended stay centers that serve outpatient surgery facilities, including ambulatory surgery centers, freestanding emergency care facilities, or other licensed facilities.
- It would be limited only to facilities for patients who receive medical/surgical care.
- After much consideration, we determined **that this just wasn't ready to include in the Guidelines for this edition.** *(Now being looked at for inclusion in the 2026 Edition)*



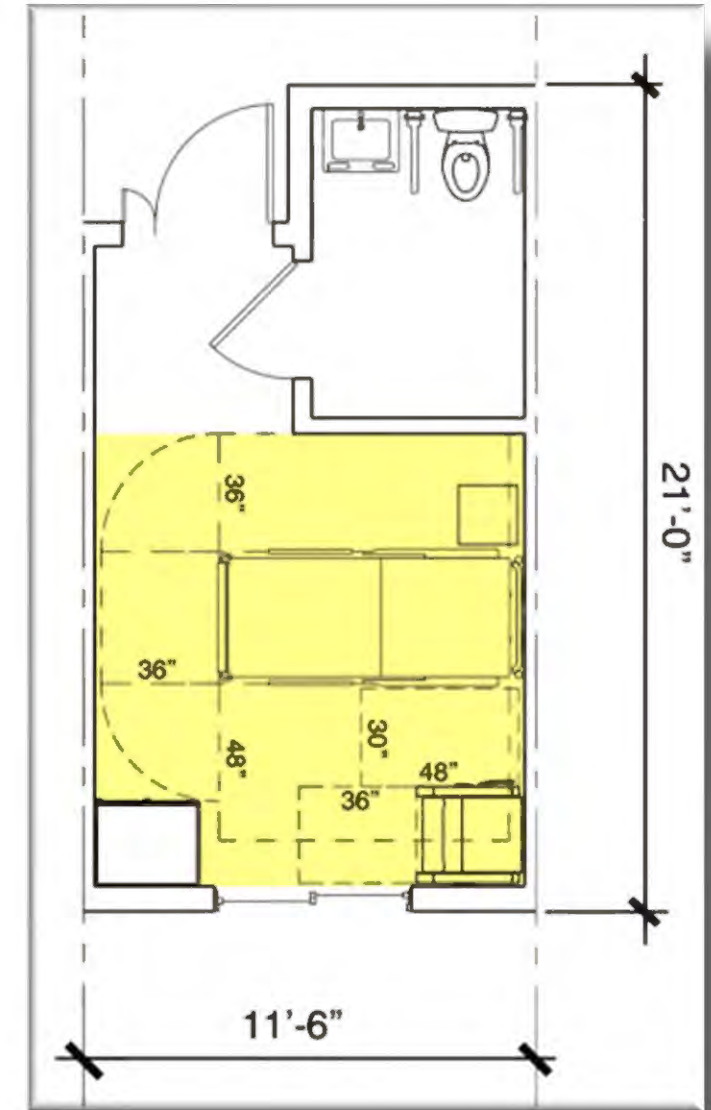
Residential Guidelines Revisions



- Significant revisions to spatial requirements for resident rooms in nursing homes – min. dimensions added to satisfy requests from regulatory agencies
- Expanded telemedicine guidance consistent with the Hospital and Outpatient documents – includes requirements for lighting, acoustics, privacy & finishes
- Consolidated and revised sections covering kitchens and food services facilities
- New language for dialysis facilities in nursing homes was added to cover size, layout and engineering requirements
- Added requirements and guidance for Palliative Care
- ASHRAE 170 included in Residential Guidelines

Resident Room Sizes

- The 2018 Residential Guidelines were intentionally silent on square footage requirements for sizing resident rooms. This was a choice made because of concern that, if a minimum size was provided, it would be taken as an absolute that would then become the base size of the space in which a resident would live, regardless of whether the size fully met resident needs.
- The unfortunate side effect of that choice has been that states have had difficulty implementing the Residential Guidelines.
- FGI received requests from several state authorities having jurisdiction (AHJs) asking for enforceable minimum square footages for resident rooms in nursing homes.
- Thus, for the 2022 Edition, the Residential Document Group reconsidered its position and agreed that basing a minimum resident room size on clearances would serve the needs of both states and nursing home residents.





Resident rooms shall be sized to accommodate the functional placement of required furnishings and equipment essential to resident comfort and safety.

Single Resident Room Size

- Minimum clear floor area of 120 square feet, excluding the bathroom, vestibule entry, and closet or wardrobe
- Minimum clear dimension of 11 feet

Multi-Resident Room Size

- Minimum clear floor area of 108 square feet per bed, excluding the bathroom, vestibule entry, and closet or wardrobe
- Minimum clear dimension of 9 feet per bed

Resident of size rooms shall be sized to accommodate the placement of required furnishings and equipment essential to comfort and safety. Sizes will be based on the use of overhead or non-overhead lifts

