

FGI

THE 2022 EDITION OF THE
FGI *GUIDELINES*



INTRODUCTION

Heather Livingston, MSL
Chief Operating Officer and Managing Editor
Facility Guidelines Institute

- With FGI since 2011
- 4 editions of the *Guidelines*
- American Institute of Architects
- American Architectural Foundation

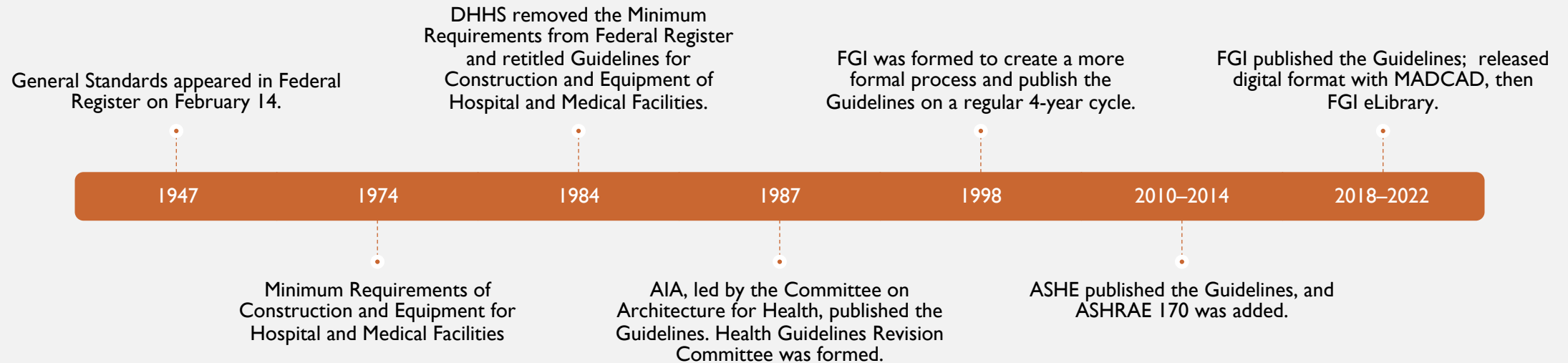


The views expressed in this presentation are the opinion of the speakers and may not be the official position of the Facility Guidelines Institute (FGI) or the Health Guidelines Revision Committee (HGRC).

TODAY'S OBJECTIVES

- Share the revision strategy, sequence, and consensus approach to the *Guidelines* revision process.
- Familiarize participants with the organization of the 2022 *Guidelines* documents.
- Review the major updates in the 2022 *Guidelines*.
- Discuss opportunities to participate in the 2026 revision process.

GUIDELINES HISTORY



FGI AND THE HGRC



ABOUT FGI

Mission

Establish and promote consensus-based guidelines and publications, advised by research, to advance quality health care.

Vision

FGI will be the leader in guiding the development of the health care built environment.

The main objectives of FGI

- To see that the *Guidelines* is reviewed and revised on a regular cycle with a consensus process carried out by a multidisciplinary group of experts from the federal, state, and private sectors
- To stimulate research in support of evidence-based guidelines
- To reinvest all net revenue derived from FGI's share from the sale of *Guidelines* documents in research and development for improved future editions of the *Guidelines*.



THE HEALTH GUIDELINES REVISION COMMITTEE (HGRC)

- Select multidisciplinary consensus body of about 140 clinicians, owner, architects, engineers, researchers, government agencies, and AHJs
- Experts on the many issues addressed in the *Guidelines*
- Wide range of expertise helps assure the *Guidelines*
 - Reflect a variety of clinical, administrative, engineering, and design concerns
 - Based on interdisciplinary consensus process



John Williams
Washington State
Department of Health
Olympia, Washington
Chair, HGRC



Ellen Taylor
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The Center for Health Design
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Duluth, Minnesota
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CBRE | Healthcare
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Vice-chair, HGRC

2026 HGRC LEADERSHIP

GUIDELINES DOCUMENT LEADERSHIP



Hospital Document Group

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EDAC, LEED AP
Johns Hopkins
Baltimore, Maryland



