WAC 246-320-600 Significant Legislative Rule Analysis (SA)
Attachment A - Proposed New Amendements

Proposed Language	Change Action	Effects of Change	Estimated cost impact
246-320-600			
246-320-600 Washington state amendments. This section contains the Washington state amendments to the ~~2010~~ 2014 edition of the *Guidelines for Design and Construction of* ~~*Health Care Facilities*~~ Hospitals and Outpatient Facilities as developed by the Facilities Guidelines Institute and published by the American Society for Healthcare Engineering of the American Hospital Association, 155 North Wacker Drive Chicago, IL 60606. The language below will replace the corresponding language of the 2014 edition of the *Guidelines* in its entirety. Subsections with an asterisk (*) preceding a paragraph number indicates that explanatory or educational material can be found in an appendix item located in the 2014 Guidelines.	**Revise**	This proposed amendment reflects the change of document version and title. It also clarifies that the following sections are intended to replace the published sections in their entirety, rather than showing strikethrough and underline format in the WAC itself.	There is minimal cost associated with the proposed change of versions in the base document. This is specifically addressed in the narrative portion of the Significant Analysis.

Part 1

1.1-6.3 Deviations

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.	**Add**	There were several stakeholder proposals that attempted to clarify the application of new construction standards to renovations to existing facilities. Many of the proposals had potential unintentional consequences. During stakeholder meetings, there was no opposition to the department's current methodology. Rather, there was the desire for guidance for planning purposes and to prevent overdesign. A recommendation to provide a white paper that describes the application of new standards was supported. Addition of this language clarifies the ability of the department to allow deviations where the intent has been met. This language is in the current (2010) version of the guidelines, but was removed in the 2014 version.	No cost impact from current practice. This proposed section prevents overly burdensome application of rules where specific situations do not warrant it. This concept is an overall cost saving.

1.2-3.8.2.1

Appendix note: 1.2-3.8.2.1 The security portion of the safety risk assessment should consider the placement of emergency call devices in public and staff toilets.	**Add**	There was a proposal to require emergency call devices in all toilets within the hospital building. Several facilities have installed similar systems where they determined that a significant risk existed. Several challenges to implementation were brought forward, including removing staff focus from critically ill patients, cost vs. benefits, and scoping for multi-tenant buildings. While there was recognition that a risk existed, it was not clear that this risk was prevalent enough to warrant a mandatory minimum standard. The most appropriate response appears to be a proposal to focus attention on this question during the design process. This proposed added appendix note reminds the safety risk assessment team that this should be considered for every facility. That way every facility can make the conscious decision during the planning process to assess the risk based on their facility, patient type and staffing levels.	There is no construction cost impact related to this proposed change.

1.2-6.1.4

~~CHAPTER 1.2 PLANNING, DESIGN, AND IMPLEMENTATION PROCESS 1.2-6.1.4 Design Criteria for Room Noise Levels (1) Room noise levels shall not exceed the sound level ranges shown for the chosen rating system in Table 1.2-2 (Minimum-Maximum Design Criteria for Noise in Interior Spaces).~~	**Delete**	Since this language has been deleted from the document there is no longer a need for any modifications.	No cost.

Table A1.2

Add a footnote to Table A1.2: The Security specialist shall review portions of the Infection Control component, specifically: construction and demolition related risks such as planned utility shutdowns, relocation and pathway disruptions.	**Add**	The purpose of this change is to ensure that the risks associated with construction and demolition activities are reviewed by a broad range of subject matter experts. There may be security risks associated with pathway disruptions, noise and utility shutdowns as this may affect control points and operation of security equipment.	This proposed change will have no impact on construction cost. These activities are planning in nature; the security specialist is present for these discussions anyway.

Part 2

FGI 2.1-4.3.1.3

2.1-4.3.1.3 Construction, Equipment, and installation of food and nutrition service facilities in a hospital shall comply with the requirements of: (1) U.S. Food and Drug Administration (FDA) (2) U.S Department of Agriculture (USDA) (3) Underwriters Laboratories, Inc. (UL) (4) NSF International (5) WAC 246-215 The Washington State Retail Food Code	**Add**	This proposed change is intended to provide clarity for designers and facilities. The Washington State Food Code (chapter 246-215 WAC) is applicable for hospital based food establishments. Providing a reference here directs the design team to consider the state specific requirements in this section. In case of conflicts between the items in this list, it is the intent of CRS that the more specific requirements in chapter 246-215 WAC take precedence.	This proposed change will have no impact on construction costs. Since these requirements are already in effect, this additional reference will have no impact.