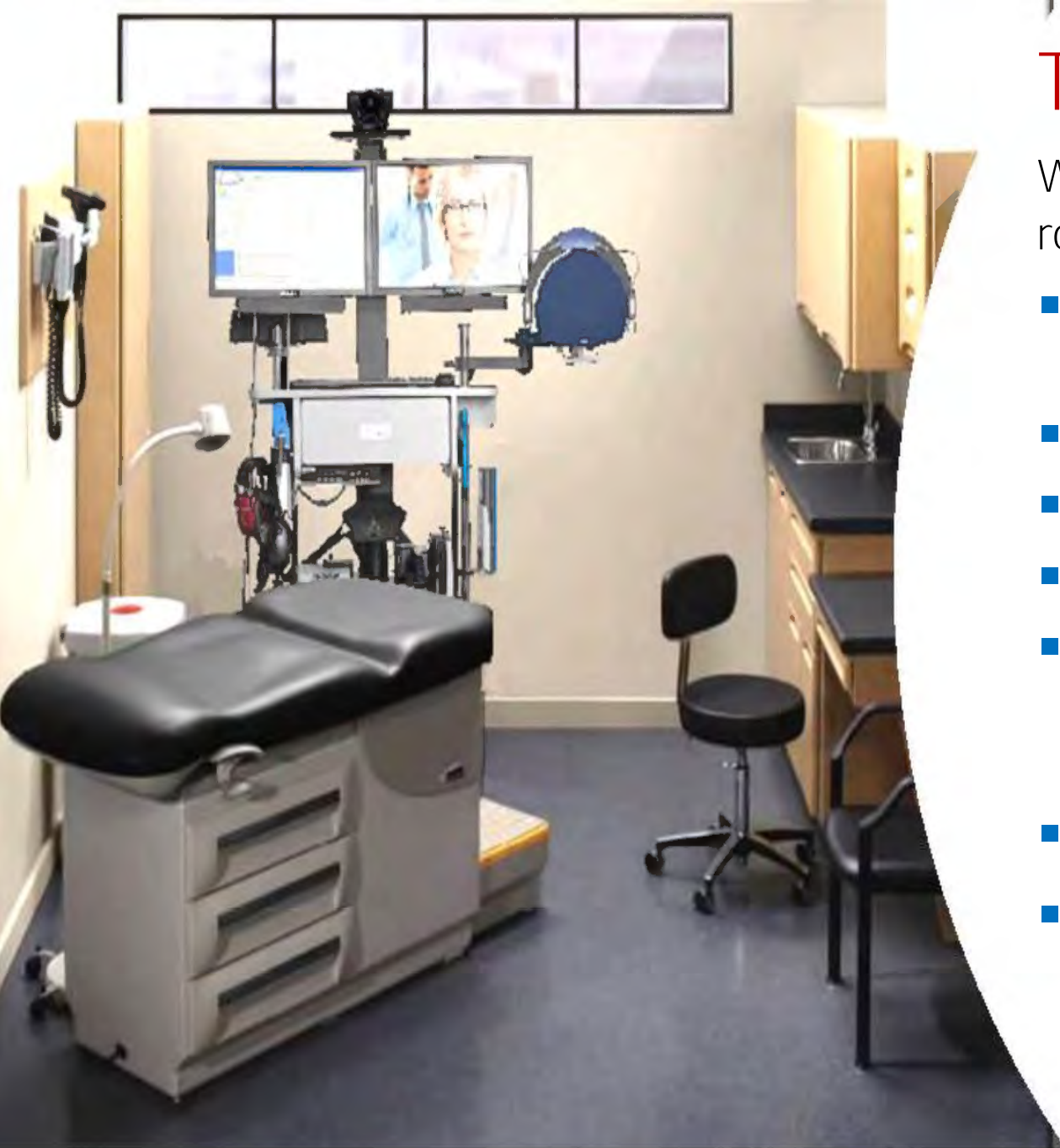
Single Resident of Size Room

- Minimum clear floor area of 200/219 square feet per bed, excluding the bathroom, vestibule entry, and closet or wardrobe
- Minimum clear dimension of 13 feet 2 in.

Multi- bed Resident of Size Room

- Minimum clear floor area of 176/192 square feet per bed, excluding the bathroom, vestibule entry, and closet or wardrobe
- Minimum clear dimension of 13 feet 2 in.





Telemedicine Services

Where used for examination purposes, the telemedicine room shall be sized to accommodate the following:

- An examination table situated within view of the camera
- Telemedicine equipment (fixed or mobile)
- Peripheral devices
- An on-site caregiver or participant presenter
- A hand-washing station that meets the requirements in Section 2.4-2.2.8 (Hand-Washing Stations) where hands-on participant examinations will be conducted.
- A documentation area
- A room where clinical telemedicine services are provided shall meet the requirements of the section of the Guidelines that directly relates to the services provided and the participant population served.



Food Service Types

The type and size of the nursing home facility shall determine the dietary environment and the food service facilities provided.

- Commercial kitchen
- Retail kitchen
- Household kitchen
- Social activity kitchen
- Outpatient therapy kitchen
- Warming/serving kitchen



Acoustics in dining: Distinguishes between small and large dining room requirements and provides design guidance in appendix



Dialysis Services

Where dialysis services are provided in the facility, the requirements of this section shall be met:

- Ea. station shall have a min. clear floor area of **80 s.f.**
- Min. headwall length of **8 ft.**
- **4 ft. min.** shall be provided between treatment chairs.
- Treatment areas shall have privacy screens or cubicle curtains.
- Handwashing within **25 ft.** of ea. treatment location.

Palliative Care

- The care area shall be designed and located to deter unrelated traffic through the unit or setting.
- Provision of single-occupant rooms should be considered to support occupant and visitor privacy.

Design for palliative care that supports comfort and well-being should:

- Minimize the institutional aspects of care and create a comfortable environment with furniture, furnishings and fixtures that are functional, safe, and residential in appearance.
- Enable personalization of spaces for individuals receiving care.
- Provide restorative break spaces for family/friends and caregivers. Exterior and interior spaces that support respite should be included.