Outpatient Document Group

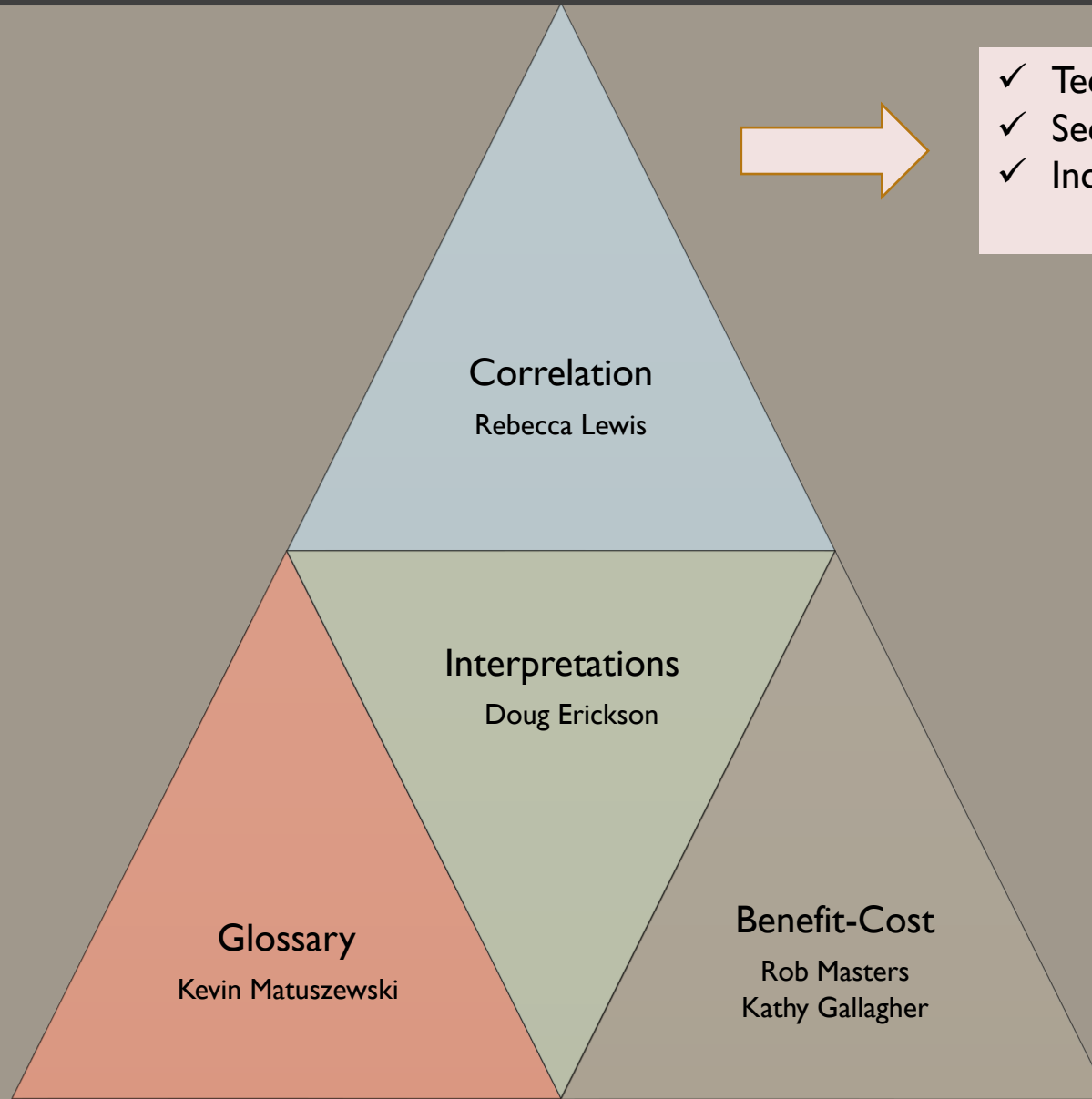
Kevin Matuszewski, AIA,
LEED AP
DPR Construction
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Residential Document Group

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Shoemith Cox Architects
Seattle, Washington