2.1-7.2.2.1

2.1-7.2.2.1 Corridor width. For corridor width requirements, see applicable building codes. In addition to building code requirements, in areas typically used for stretcher transport, minimum corridor or aisle width of 6 feet shall be provided.	**Add**	Building codes establish minimum corridor widths for egress. FGI 3.7-7.2.2.1 recognizes the operational need to set minimum corridor widths at outpatient surgical facilities with a minimum 6 foot wide corridor where patients are transported on stretchers. Since the FGI recognizes the operational need for a minimum 6 foot wide corridor at outpatient occupancies where patients are transported on stretchers, it is consistent to propose a minimum 6 foot wide corridor at hospitals where outpatients are transported on stretchers.	This proposed change will have no impact on construction cost. Since the current requirement is 6 feet, there is no cost change.

2.1-7.2.2.10 Handrails

(1) Unless the Safety Risk Assessment determines that handrails are not needed, handrails shall be installed on ~~both sides~~ one side of patient use corridors.	**Add**	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 and the facility's ability to provide equipment or staff to assist them. Since this may vary from facility to facility, this should be a conscious decision by the safety risk assessment team for each project. Patient corridors have many obstacles to providing continuous handrails, such as doors, equipment, and alcoves. Requiring handrails in these areas may encourage unsafe ambulation.	This proposed change will reduce the cost by limiting handrails to one side of the corridor, or allowing an operational remedy. Reducing the requirement to one handrail per corridor will save $30 per linear foot. Even smaller hospitals have hundreds of feet of corridor, so total savings for a new facility would be in the magnitude of tens of thousands of dollars.

FGI 2.1-7.2.3.1(14)

~~CHAPTER 2.1 COMMON ELEMENTS FOR HOSPITALS 2.1-7.2.3 Surfaces 2.1-7.2.3.2 Flooring 2.1-7.2.3.2(14) The floors and wall bases of kitchens, soiled workrooms, and other areas subject to frequent wet cleaning shall be either seamless flooring with integral coved base, sealed ceramic tile with ceramic tile base, or equivalent.~~	**Add**	This is one of many proposed deletions to our current rule that is the result of a Washington state amendment being incorporated at the national level. The strikethrough language shown is our current state amednment. The department carried this amendment to the national code writing committee, and was successful in making a change. The 2014 version of the guideline now aligns with the concept that this amendment originally addressed. As such, the amendment is no longer needed. Other similar deletions will be noted with the phrase "Washington state amendment or it's equivalent was incorporated at the national level."	There is no cost impact by deleting this change. The new base language matches our current state amendment.

FGI 2.1-7.2.3.1(6)

2.1-7.2.3.1(6) The following rooms shall have floor and wall base assemblies that are monolithic and have an integral coved wall base that is carried up the wall a minimum of 6 inches (150 mm) and is tightly sealed to the wall: *(a) -(j) no changes proposed* (k) Central Processing rooms (l) Sterile Processing rooms	**Add**	Walls and wall protection, FGI section 2.1-7.2.3.2 (1)(c) calls for wall finishes in the sterile processing room to be free of fissures, open joints, or crevices that may retain or permit passage of dirt particles. Rationale: The floor should have the same requirements for being free of fissures, open joints, or crevices that may retain or permit passage of dirt particles. Integral coved base meets this requirement. It is impossible to clean under the toe of rubber base where dust, dirt and contaminants build up over time. In order to continue limiting the amount of contaminants in these areas, integral coved base is proposed as a requirement. This is consistent with the interpretation of the current rule.	Since this proposal is consistent with current requirement, there is no change in construction cost.

2.1-8.2.1 General

~~**2.1-8.2.1 General** 2.1-8.2.1.1 Mechanical system design (f) VAV systems. The energy saving potential of variable-air-volume systems is recognized, and the requirements herein are intended to maximize appropriate use of those systems. Any system used for occupied areas shall include provisions to avoid air stagnation in interior spaces where thermostat demands are met by temperatures of surrounding areas and air movement relationship changes if constant volume and variable volume are supplied by one air-handling system with a common pressure dependent return system.~~	**Delete**	The Washington state amendment or its equivalent was incorporated at the national level. These sections were revised by the national committee to adequately resolve the issues addressed by the amendment. Therefore, the amendment is no longer needed and is proposed to be deleted.	There is no cost impact of deleting this change. The new base language matches our current state amendment.