Palliative Care

The following design elements should be considered based upon the care population being served:

- Site features, including indoor and outdoor activity areas
- Clinical spaces, resident rooms, common spaces, and administrative areas
- Group meeting, educational, and therapy spaces
- Quiet rooms (to support sensory stabilization).
- Positive auditory, olfactory, visual, and tactile elements enhanced by lighting and acoustical systems



ASHRAE 170 - 2021

Changes to the Residential *Guidelines: ASHRAE 170-2021*

- Residential Document Group worked with the ASHRAE 170 committee to coordinate requirements for residential health, care, and support settings.
- FGI to include Standard 170 with Addendum(s) in the 2022 Residential *Guidelines* –reference for Nursing Homes and Hospice –Assisted Living alignment with MERV 8 and recirculating PTAC requirements.
- Revised references for ASHRAE 62.1 and 62.2 – “nontransient” vs. “transient” residents.





Emergency Conditions Project Overview

- Assemble design guidance for facilities during the following emergency situations:
 - ✓ Weather
 - ✓ Pandemics
 - ✓ Wildfires
 - ✓ Other emergency situations
- Establish baseline planning and design standards for health and long-term care facilities.
- Create a white paper with best practices and draft *Guidelines* requirements for public review.
- Create new Emergency Conditions *Guidelines* with baseline requirements.



- 130 members
- 9 subcommittees and Executive, Steering, and Advisory committees
- Most began meeting in May; SRA was formed in July

- Safety Risk Assessment
- Surge Capacity
- Alternate Care Sites
- Modular
- Resiliency
- Renovations/Future Facilities
- Small and/or Rural Health Care Facilities
- Long-term/Residential Care Considerations
- Operational Considerations

Timeframes :

1. Immediate
2. Temporary
3. Semi-Permanent
4. Permanent



Emergency Conditions : Configuration

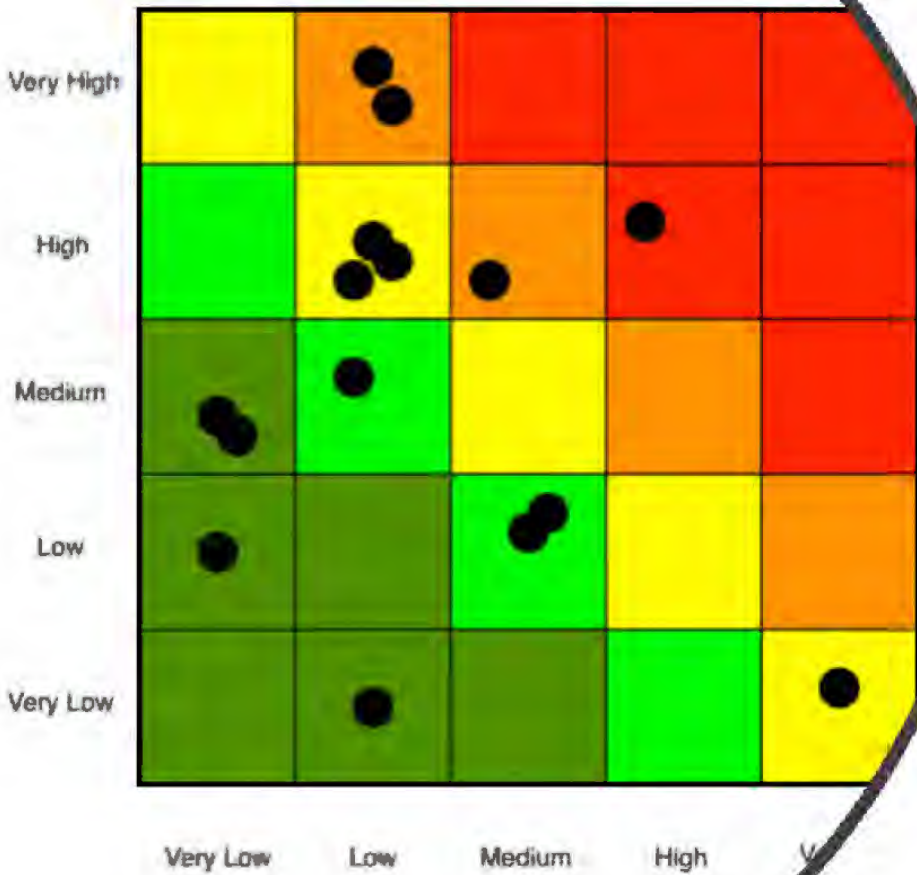
- **Risk Assessments.** Included in this chapter is the proposed framework for a disaster, emergency, and vulnerability assessment.
- **Surge Capacity Considerations.** This chapter covers an array of surge-related topics, including conversion of exterior areas to support spaces, building access during an emergency event, repurposing of existing spaces for patient care during a surge event, PPE storage and supply, and medical gas system expansion.
- **Alternate Care Sites.** Considerations for use of tents, modular facilities, and repurposed structures as alternate care sites are outlined in this chapter.
- **Resiliency.** This chapter addresses the ways in which health and residential care organizations can plan for resiliency in the face of various emergency events.
- **Renovation and Future Facility Design.** The need to reconsider standard design approaches when planning for emergency conditions in new construction and renovation projects is discussed in this chapter.
- **Small and/or Rural Health Care Facilities.** Emergency preparedness and response planning for rural facilities are reviewed through the lens of risks and unique challenges inherent to small facilities in urban settings as well as facilities in remote settings.
- **Emergency Preparedness in Residential Settings.** Primarily focused on nursing homes, hospice facilities, and assisted living settings, this chapter proposes recommendations for emergency response to pandemics, and other emergencies. A key recommendation of the subcommittee is the provision of single-occupant rooms in these residential care facilities.



Chapter 1: Risk Assessments

- Builds hazard vulnerability assessment into development of safety risk assessment
- Requires identification of anticipated hazards specific to geographic location
- Disaster, Emergency, and Vulnerability Assessment (DEVA) prompts assessment of hazards specific to the project, risk/likelihood of emergency events, consequences of such events, and potential solutions.
- Design features that provide resilience, hardening, flexibility and adaptability during a disaster/emergency shall be identified.