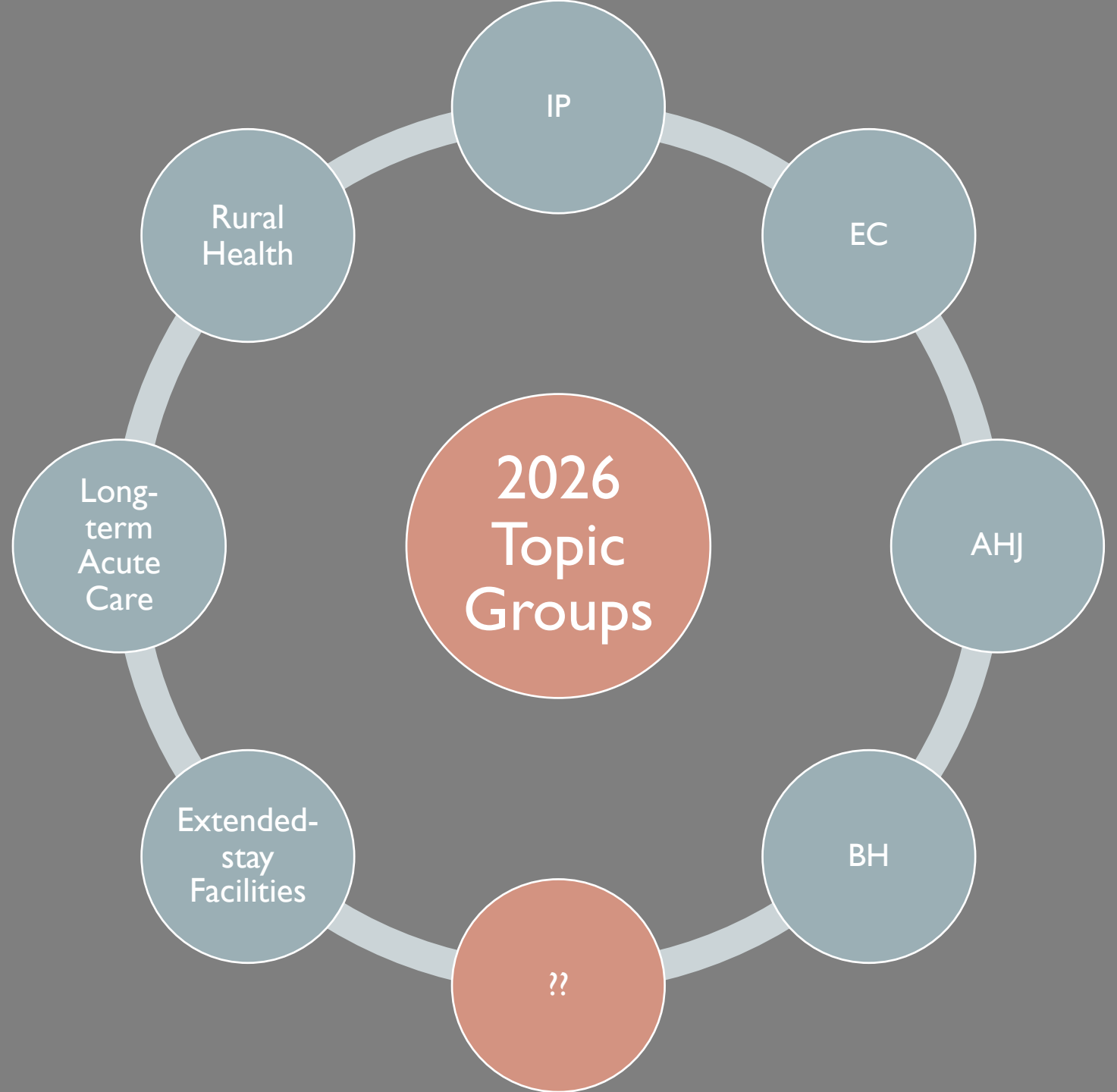
STANDING COMMITTEES



- ✓ Technology
- ✓ Security
- ✓ Inclusive Environments

TOPIC GROUPS

- Infection Prevention
- Emergency Conditions
- Authorities Having Jurisdiction
- Behavioral Health
- Rural Health
- Long-term Acute Care
- Extended-stay Facilities



TASK GROUPS

Procedure/operating room and Class
2/Class 3 imaging room use

Usability of the *Guidelines*

Plumbing

Dental facilities?

Rehab hospitals?

Rural emergency hospitals?

USING THE *GUIDELINES*

“GUIDELINES” ARE MINIMUM STANDARD

- Code language in the *Guidelines*: For clarity and adoptability, these standards are presented in “code language.”
- Main body of the text = minimum requirements
- Appendix text = information to help *Guidelines* users understand and meet the requirements
- Every proposal and comment is reviewed and voted on by the HGRC.

Benefit-Cost Committee Reviews Each Proposal and Comment

Step 3: Benefit-Cost Analysis

The matrix with dropdown responses below must be filled out. However, please also describe the benefit-cost implications of your comment for consideration by the Health Guidelines Revision Committee.