~~**2.1-8.2.1.1 Mechanical system design** (2) Air-handling systems with unitary equipment that serves only one room. These units shall be permitted for use as recirculating units only. All outdoor air shall be provided by a separate air-handling system with proper filtration, as noted in 2.1-8.2.5.1 (Filter efficiencies). (a) Recirculating room HVAC units themselves shall have a MERV 6 (or higher) filter in Filter Bank 1 and are not required to have Filter Bank 2. For more information see AIA (2006). (b) Recirculating room units shall be allowed in General Laboratory rooms and Sterilizer Equipment rooms provided at least 6 air changes are provided by the air handling system and adequate total cooling capacity is provided.~~		continued from previous page	

2.1-8.2.2 HVAC Requirements for Specific Locations

~~2.1-8.2.2.7 Emergency and radiology waiting areas~~ ~~When these areas are not enclosed, the exhaust air change rate shall be based on the general volume of the space designated for patients waiting for treatment.~~	**Delete**	Washington state amendment or equivalent was incorporated at national level. These sections were revised by the national committee to adequately resolve the issues addressed by the amendment.	There is no cost impact of deleting this change. The new base language matches our current state amendment.

2.1-8.2.4 HVAC Air Distribution

~~2.1-8.2.4.2 HVAC ductwork~~ ~~*(2) Humidifiers~~ ~~(a) If humidifiers are located upstream of the final filters, they shall be at least twice the rated distance for full moisture absorption upstream of the final filters.~~ ~~(b) Ductwork with duct-mounted humidifiers shall have a means of water removal.~~ ~~(c) Humidifiers shall be connected to airflow proving switches that prevent humidification unless the required volume of airflow is present or high-limit humidistats are provided.~~ ~~(d) All duct takeoffs shall be sufficiently downstream of the humidifier to ensure complete moisture absorption.~~ ~~(e) Steam humidifiers shall be used. Reservoir-type water spray or evaporative pan humidifiers shall not be used.~~ ~~Appendix Language: A2.1-8.2.4.1(2) It is recognized that some facilities may not require humidity control within the ranges in table 2.1-2 and that the final determination of a facility's ability to control humidity will be made by that facility.~~	**Delete**	The modification to the text was intended to clarify the code; however, this clarification is thought to be of minimal value. The current appendix note is confusing and potentially conflicting with federal standards. The note is proposed to be deleted.	The clarification made no impact to cost; removing it would do the same. The appendix is unenforceable and is intended to provide guidance. Other referenced standards are currently more stringent than this appendix language.

2.1-8.3.4.3 Lighting for specific locations in the hospital

(7) When installed in patient care areas, uplight fixtures or troughs that create ledges that collect dust shall be provided with a lens on the top of the fixture to facilitate cleaning.	**Add**	This proposed change addresses the increasingly frequent use of up-light or trough fixtures in patient care areas which create ledges or troughs that collect dust. These up-light or trough fixtures are basic wall mounted light fixtures (usually indirect fluorescent type) with no lens (open on top with exposed light tube/bulb). With no lens, dust/dirt/bacteria collects inside the fixture, which cannot be readily cleaned as part of the regular housekeeping routine. Easily cleanable surfaces are a common requirement for most other components of the care environment. Top lensed up-light fixtures are very standard and lenses can be easily fit for custom details.	This proposed change will increase construction costs, approximately $0-$40 per fixture. Most Hospital Grade fixtures already come supplied with these up-light lenses with no additional cost.

2.1-8.4.3.6 Scrub sinks

~~**2.1-8.4.3.6 Scrub sinks.** Freestanding scrub sinks and lavatories used for scrubbing in procedure rooms shall be trimmed with foot, knee, or electronic sensor controls; single-lever wrist blades are not permitted.~~	**Delete**	The Washington state amendment or its equivalent was incorporated at the national level. These sections were revised by the national committee to adequately resolve the issues addressed by the amendment. Therefore, the amendment is no longer needed and is proposed to be deleted.	There is no cost impact of deleting this change.

Table 2.1-2 Locations for Nurse Call Devices in Hospitals

Staff lounge - Duty Station Optional	**Add**	A report from a recent small hospital construction project where this was required stated that significant cost was added to the ongoing operations of the hospital due to overtime pay of off-duty staff. The rules require nurse call alerts at staffed locations such as nurse stations, support areas, etc. Providing a nurse call in a staff lounge creates an unintended consequence and cost for small facilities.	This proposed code section reduces the cost of construction between $200-$500 per staff lounge. There is the potential for significant savings relating to reduction of ongoing staff costs.