Risk

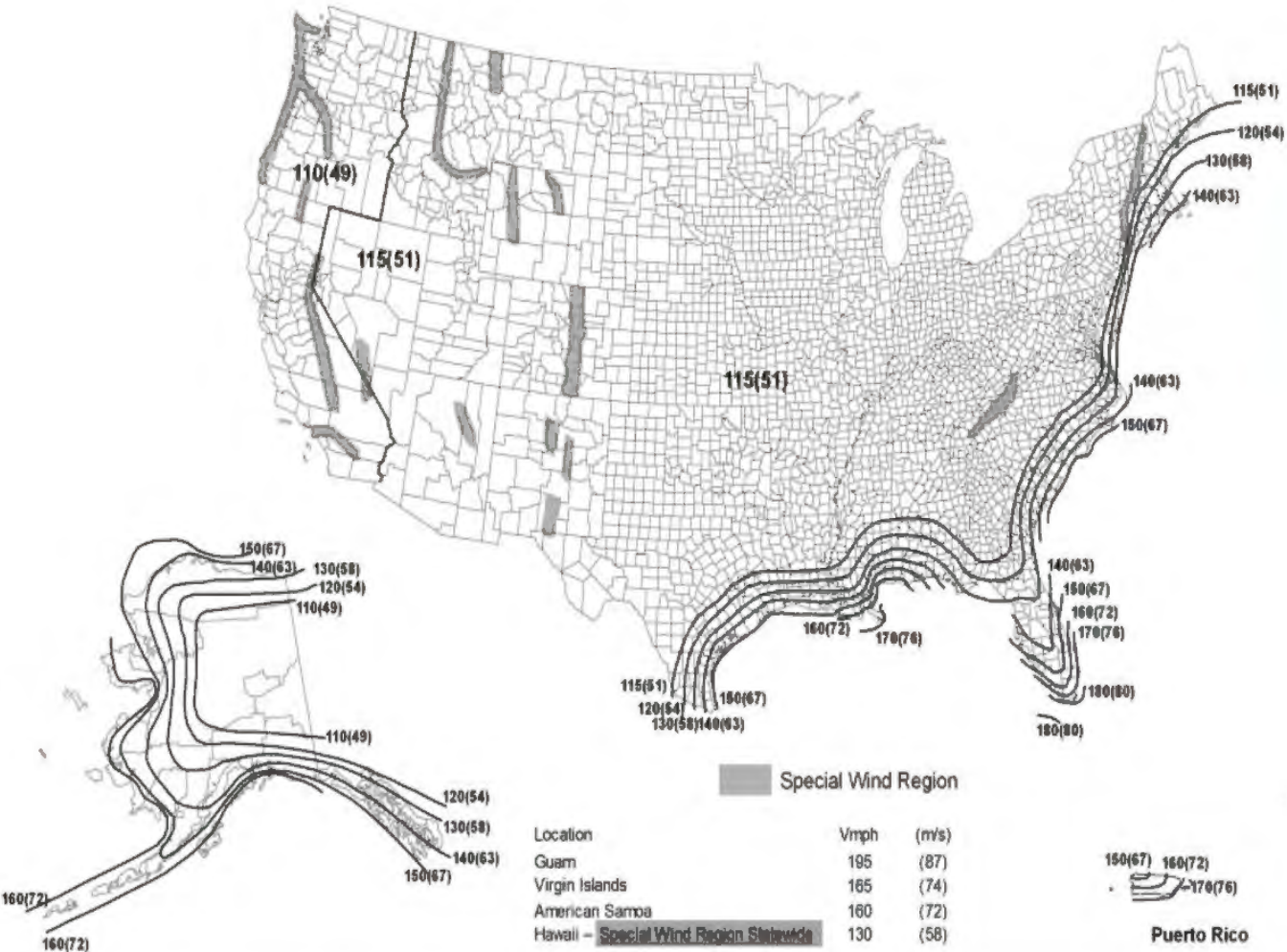


Likelihood

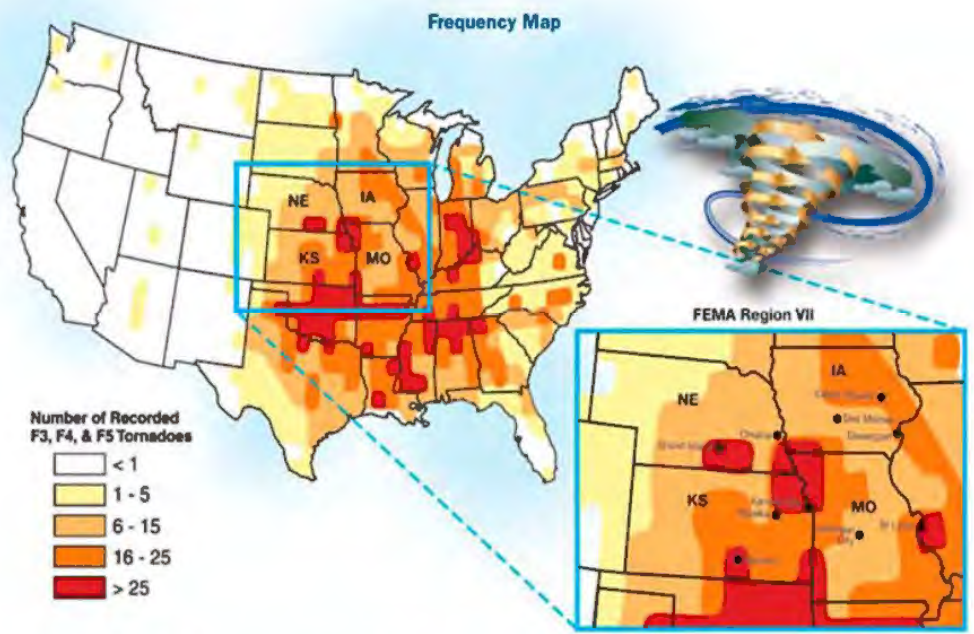
- d. Information management
- e. Patient privacy
- f. Infection control
- g. Staff safety / personal provisions / areas of respite
- 2. Operations protecting patient health and life safety
 - a. Transporting / pre-positioning resources for response
 - b. Emergency access and exiting
 - c. Patient transport
 - d. Availability of supplies and commodities
 - e. Safety inspections / precautions
 - f. Security protocols / check-points
- Operations protecting public health and life safety
 - a. Minimize threat to health and safety of occupants or general public
 - i. Isolation of patients
 - ii. Containment of hazardous materials
 - iii. Disposal of contaminated waste
 - iv. Emergency access and exiting
 - v. Maintain operations
 - b. Additional hours (FTE / Consultant / ...)