Benefit-Cost Implications

Benefits

Patient/staff safety

Select Implicatio... ▾

Patient care

Select Implicatio... ▾

Operational efficiency

Select Implicatio... ▲

Select Implications

Negative Impact

Neutral

Added Benefit

Costs

Capital cost

Select Implicatio... ▾

Clinical operations

Select Implicatio... ▾

Facility operations

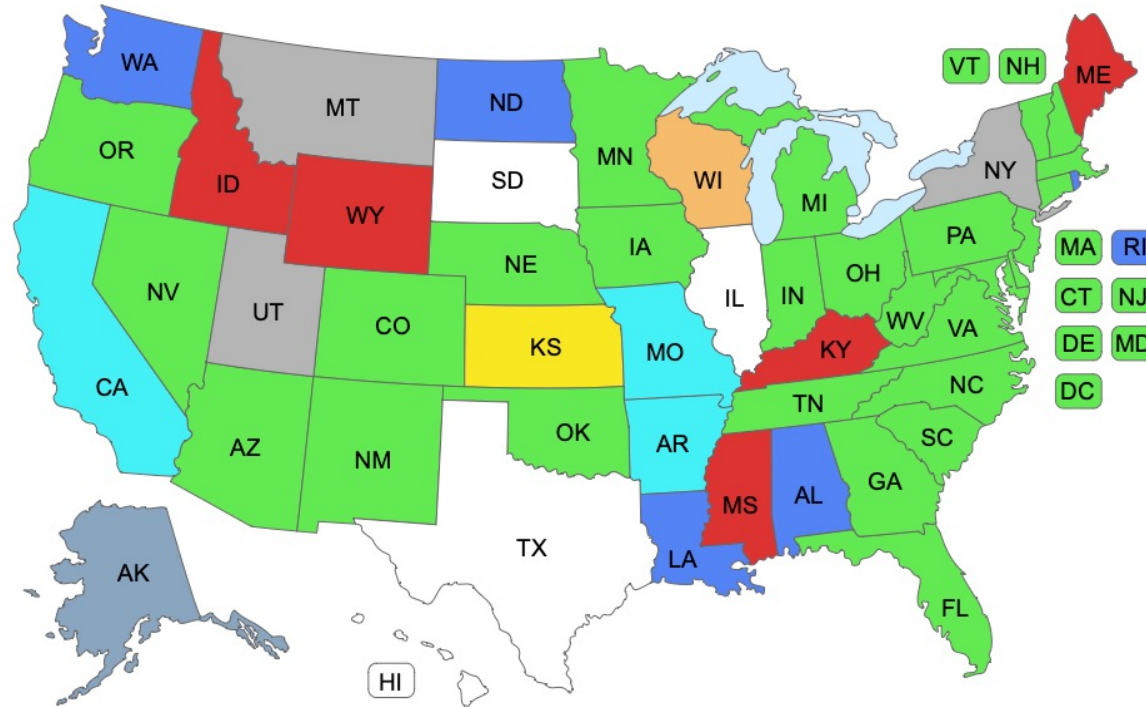
Select Implicatio... ▾



WRITTEN FOR FLEXIBILITY

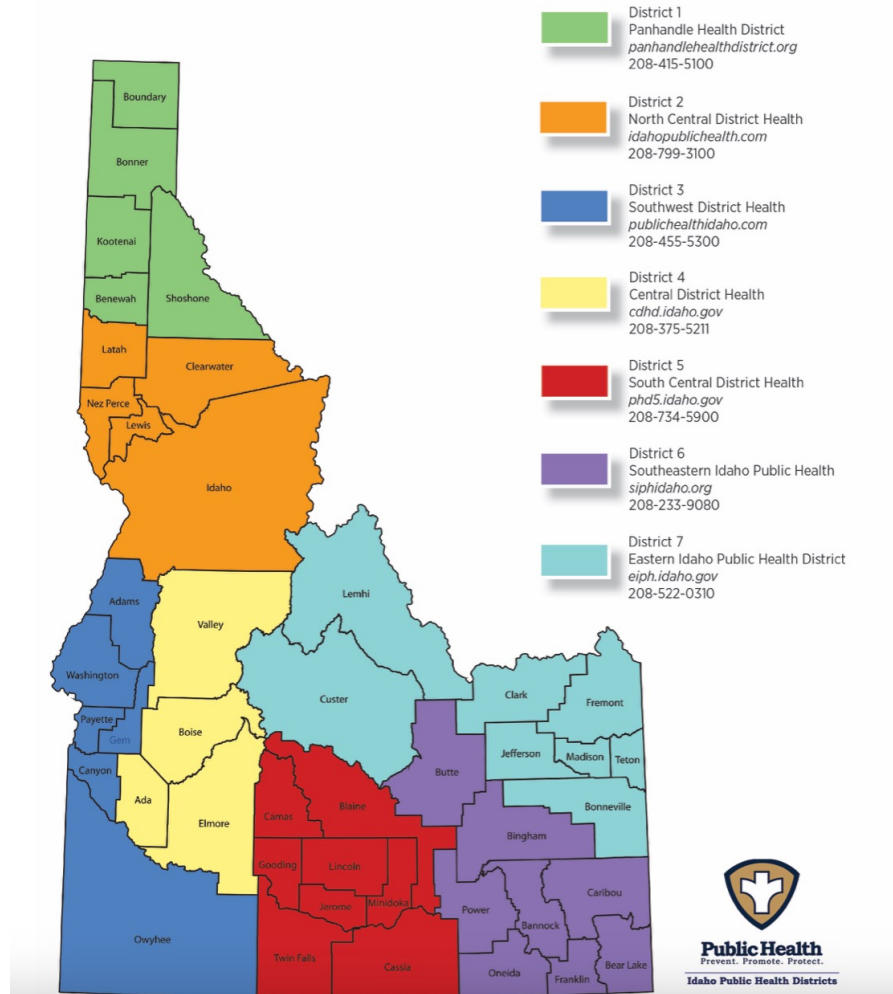
“When the *Guidelines* documents are used as regulation, latitude should be granted in complying with the requirements as long as the health and safety of the facility’s occupants will not be compromised. Design innovation should be encouraged and authorities having jurisdiction should grant exceptions where the intent of the standard is met.”