***2.2-2.2.2.5 Hand-washing stations**

~~*2.2-2.2.2.5 Hand-washing stations (1) Location (a) A hand-washing station shall be provided in every toilet room serving more than one patient. Alcohol-based hand sanitizers shall be provided where sinks are not required.~~ ~~(b) A hand-washing station shall be provided in the patient room in addition to that in the toilet room. (i) This hand-washing station shall be convenient for use by health care personnel and others entering and leaving the room. (ii) When multi-patient rooms are permitted, this station shall be located outside the patients' cubicle curtains.~~	**Delete**	The primary purpose for this amendment was to address the need for a handwashing station during renovation of existing facilities. This concept is addressed in the 2014 version by allowing a single station in renovated areas. The public has raised several questions about this amendment over this enforcement cycle. As a result, this requirement is proposed to be deleted.	Since the allowance for a single sink exists as an option for renovated facilities , this change has no cost impact on renovations. For newly constructed facilities, this change will increase cost.

2.2-2.2.6 Support Areas for Medical/Surgical Nursing Units

~~2.2-2.2.6.5 Hand-washing stations. For design requirements, see 2.1-2.6.5. (1) Hand-washing stations shall be conveniently accessible to the medication station and nourishment area. "Convenient" is defined as not requiring staff to access more than two spaces separated by a door. (2) If it is convenient to each area, one hand-washing station shall be permitted to serve several areas.~~	**Delete**	The national committee deleted the word "convenient" in the 2014 version of the guidelines. The deletion of the word convenient and addition of new defined terms made this amendment obsolete.	No cost. The new base language gives a direction that is similar to our current state amendment.

2.2-3.2 Freestanding Emergency Care Facility

~~2.2-3.2.1 General~~ ~~2.2-3.2.1.1 Definition~~ ~~(1) "Freestanding emergency care facility" shall mean an extension of an existing hospital emergency department that is physically separate from (i.e., not located on the same campus as) the main hospital emergency department and that is intended to provide comprehensive emergency service. (2) A freestanding emergency care facility that does not provide 24-hour-a-day, seven-day-a-week operation or that is not capable of providing basic services as defined for hospital emergency departments shall not be classified as a freestanding emergency care facility and shall be described under other portions of this document. Any facility advertising itself to the public as an emergency department or facility shall meet the requirements of Section 2.2-3.2.~~ ~~2.2-3.2.1.2 Application. Except as noted in the following sections, the requirements for freestanding emergency service shall be the same as for hospital emergency service as described in Section 2.2-3.1 (Emergency Service). 2.2-3.2.2 Facility Requirements. This section is not adopted~~	**Delete**	These requirements are reorganized into the new chapter 2.3 "Freestanding Emergency Departments." The current sections have been deleted. The original concern over application of the rule are resolved in the new chapter. The department believes that it can apply the rule appropriately with the 2014 language.	No cost. The application of the 2014 version would be the same as with the current language.

2.2-3.3.3 Pre- and Postoperative Patient Care Areas

~~*2.2-3.3.3.3 Post-anesthetic care unit (PACU)~~ ~~(4) Each PACU shall contain the following:~~ ~~(a) A medication station. (b) Hand-washing stations. At least one hand-washing station with hands-free or wrist-blade operable controls shall be available for every six beds or fraction thereof, uniformly distributed to provide equal access from each bed.~~ ~~(c) Nurse station with charting facilities.~~ ~~(d) Clinical sink.~~ ~~(e) Provisions for bedpan cleaning. (f) Storage space for stretchers, supplies, and equipment.~~ *(Delete existing amendment, revise new section as follows:)* 2.1-2.6.5.3 Additional Requirements for handwashing stations that serve multiple patient care stations. *(1) Not shown for clarity* *(2) Not shown for clarity* (3) Post anesthesia care unit (PACU) hand-washing stations. At least one hand-washing station with hands-free or wrist-blade operable controls shall be available for every six beds or fraction thereof, uniformly distributed to provide equal access from each bed.	**Revise**	This proposed change relocates the requirement to match the reformatting of the base document. No technical change is proposed.	No cost. There is no change in the technical requirement, just relocation to the appropriate section in the new edition.