Risk Assessment for Implementation

Use of Zone Maps



- Notes:
1. Values are nominal design 3-second gust wind speeds in miles per hour (m/s) at 33 ft (10m) above ground for Exposure C category.
 2. Linear interpolation between contours is permitted.
 3. Islands and coastal areas outside the last contour shall use the last wind speed contour of the coastal area.
 4. Mountainous terrain, gorges, ocean promontories, and special wind regions shall be examined for unusual wind conditions.
 5. Wind speeds correspond to approximately a 7% probability of exceedance in 50 years (Annual Exceedance Probability = 0.00143, MRI = 700 Years).



SOURCE: FEMA 361, Design and Construction Guidance for Community Shelters, July 2000

Levels of Risk for High-Wind Events

Number of Tornadoes (see Wind Zone Map)	Wind Zone (see Frequency Map)			
	I	II	III	IV
<1	LOW Risk	LOW Risk	LOW Risk	MODERATE Risk
1-5	LOW Risk	MODERATE Risk	HIGH Risk	HIGH Risk
6-10	LOW Risk	MODERATE Risk	HIGH Risk	HIGH Risk
11-15	HIGH Risk	HIGH Risk	HIGH Risk	HIGH Risk
>15	HIGH Risk	HIGH Risk	HIGH Risk	HIGH Risk

- LOW Risk - Sheltering from high winds is a matter of preference.
- MODERATE Risk - Shelter should be considered for protection from high winds.
- HIGH Risk - Shelter is the preferred method of protection from high winds.

Chapter 2: Surge Capacity Considerations

Hospitals

- Additional storage for remote facilities
- Considerations for infrastructure needed to convert from a non-clinical space to a patient space
- In areas identified as surge capacity locations, any added med gas outlets or electrical outlets shall be in a secured tamper-resistant housing
- Exterior surge locations shall be identified, and a risk assessment performed
- Impact of emergency events on supply chain, supply storage
- Means to locate IV pumps and monitors outside patient rooms

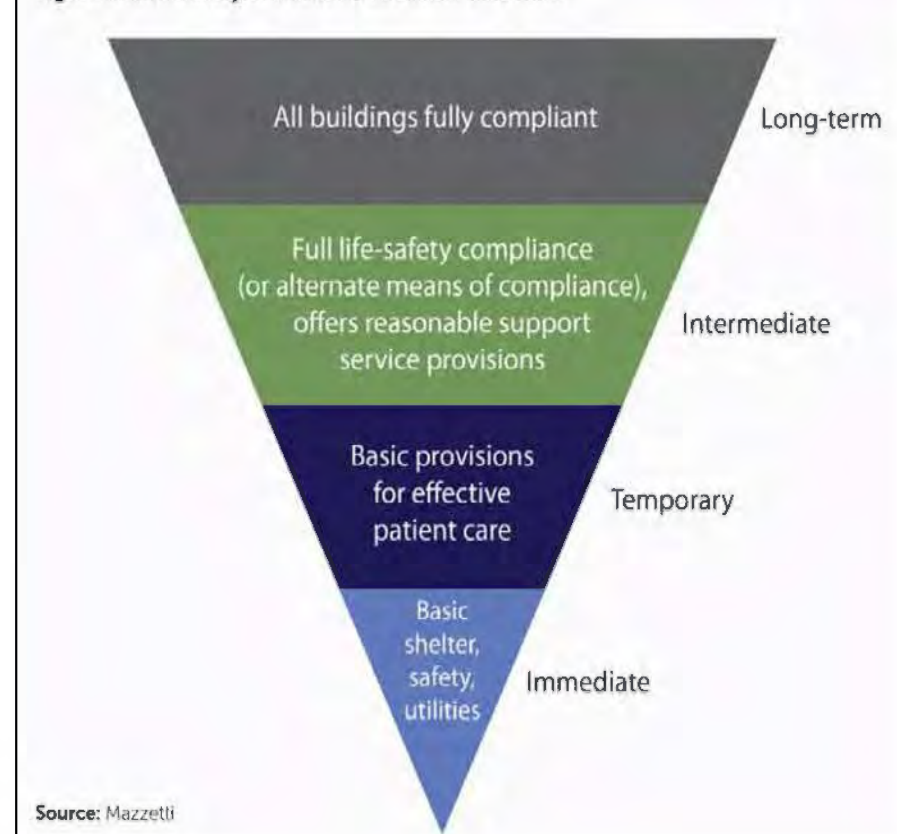




Chapter 3: Alternate Care Sites

- The ACS subcommittee addressed strategies for compliance and created a compliance matrix tool to assist facilities that need to surge to an alternate care site.
- Recommends addressing potential for ACS deployment in emergency planning.
- Discusses advantages/disadvantages of tents, repurposed structures, and modular buildings.
- Includes technical recommendations for building systems operating in ACSs.