ADOPTION
OF THE
GUIDELINES



Key	
2018	
2014	
2010	
2006	
2001	
1996-97	
Equivalency*	
HVAC Only	

Idaho Public Health Districts



USING THE GUIDELINES IN IDAHO

2006 Guidelines for Design and Construction of Health Care Facilities

- General hospitals
- Freestanding EDs

Applies to:

- New construction
- Additions
- Conversions
- Remodeling

Newer version permitted at owner's request

WHERE TO FIND THE *GUIDELINES* AND SUPPORTING RESOURCES

https://fgiguideines.org

Newsletter Signup Contact Us My Guidelines Search here



Guidelines Resources News & Updates Purchase

Facility Guidelines Institute

The keystone to health care planning, design, and construction

Adoption Map >

Errata & Addenda >



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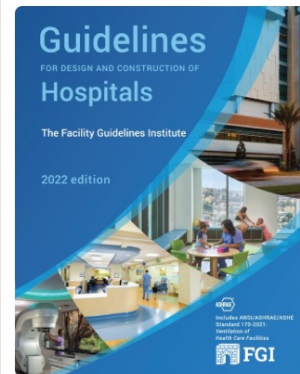
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Products

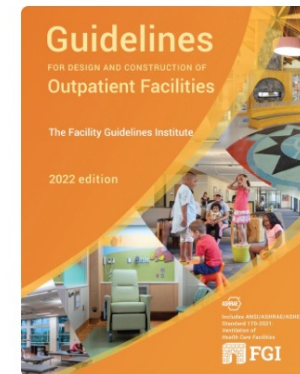
Paperback Books Digital Books

Select Edition Select Category



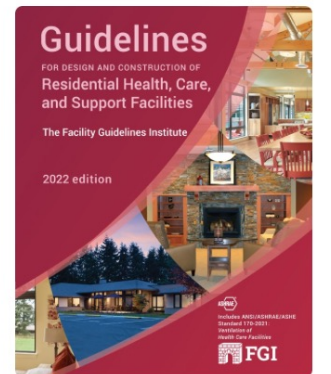
2022 Edition

2022 Guidelines for Design and Construction of Hospitals
\$235 / Multiple-User | \$90 / Single-User



2022 Edition

2022 Guidelines for Design and Construction of Outpatient Facilities
\$235 / Multiple-User | \$90 / Single-User



2022 Edition

2022 Guidelines for Design and Construction of Residential Health, Care, and Support Facilities
\$235 / Multiple-User | \$90 / Single-User

LIBRARY OF *GUIDELINES* DOCUMENTS

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2018 Hospital Chapter 1.1: Introduction

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Appendix material, intended to be advisory only, is offset and begins with the letter "A" following the corresponding section in the main text.

- 1.1-1 General
 - *1.1-1.1 Application
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- The provisions of this chapter shall apply to all new construction and major renovation projects in hospitals.
 - A1.1-1.1 Application. This document covers hospitals common to communities in the United States. Specialty hospitals with unique services will require special consideration. However, sections herein may be applicable for parts of any facility and may be used where appropriate.
- *1.1-1.2 Minimum Standards for New Facilities and Major Renovations
 - A1.1-1.2 Performance vs. prescriptive standards. The minimum standards in the *Guidelines* have been established to obtain a desired performance result. Prescriptive limitations (such as exact minimum dimensions or quantities), when given, describe a condition that is commonly recognized as a practical standard for normal operation. For example, reference to a room or area by the patient, equipment, or staff activity that identifies its use avoids the need for complex descriptions of procedures for appropriate functional programming.
- 1.1-1.2.1 Each chapter in this document contains information intended as minimum standards for design and construction of new hospitals and major renovations of existing hospitals.
- *1.1-1.2.2 Standards set forth in the *Guidelines* shall be considered minimum and do not prohibit designing facilities and systems that exceed these requirements.
 - A1.1-1.2.2 The *Guidelines* text is not intended to restrict innovation and improvement in design or construction techniques. Accordingly, authorities adopting these standards as code may approve plans and specifications that contain deviations if they determine the applicable intent or objective of the standards has been met. For more information, see sections [1.1-3.1.2](#) (Exceptions) and [1.1-6](#) (Equivalency Concepts). Final implementation of *Guidelines* requirements may be subject to decisions of the authority having jurisdiction.

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2018 Hospital Chapter 1.1: Introduction

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1.1 Introduction

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- 1.1-2 Site preparation for and construction of entirely new structures and systems
 - 1.1-2.1 Site preparation for and construction of entirely new structures and systems
 - 1.1-2.2 Structural additions to existing facilities that result in an increase of occupied floor area
 - 1.1-2.3 Change in function in an existing space
- 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.
 - 1.1-3.1.1.2 Major renovation projects. Projects with either of the following scopes of work shall be considered a major renovation and shall comply with the requirements for new construction in the *Guidelines for Design and Construction of Hospitals* to the

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☰ 2018 Hospital Chapter 2.1: Common Elements for Hospitals

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Appendix material, intended to be advisory only, is offset. It begins with the letter "A" following the corresponding section in the main text.

***2.1-1 General**

A2.1-1 This chapter contains elements that are common to most types of hospitals.

2.1-1.1 Application

2.1-1.1.1 The common elements in this chapter shall be required for a project when referenced from a specific [below].

2.1-1.1.2 Additional specific requirements are located in the facility chapters listed below:

- General hospitals (Chapter 2.2)
- Freestanding emergency care facilities (Chapter 2.3)
- Critical access hospitals (Chapter 2.4)
- Psychiatric hospitals (Chapter 2.5)
- Rehabilitation hospitals (Chapter 2.6)
- Children's hospitals (Chapter 2.7)
- Mobile/transportable medical units (Chapter 2.8)

2.1-1.1.3 Cross-references in this chapter and in the facility chapters include the section as identified by number otherwise noted.