2.2-3.3.3.3 (Hybrid Operating Room)Control Room

(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.	**Add**	One commenter was concerned that in certain cases a door decreases the ability to communicate between those in the OR and control room. It was broadly acknowledged that removing this door could create infection control risks if the control room was not constructed like the main operating room. An appropriate balance was struck to accomodate the operational needs while at the same time protecting the patient.	This proposal would have no net increase in construction cost. The savings gained by removing the door would be balanced by the higher cost of finishes in the control room.

2.2-3.3.4.3 Phase I post-anesthetic are unit (PACU)

(b) PACU size. A minimum of 1.5 post-anesthesia patient care stations or as determined by the functional program per operating room shall be provided.	**Add**	Depending upon the type of surgery, duration of surgery and patient flow, institutions may need fewer post-anesthesia patient care stations.	This proposed change will reduce the construction cost, depending on the size and use of the facility. Since the department has never regulated PACU station ratios, it is difficult to quantify what the ratio is or what the savings would be.

2.2-3.4.2.1 CT scanner room

(1)(b) CT scanner rooms(s) shall be sized to allow a minimum clearance of 4 feet ~~all sides of the gantry or table.~~on patient transfer and foot and 3 feet clear on non-transfer side of the table.	**Add**	Patient care does not require access on all sides of the gantry but does require clearance around the table. The 4”-0” clear is not required for patient care behind the gantry and is greater than the required service area from manufacturers.	This proposed change reduces initial construction costs by approximately $4,500 per room.

2.2-3.4.4(2) MRI scanner room space requirements

(2) The MRI scanner room shall have a minimum clearance of 4 feet on ~~all sides of the gantry assembly or table.~~ the transfer side and foot of the table and 3 feet clearance on the non-transfer side of the table and the door swing shall not interfere with the patient transfer. ~~The door swing shall not encroach on these minimum clearances.~~	**Add**	Patient care does not require access on all sides of the gantry but does require clearance around the table. The 4”-0” clear is not required for patient care behind the gantry and is greater than the required service area from manufacturers.	This proposed change reduces initial construction costs by approximately $4,500 per room.

2.2-3.5.2 Interventional Imaging Procedure Room

2.2-3.5.2.1 Space requirements. The procedure room shall be large enough to accommodate required equipment and clearances in accordance with the manufacturer's technical specifications. (1) The procedure room shall have a minimum clear dimension of 18 feet (5.49 meters). (2) The procedure room shall be sized to allow a minimum clearance of 4 feet (122 centimeters) on all sides of the gantry assembly or table. **2.2-3.5.2.2 Ceilings** Ceilings in interventional imaging procedure rooms shall be designed as semi-restricted, see 2.1-7.2.3.3(3) for finishes.	**Add**	2.2-3.4.1.4(2)(b) refers the reader to interventional radiology room requirements for ceiling assemblies. There is no reference to ceiling assembly requirements in this section. A reference needs to be added for the type of ceiling designation and refer the reader back to the finish section.	No cost. This is a coordination issue; provides reference to correct section.

2.2-3.3.4.2 Preoperative patient care area

2.2-3.3.4.2(2)(b)(ii) Where bays are used, an aisle with a minimum clearance of ~~8 (2.44 meters)~~ 6 feet (1.83 meters) independent of the foot clearance between patient stations or other fixed objects shall be provided.	**Add**	Bays are defined in the FGI glossary as a space for human occupancy with one hard wall at the headwall and three soft walls (e.g., cubicle curtains or portable privacy screen). Eight foot clearances in corridors originated from in-patient hospitals minimum corridor width to allow for transportation of beds in both directions. The typical medical surgical patient bed is 40 inches wide and the typical recovery gurney width is 33 inches. Reducing the minimum clearance between bays to 6 feet would still allow two stretchers to pass without disturbing the curtains at the foot of the bays. Requiring 8 foot clearance between bays is excessive as beds are not used for typical patient transport in the pre-operative area.	This proposed change will not increase construction cost. By reducing the increase in requirements from 2010 standards, this modification saves approximately $2,000 per bay (8SF x $250). No operating cost impact.