Figure 3-1: Hierarchy of Needs for Alternate Care Sites



Modular Construction Recommendations

- Modular subcommittee recommendations have been rolled into Alternate Care Sites.
- Modular subcommittee created recommendation for pre-approved prototype that could be quickly deployed for emergency use.





Chapter 4: Resiliency

Hospital

An incident command center (ICS) room

- 200 sq. ft. minimum
- Accommodate the number of seats necessary for critical positions
- Be supplied with essential electrical power

Critical function areas located above floodplain

- Pharmacy
- Laboratory
- Blood bank/storage
- Sterile processing facilities

Chapter 5: Renovations and Future Facilities

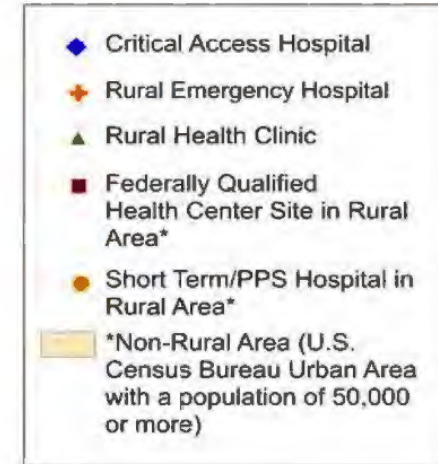
- Recommend inclusion of “acuity adaptable exam rooms”
- All exam rooms “telemedicine-capable”; recommendation that requirement is HIPAA, not space-based
- % of PACU capable of negative pressure (ICRA based)
- % of PACU All conversion-ready with an anteroom
- One EVS room per patient unit to improve ability to contain
- New staff shower room required
- Added oxygen and vacuum outlets for most patient care spaces



Chapter 6: Small and/or Rural Health Care Facilities

- Multidisciplinary team to develop Incident Command System
- Allow percentage of patient rooms to be converted to negative pressure
- Flexible triage/intake space to accommodate unidirectional flow
- Appendix considerations for site preparations, such access control, communications, etc.

Selected Rural Healthcare Facilities in New Jersey



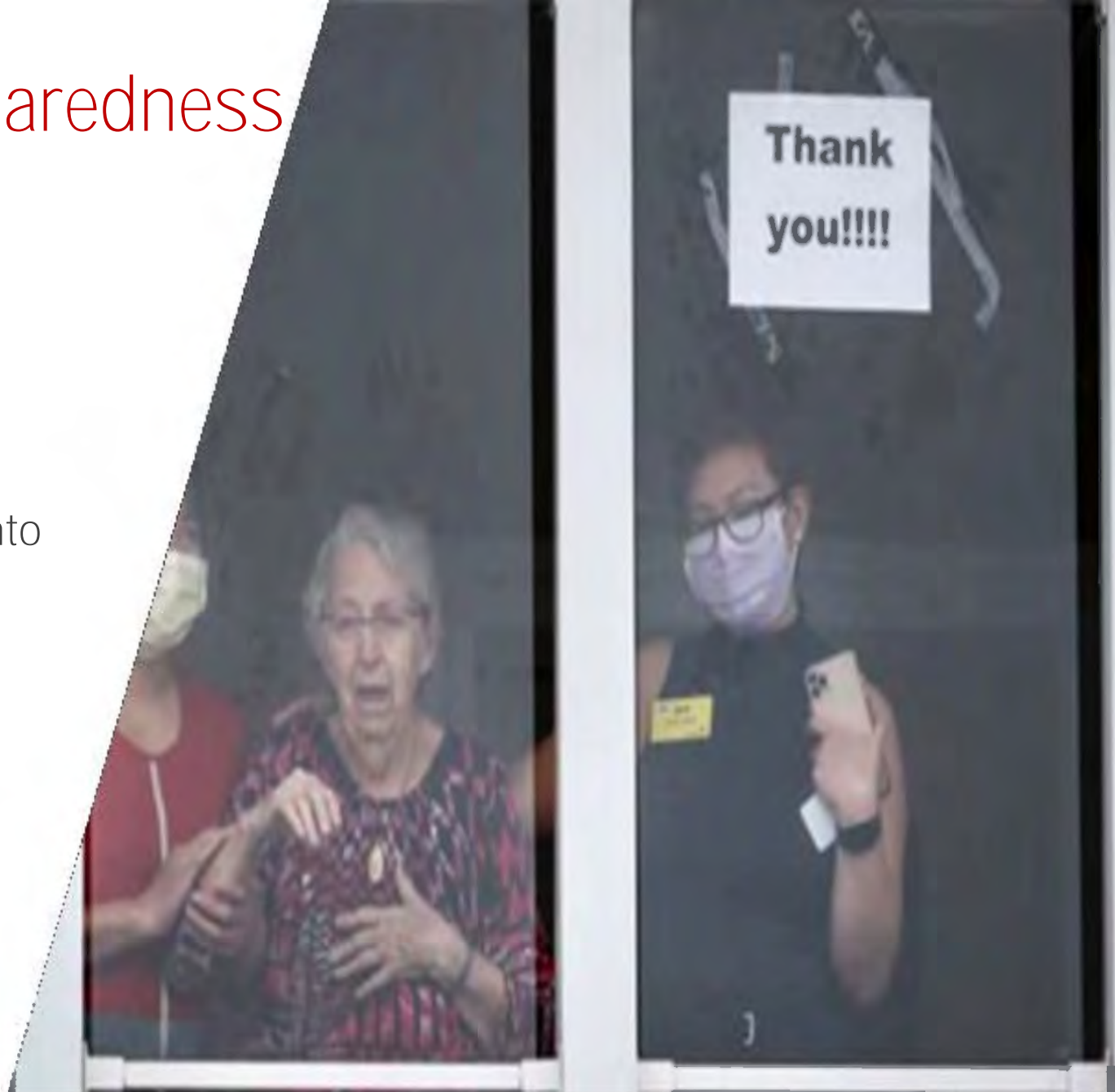
Chapter 7: Emergency Preparedness in Residential Settings