2.1-1.1.4 Outpatient projects located in hospitals shall meet the requirements of the FGI *Guidelines for Design and Construction of Outpatient Facilities*.

2.1-1.2 Functional Program

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Errata Issued

The following correction, **published on 4/13/18**, has been made to both the digital version and the 2nd printing of the 2018 Guidelines for Design and Construction of Hospitals. This erratum applies to the uncorrected 1st printing.

2.1-1 General
...

2.1-1.1.4 Outpatient projects located in hospitals shall meet the requirements of the FGI *Guidelines for Design and Construction of Outpatient Facilities*.

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Text highlighted in gold indicates a related query was received followed by the issuance of a formal interpretation. See the "Interpretations" tab above.

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***2.1-3.2.1 Examination Rooms**

Where an examination room is provided, it shall meet the requirements in this section.

A2.1-3.2.1 Offices and/or practitioner consultation rooms may be combined with examination rooms.

2.1-3.2.1.1 General

(1) Patient privacy

(a) See [Section 2.1-3.1.2](#) (Patient Privacy) for requirements.

(b) Provision shall be made to preserve patient privacy from observation from outside an examination room.

(2) See the following tables for exam room requirements:

(a) [Table 2.1-1](#) (Electrical Receptacles for Patient Care Areas in Outpatient Facilities)

(b) [Table 2.1-2](#) (Station Outlets for Oxygen, Vacuum, Medical Air, and Instrument Air Systems in Outpatient Facilities)

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☰ 2018 Outpatient Chapter 2.1: Common Elements for Outpatient Facilities

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Interpretations and Applications Guidance

Note: A printable PDF version of this interpretation can be found the bottom of this page.

INTERPRETATION REQUEST #1

Guidelines edition: 2018 Outpatient	Guidelines reference: 2.1-3.2.1.1 (1)
-------------------------------------	---------------------------------------

Our regional health care system is developing a standard layout for exam rooms and working with our local AHJ on multiple projects. Before we finalize the designs, we want to clarify two requirements in Section 2.1-3.2.1 (Examination Rooms) in the 2018 FGI *Guidelines for Design and Construction of Outpatient Facilities*.

1 – Means for providing visual privacy in an exam room

Section 2.1-3.2.1.1 (1) requires appropriate levels of patient speech and visual privacy. Our health care system has a children's specialty center that only uses a room layout with the exam table against the wall. For infection control and patient safety reasons, we prefer not to have cubicle curtains in exam rooms. Instead, the door swing is intended to provide privacy by preventing observation from outside the room.

Question: Is it acceptable for the door into an exam room to be the only method of providing privacy?

Follow-up questions: If yes, is there a door angle requirement? 45 degrees? 90 degrees? If the door is acceptable as a privacy measure, does it need to have a door swing restrictor to limit it to a 90-degree swing?

Response: Yes, the *Guidelines* permits use of the exam room door as the only means of providing privacy. There is no door angle requirement, but to be accessible doors must be able to open 90 degrees. A door swing restrictor is not

Is it acceptable for the door into an exam room to be the only method of providing privacy?

GUIDELINES LIBRARY TOOLS

Which type of procedures can be performed in the rooms listed in this table?

What is considered an “invasive procedure”?

What dictates the physical environment features each treatment space will need?

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☰ 2022 Outpatient Chapter 2.1: Common Elements for Outpatient Facilities

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Table 2.1-4: Exam/Treatment, Procedure, and Operating Room Classification¹

Room Type	Use	Design Requirements ²		
		Area Type	Location	Surfaces
Exam or treatment room	Patient care that may require high-level disinfected or sterile instruments but does not require the environmental controls of a procedure room	Unrestricted area	Accessed from an unrestricted area	<i>Flooring:</i> cleanable and wear-resistant for the location; stable, firm, and slip-resistant <i>Wall finishes:</i> washable <i>Ceiling:</i> cleanable with routine housekeeping equipment; lay-in ceiling permitted
Procedure room	Patient care that requires high-level disinfected or sterile instruments and some environmental controls but does not require the environmental controls of an operating room	Semi-restricted area	Accessed from an unrestricted or a semi-restricted area	<i>Flooring:</i> cleanable and wear-resistant for the location; stable, firm, and slip-resistant <i>Floor and wall base assemblies in cystoscopy, urology, and endoscopy procedure rooms:</i> monolithic floor with integral covered wall base carried up the wall a minimum of 6 inches (15.24 centimeters) <i>Wall finishes:</i> washable; free of fissures, open joints, or crevices