2.4 Critical Access Hospitals

2.4-1.1 Application Chapter 2.4 contains specific requirements for small rural hospitals. The functional program for these facilities must clearly describe a scope of services that is appropriate for Chapter 2.4. For facilities with services that are not appropriately addressed in Chapter 2.4, the appropriate portions of Chapters 2.2, 2.3, 2.5, 2.6 and 2.7 will apply.	**Add**	The intent of these proposed changes is to clearly set the scope for the application of the chapter for critical access hospitals. We recognize the need for different minimum standards for small rural facilities, regardless of their participation in federal reimbursement programs. Physical environment standards should be determined by the actual scope of services provided, not reimbursement strategy. This proposal modifies the requirement to stress the importance of performing a functional program review to determine the most appropriate application of the standard.	The proposed use of this new chapter will reduce the cost of construction for smaller remote hospitals. The modification of scope, i.e. applying regulations based on function, are consistent with current regulations and practice. Therefore, many of those savings are being realized today. This change will make the new code allowances for critical access hospitals applicable to all small rural hospitals with a limited scope of service. This change would prevent smaller hospitals that perform a broader scope of services from being exempt for the safety requirements that go along with the increased scope. Again, this is consistent with current regulations so there is no anticipated increase in cost.

PART 3 Outpatient Facilities

3.1-3.2.3.2 Special Purpose Examination Room

(c) A room arrangement in which an examination table, recliner, bed or chair is placed at an angle, closer to one wall than another or against a wall to accommodate the type of patient being served, shall be permitted.	**Add**	The proposal addresses room layout for specialty clinics where the preferred location for the patient bed, table, exam, chair, etc., differs from the required clearances. The preferred layout is due to the patient population seen in the clinic and the need to address patient safety and falls.	There is no cost impact to this proposal. This change clarifies the arrangement of furniture in a space or on a plan; it does not impact the room size.

3.1-4.1.2 Laboratory Testing/Work Area

~~(2) Work counters shall be sufficient to meet equipment specifications and lab technician needs and have the following:~~ ~~(a) Sinks.~~ ~~(b) Communications service.~~ ~~(c) Electrical service.~~	**Delete**	The national committee deleted the reference to vacuum systems as not necessary. This addresses the state amendment.	No cost. There is no technical change to this section.

3.1-6.1.1 Vehicular Drop-Off and Pedestrian Entrance

~~3.1-6.1.1 Vehicular Drop-Off and Pedestrian Entrance (for ambulatory surgery facilities only). This shall be at grade level, sheltered from inclement weather, and accessible to the disabled.~~ ~~A3.1-6.1.1 Accessibility requirements for all facility types can be found in 1.1-4.1~~	**Delete**	The Washington state amendment or its equivalent was incorporated at the national level. These sections were revised by the national committee to adequately resolve the issues addressed by the amendment. Therefore, the amendment is no longer needed and is proposed to be deleted.	No change in cost for current requirements because the new proposed requirements are essentially the same.

3.1-7.1.3 Provision for Disasters			
~~3.1-7.1.3.1 Earthquakes. Seismic force resistance of new construction for outpatient facilities shall comply with Section 1.2-6.5 (Provisions for Disasters). Where the outpatient facility is part of an existing building, that facility shall comply with applicable local codes.~~	**Delete**	The national committee deleted this section. Since this requirement no longer exists, no amendment is necessary.	No cost.
3.1-7.2.2 Architectural Details			
~~3.1-7.2.2.1 Corridor width (1) Public corridors shall have a minimum width of 5 feet (1.52 meters). Staff-only corridors shall be permitted to be 3 feet 8 inches (1.12 meters) wide unless greater width is required by NFPA 101 (occupant load calculations). Existing clinics that do not use gurneys shall meet the requirements of NFPA 101 for appropriate occupancy type.~~	**Delete**	The national committee deleted all technical references in this section and refers you to current building codes. Since this section is deleted, no amendment is necessary. Further amendments to this concept are described under new amendments.	No cost impact by deleting our state amendment. The base language removed the original requirement that our amendment lessened.

3.1-7.2.2.2 Ceiling height. The minimum ceiling height shall be 7 feet 10 inches (2.39 meters), with the following exceptions: *(1) Omitted for clarity* ~~(2) In radiography, procedure and operating rooms and other rooms with ceiling-mounted equipment or fixtures in the stowed position, the minimum height from the lowest protruding element of the equipment or fixture when it is in the stowed position shall be no less than 7 feet~~. (3) *Omitted for clarity*	**Add**	This proposal would not adopt the second exception of this section, the first and third exception would remain as published. Many boom mounted shelves for cauterization equipment, etc. have three shelves. It is not possible to have this system be stowed above 7'-0" and reach the location where it is needed for patient care. Practically, since there are so many booms configured this way today, enforcement would be problematic.	This proposed change saves cost. If booms were limited in this way, the number of booms and floor mounted equipment would greatly increase.