Fundamental Requirements

- Single-bedded resident rooms
- Maximum of 10% of resident rooms can be double
- Negative pressure visitation room – divided into zones
- Shower and changing area for staff use

Appendix

- Dedicated staff entrance physically separated from other entrances
- Technologies enabling e-visits
- Real-time locating systems to track residents



Operational Considerations

Provides considerations for new, renovated, and temporary facilities. Chapter addresses:

- Support services
- Staffing and staff support concerns
- Circulation patterns
- Flexible-use space
- Social and economic impact
- Considerations for airborne infection control



Draft Guidelines for Emergency Conditions in Health and Residential Care Facilities

The recommended guidelines presented here have been consolidated from the independently developed recommendations at the end of the chapters in this white paper. Because experience from the field is critical to developing requirements and recommendations that are neither too restrictive nor too permissive, users of the *Guidelines* are encouraged to comment on the proposed changes using FGI's online comment platform. For more about the draft FGI Emergency Conditions *Guidelines* and the comment period, please read the preface at the beginning of this white paper.

The proposed new language shows changes to the 2018 FGI *Guidelines* recommended by the Emergency Conditions Committee. Additions are underlined, and deletions indicated with a ~~strikethrough~~. Where an appendix item (i.e., a non-enforceable recommendation or guidance on applying a requirement) has been provided, an asterisk (*) precedes the section number (e.g., *1.2-4 Safety Risk Assessment). Appendix items can be identified by the letter "A" that precedes the correlating section number (e.g., A1.2-4 SRA). The text shown has been excerpted from the 2018 *Guidelines* and is not comprehensive.

Proposed Language Based on the 2018 Hospital Guidelines

Chapter 1.1 Introduction

*1.1-2 New Construction

Projects with any of the following new construction and shall comply with the requirements in the *Guidelines for Design and Construction of Outpatient Facilities*:

A1.1-2 Resiliency in new construction. Incorporation of design elements for resiliency should be considered when renovating an existing facility where continuity of patient care services is required in the event of an emergency. Refer to Section 1.2-4.9 (Disaster Assessment) for applicability.

1.1-3 Renovation

1.1-3.1 General

1.1-3.1.1 Compliance Requirements

*1.1-3.1.1.1 Where renovation or replacement work is done in an existing facility, all new work or additions or both shall comply with applicable sections of the *Guidelines* and local, state, and federal codes.

A1.1-3.1.1.1 Resiliency in renovation projects. Incorporation of design elements for resiliency should be considered when renovating an existing facility where continuity of patient care services is required in the event of an emergency. Refer to Section 1.2-4.9 (Disaster, Emergency, and Vulnerability Assessment) for applicability.

Proposed Language Based on the 2018 Outpatient Guidelines

Chapter 1.1 Introduction

*1.1-2 New Construction

Projects with any of the following scopes of work shall be considered new construction and shall comply with the requirements in the *Guidelines for Design and Construction of Outpatient Facilities*:

A1.1-2 Resiliency in new construction. Incorporation of design elements for resiliency should be considered in new construction projects where continuity of patient care services is required in the event of an emergency. Refer to Section 1.2-4.9 (Disaster, Emergency, and Vulnerability Assessment) for applicability.

1.1-3 Renovation

1.1-3.1 General

1.1-3.1.1 Compliance Requirements

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A1.1-3.1.1.1 Resiliency in renovation projects. Incorporation of design elements for resiliency should be considered when renovating an existing facility where continuity of patient care services is required in the event of an emergency. Refer to Section 1.2-4.9 (Disaster, Emergency, and Vulnerability Assessment) for applicability.

Proposed Language Based on the 2018 Residential Guidelines

Chapter 1.2 Planning/Predesign Process

1.2-2.2 Functional Program Content

...

1.2-2.2.2 Functional Requirements...

1.2-2.2.2.2 Explanation of the functional requirements for the project shall cover, at minimum, the following:

...

(2) Operational circulation patterns. These shall include interior and exterior circulation patterns for:

*(a) Residents, staff, and family/visitors

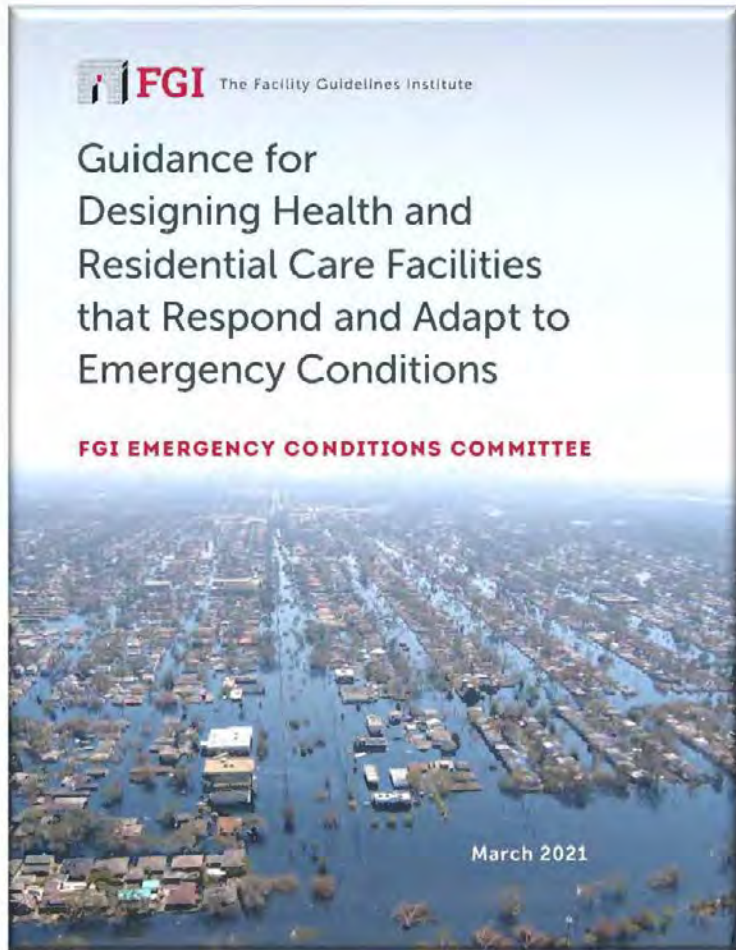
A1.2-2.2.2.2 (2)(a) Circulation pattern considerations. Infectious disease events may require residential care facilities to alter building circulation patterns. Residential care organizations should identify in the emergency operations plan:

a. Provisions for resident food deliveries in the event of altered circulation patterns

b. How staff work areas can be adapted to minimize unrelated travel through other areas of the facility

(b) Equipment for infectious waste handling

E C Project Outcome



- Released April 1, 2021
- Three-month comment period from April 1 through June 30, 2021 to gather public input on the recommended text
- The intention was to release this a supplement to the **2022 Guidelines**
- Timing resulted in insufficient feedback
- FGI elected to post the document as a whitepaper and use it as a guide to possible future changes in the **Guidelines**
- It is Available for free download at www.fgiguideines.org

So, What Happens Next ?

- The code change cycle for the **2026 edition** began with the 1st public comment period that ended June 30th 2023
- We received 1533 proposals suggesting additions, deletions or modifications to the **Guidelines**
- The HGRC began the process of reviewing those proposals in September of 2023 and concluded voting on those proposals in December of 2024
- The FGI staff put together a **2026 Proposed Guidelines Draft** which was released in June 2024
- The 2nd public comment period began in June of 2024 and ended September 30th 2024
- We received 681 comments on the proposed draft
- The HGRC has begin reviewing those comments and will begin voting on the comments in December to finalize the **2026 edition** changes

Major Hospital Topics for the 2026 Edition

Building Systems -

- Review to ensure content is current
Incorporate new technology and systems
- Align with ANSI/ASHRAE/ASHE & NFPA Codes

Mobile Units -

- 96 Hours on Site
- Certification
- Testing and Documentation
- Med gas and Vacuum

Behavioral & Mental Health -

- Review for and identify “areas of concern” and sections where additional appendix language would be beneficial.
- Seclusion Room requirements

Rehab -

- Min requirements for Nurse Call, Med gas, power, wifi/ethernet
- Review Clearances & Minimum Patient Area with and without ceiling lift for
- Evaluate Area SF for Patient Living Areas
- Hydrotherapy Pool requirements

Rural Hospitals -

- Rural emergency hospital (REH)
- Examination of Small House Hospice
- Provisions for flexible Patient Care Spaces
- Follow up on flexible room tool developed in last cycle

Major Outpatient Topics for the 2026 Edition

Building Systems -

- Review facility Chapters to assess if references are adequate or relevant to each facility Chapter.
- Eliminate duplicate references set by part 1
- Modify requirements to correlate with hospital and residential books.
- Fix ASHRAE 170 references to correlate with facility chapters.

Behavioral & Mental Health –

- Review nomenclature to eliminate confusion
- Determine appropriateness of terms
- Review for enforceable language
- Review Transitions from Inpatient to Outpatient

Operating and Imaging Facilities -

- Add Hybrid Operating Room requirements to Surgery Facilities
- Add Class 2 Interventional Imaging requirements to Imaging Facilities
- Scrub' common elements for Imaging Facilities
- Review appendix language

Common Elements -

- Compliance by project type: New construction, major renovation, etc.
- Planning and Design Considerations and Requirements
- Move unenforceable text to appendix

Extended Stay Centers

Major Residential Topics for the 2026 Edition

Enforceability –

Enforceability of the content

- ✓ Too many cross-references
- ✓ Best practice vs. minimum requirement
- ✓ It's just wrong or outdated
- ✓ Requirement is vague and needs to be made more clear

Adoptability of the Guidelines by AHJ's

Laundry –

- Review commercial laundry room requirements
- Review soiled holding & workroom, clean workroom and supply requirements in each chapter
- Review personal laundry room requirements
- Clarify laundry room requirements for the variety of scales of facility types within the residential document

Resident Room Capacity -

- Propose single-bed rooms as the minimum standard
- Review minimum room size requirements for shared resident rooms for individuals of size
- Review general requirements for resident rooms for individuals of size
- Review requirements for resident rooms for residential behavioral and mental health

Dialysis -

- Review the requirements of dialysis in skilled nursing vs. requirements in the Outpatient Document
- Determine minimum standards for residents who do peritoneal dialysis in skilled nursing or assisted living resident rooms

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