CHANGES TO THE
2022 HOSPITAL
GUIDELINES

Good Care Medical Facility									
Hazard Assessment - East Campus									
Year - 2017									
Emergency Management - Hazard and Vulnerability Assessment Tool									
Hazard Type	EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITGATION)					RISK	
			HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE		EXTERNAL RESPONSE
		Likelihood this will occur	Possibility of Death or Injury	Physical Losses and Damages	Interruption of Services	Preplanning	Time, Effectiveness, Resources	Community / Mutual Aid Staff & Supplies	* Relative threat
		0 = N/A	0 = N/A	0 = N/A	0 = N/A	0 = N/A	0 = N/A	0 = N/A	
		1 = Low	1 = Low	1 = Low	1 = Low	1 = High	1 = High	1 = High	
		2 = Moderate	2 = Moderate	2 = Moderate	2 = Moderate	2 = Moderate	2 = Moderate	2 = Moderate	
		3 = High	3 = High	3 = High	3 = High	3 = Low	3 = Low	3 = Low	
									0 - 100%
H	Active Shooter								0%
14	Bomb Threat								0%
15	Child Abduction								0%
16	Civil Disturbance								0%
17	Cyberattack								0%
18	Data Breach								0%
19	Evacuation								0%
20	Forensic Admission								0%
21	Hostage Situation								0%
22	Infant Abduction								0%
23	Labor Action / Strikes / Work Stoppage								0%
24	Mass Casualty Incident - HazMat								0%
25	Mass Casualty Incident - Medical/Infectious								0%
26	Mass Casualty Incident - Trauma								0%

SAFETY RISK ASSESSMENT

BEHAVIORAL
AND
MENTAL
HEALTH

RISK ASSESSMENT MATRIX				
SEVERITY PROBABILITY	Catastrophic (1)	Critical (2)	Marginal (3)	Negligible (4)
Frequent (A)	High	High	Serious	Medium
Probable (B)	High	High	Serious	Medium
Occasional (C)	High	Serious	Medium	Low
Remote (D)	Serious	Medium	Medium	Low
Improbable (E)	Medium	Medium	Medium	Low
Eliminated (F)	Eliminated			