3.1-7.2.3.1(5) Walls and bases

3.1-7.2.3.1(5) The following rooms shall have floor and wall base assemblies that are monolithic and have an integral coved wall base that is carried up the wall a minimum of 6 inches (150 mm) and is tightly sealed to the wall: (a) Operating rooms (b) Interventional Imaging rooms, including cardiac catheterization labs (c) Cystoscopy, urology, and minor surgical procedure rooms (d) Endoscopy procedure rooms (e) Endoscopy instrument processing rooms (f) IV and chemotherapy preparation rooms (g) Airborne infection isolation (AII) rooms (h) Anterooms to AII and PE rooms, where provided (i) <u>Sterile Processing Rooms</u>	**Add**	Current rules call for wall finishes in the sterile processing room to be free of fissures, open joints, or crevices that may retain or permit passage of dirt particles. Rationale: The floor should have the same requirements for being free of fissures, open joints, or crevices that may retain or permit passage of dirt particles. Integral coved base meets this requirement. In order to continue limiting the amount of contaminants in these area integral coved base should be required. We believe this is consistent with the intent of the FGI, see FGI white paper 'Sterile Processing in the Surgical Suite' (Sept 15, 2014). This is consistent with the interpretation of the current rule.	Since this is consistent with current requirement, there is no change in construction cost.

3.1-8.2.3.34.1 Return air systems.

~~3.1-8.2.3.34.1 Return air systems. For patient care areas where invasive applications or procedures are performed and rooms containing materials used in these applications and procedures, return air shall be via ducted systems.~~	**Delete**	Reference to ducted return systems have been referred to in the ASHRAE 170 document. This proposal deletes the previous state amendment to require ducted returns only in specific locations. The purpose of the amendment at that point in time was to address concerns from the ASHRAE 170 committee that ducted return requirements were not properly scoped in the FGI document. In this version of the guidelines, the scope of regulating ducted returns has been given directly to the ASHRAE 170 standard. Several revision cycles have passed for ASHRAE 170, and we believe sufficient analysis has been given to the issue to resolve previous concerns. Based on the desicions of the national committee, we beleive the previous state amendment was too far reaching. We propose reverting back to the language established by the national standard.	This proposed change adds approximately 15% to the mechanical system design for certain outpatient clinics: specifically advanced diagnostic and treatment, urgent care, cancer treatment, outpatient surgery, dialysis, psychiatric, and rehabilitation clinics.

3.5 Specific Requirements for Freestanding Urgent Care Facilities

3.5-1.1 Application This chapter applies to facilities that provide urgent care to the public but are not freestanding emergency departments~~, or do not provide care on a 24-hour-day, seven-day-per-week basis~~. The functional program for these facilities must clearly describe a scope of services that are appropriate for urgent care, as determined by the department.		The intent of these two changes is to adopt the chapter of the FGI for urgent care facilities. The technical change eliminates the condition that these facilities cannot provide care for 24 hour, seven days per week basis. In this case, the application of a particular set of physical standards should be based on the type and duration of the care provided. Restricting the hours of operation in this case is an artificial limiter. The scope of services provided should be the sole determiner of whether this chapter can be used or not. To clarify this, the department proposes to add a sentence that provides a more heightened attention to the importance of the functional program review.	This proposed change will have no impact on construction costs. Previously the department has considered these free standing EDs or allowed the use of this chapter as an alternative method. This change represents a continuation of current practice.

3.7-3.6.13.1 (2) Location.

3.7-3.6.13.1 (2) Location. The sterile processing room shall be designed to provide a one-way traffic pattern of contaminated materials/instruments to clean materials/instruments to the sterilizer equipment. Two remotely located doors shall be provided as follows: (a) Entrance to the contaminated side of the sterile processing room shall be from the semi-restricted area. (b) Exit from the clean side of the sterile processing room to the semi-restricted area or to an operating room shall be permitted.	**Add**	The purpose of this proposed section is to clarify that two doors are required for this particular room. The current rule directs you to do this; however, we feel the added language would be more clear. We have confirmed this is the intent with the FGI focus group chair. It is also described this way in the FGI white paper on the subject, as well as the new practice guidelines.	This proposed change will have no impact on construction costs, this is for clarification purposes only. The base 2014 text represents a cost reduction by reducing the number of rooms required. However, the current method is still acceptable, so there is no cost impact.

3.7-5.1.2 On-Site Sterilization Facilities

When sterilization occurs on site, ~~the requirements in Section 3.7-3.6.13 (Sterile Processing Room) shall be met.~~ one of the following conditions shall apply: (1) Outpatient surgical facilities with 3 or fewer operating rooms where immediate use sterilization occurs on-site, the requirements in Section 3.7-3.6.13 (Sterile Processing Room) shall be met. (2) Outpatient surgical facilities with 4 or more operating rooms, or facilities which do not use immediate use sterilization, decontamination and sterilization shall meet the requirements of 2.1-5.1.	**Add**	The 2014 guidelines allow soiled functions and clean functions to be combined in a single processing room. Currently two separate rooms are required. Discussions with the FGI sub-committee that created this section identified several questions about the scope and applicability of this new option. This change reflects what we believe to be the intent of the guidelines. We added the phrase 'immediate use sterilization' to establish that this design is acceptable for a very specific type of sterilization process. More traditional sterilization methods will require traditional layouts. This change also states that the new option is not intended to be used for larger facilities. The sub-committee could not identify a threshold where this option is not acceptable, but did suggest a threshold existed. Based on a review of currently licensed facilities, the overwhelming percentage of ambulatory surgery facilities within the state have three or fewer operating rooms. We choose four operating rooms as the threshold to allow most facilities to take advantage of this option, while limiting the option for the largest most complex facilities.	This proposed change will have no impact on construction costs. Currently, facilities are required to have two separate rooms. By allowing the substitution of one larger room, there will be some minimal cost savings. While this saving would not be realized larger facilities, it does not differ from the current requirement.

3.9 SPECIFIC REQUIREMENTS FOR ENDOSCOPY FACILITIES

3.9-3.3.2.2(2)(b) Where bays are used, an aisle with a minimum clearance of ~~8 (2.44 meters)~~ 6 feet (1.83 meters), independent of the foot clearance between patient stations or other fixed objects, shall be provided.	**Add**	Same as previous amendment for preoperative areas.	This proposed change will not increase construction costs. By reducing the increase in requirements from 2010 standards, this modification saves approximately $2,000 per bay (8SF x $250). No operating cost impact.

Part 4 - ASHRAE 170

(Amend 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 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.	**Add**	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 have participated in the interpretation/revision process with AHSRAE 170 and this change represents our best estimation of what the requirements of ASHRAE 170 will be.	This proposed change will have no impact on construction costs. The requirements for this new type of room are very similar to the existing requirements for sub-sterile rooms. This new room type will replace the old substerile rooms, so there is no practical impact.

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 the 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.~~	**Add**	The principles of infection prevention would dictate that the anteroom, the location where Personal Protective Equipment is 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.	This proposed change will have no impact on construction cost. Two alternatives are currently acceptable and there is no cost differential between the two.

CHAPTER 5.1 MOBILE, TRANSPORTABLE, AND RELOCATABLE UNITS

~~**5.1 7.2 Architectural Details and Surfaces for Unit Construction**~~ ~~5.1 7.2.2 Surfaces If the mobile unit is permanently installed, finishes shall comply with the requirements in this section.~~ ~~5.1 7.2.2.1 Interior finish materials~~ ~~(1) Interior finish materials shall meet the requirements of NFPA 101.~~	**Delete**	The Washington state amendment eliminated the application of more stringent Class A finish requirements in favor or a broad reference to national standards. The 2014 version does the same. The 2014 version also moves this concept to Chapter 5. Therefore, the current amendement is no longer necessary.	No cost.

~~Current state amendment deletes the low-end humidity requirements for: Class B and C operating rooms, Operating/surgical cystoscopy, Delivery rooms, Treatment rooms, Trauma rooms, Laser eye rooms, Class A Operating/Procedure rooms and Endoscopy rooms.~~	**Delete**	Humidity rates in operating rooms have been the subject of debate for many years. The current rule was based on the concern that undue attention was being placed on humidity levels because concern over fire risk. This issue is resolved in more current versions of the fire code. ASHRAE 170 prescribes humidity levels to assist with infection control, comfort and odor control. We have no substantiation to modify this standard. Several facilities and designers have pointed out that our current state amendment creates confusion over the current minimum standard. This proposed change makes us consistent with the industry and federal regulations.	There is no practical cost impact to these facilities. While we currently have no low-end humidity requirements in this standard, we enforce federal regulations that do. To the regulated facility, there will be no change, therefore no cost impact.