UPDATES TO EMERGENCY DEPARTMENT ACCESS

Change is the result of Laura's Law
in Massachusetts

1. Video surveillance system for
public entrances to the ED
2. Duress alarm system where
entrances are locked



INFECTION PREVENTION

Airborne Infection Isolation Rooms, PE,
AII/PE rooms

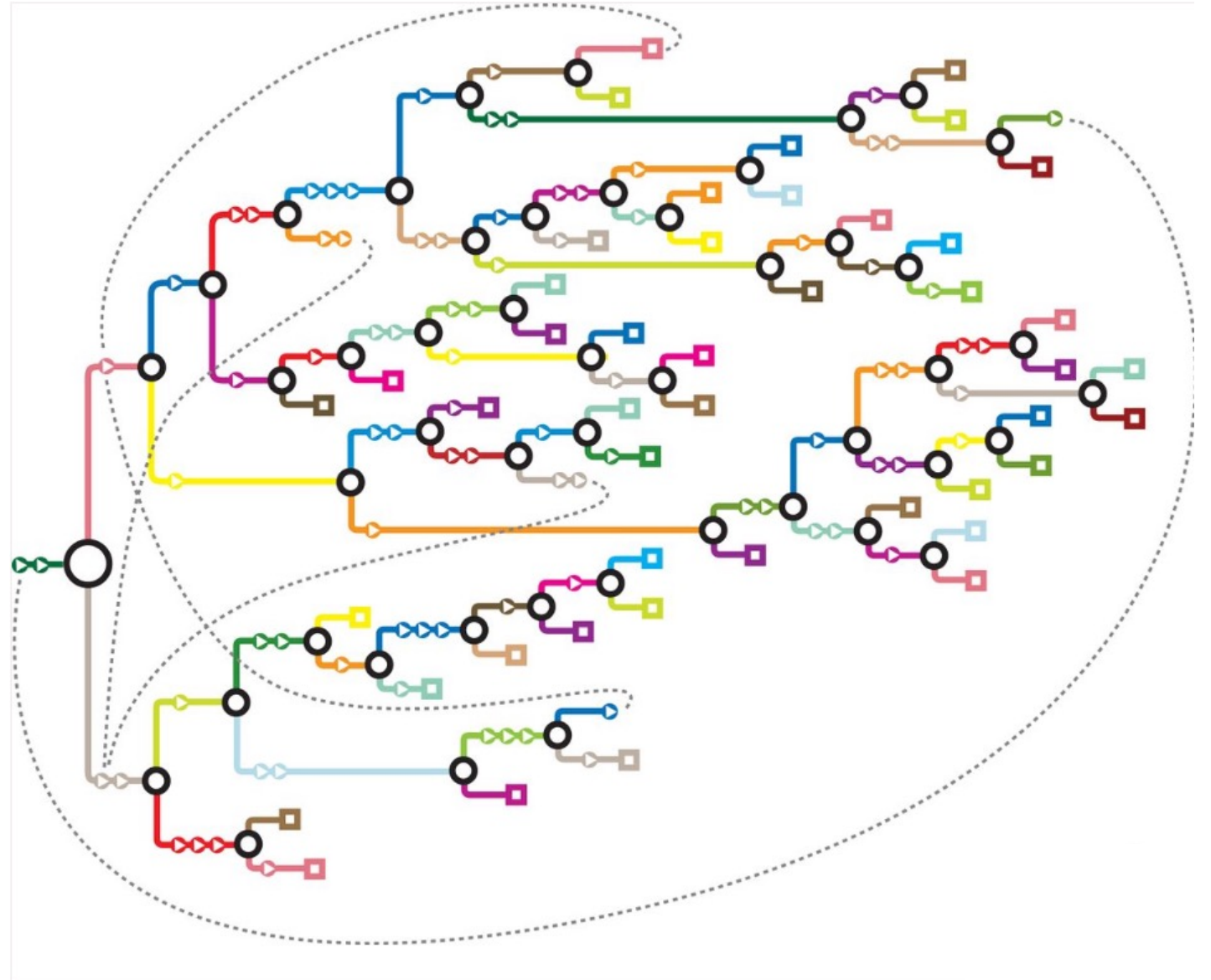
- Number required based on the ICRA

All Anterooms

- **An anteroom is not required**
- Inclusion determined by the ICRA
- Appendix for anteroom space for doffing PPE



NEW WAYS TO
APPLY
REQUIREMENTS



PRE- AND POST-OP

2018: 2 stations per procedure room, OR, Class 2 imaging room, and Class 3 imaging room

2022: 1.5 per procedure room, OR, Class 2 imaging room, and Class 3 imaging room



Holy Cross Health



CEILING IN OPERATING ROOMS AND CLASS 3 IMAGING ROOMS

Ceilings in restricted areas

- Remain monolithic
- Added Protective Environment Rooms to the list of OR, Class 3 imaging and sterile compounding

Modular or prefabricated laminar flow ceiling systems allowed if:

- Seams / access doors gasketed
- Structurally rated assembly
- Access for testing, maintenance, replacement
- Diffuser compliant w/ASHRAE 170
- Devices and related controls UL/ETL labeled

Call (nurse) systems

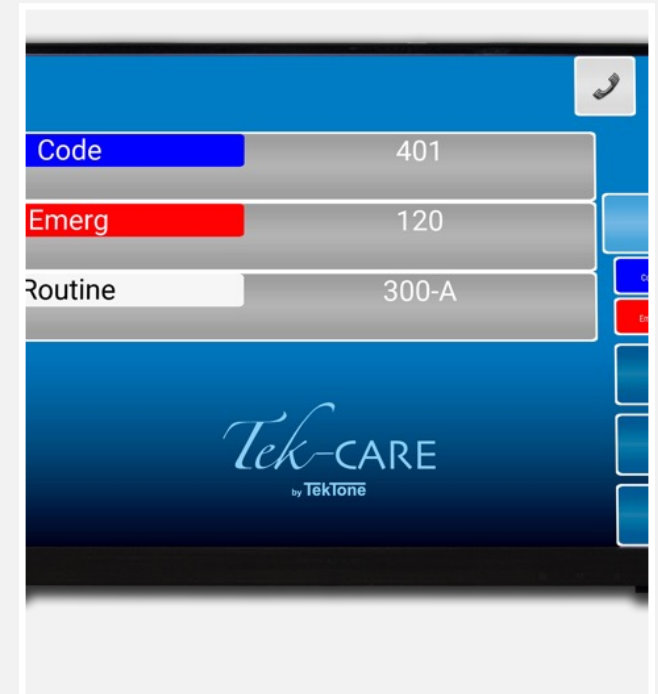
- Removed optional locations
- Clarified use of wireless and radiofrequency systems
- Changed terminology from “station” and to “device”

BMH pull cords

- Detachable
- No longer than 6 inches

Modernized section on Telecomm Systems

NURSE CALL



GENERAL HOSPITAL

- A hospital with 35 or fewer licensed beds may use the chapter on Critical Access or Small Hospitals.
- Place for meditation, bereavement and/or prayer: 1 per hospital, not 1 per unit.



GENERAL HOSPITAL

NICU room size

Multiple-infant rooms

Minimum clear floor area ± 20 to 150 SF

Single-infant rooms

Minimum clear floor area ± 65 to 180 SF

Windows not required in individual rooms if daylight can be viewed.



GENERAL HOSPITAL



NICU room type

Neonatal Couplet Care Room (300 SF) for a hospitalized mother and NICU patient

- 150 SF for bed
- 150 SF for infant station

Where combined with LDRP must have 435 SF clear floor area



HOSPICE AND/OR PALLIATIVE CARE ROOM

Minimum Room Dimensions

- ✓ 153 SF clear floor area
- ✓ Minimum 10' at head of patient bed
- ✓ Clear floor area includes 33 SF for family support zone; provides space for overnight stay
- ✓ In renovation – may be reduced to 120 SF
- ✓ Mobile telemedicine cart permitted

BURN TRAUMA CRITICAL CARE UNIT



Meet ICU criteria

Maximum of one patient per room

Patient room designed as Protective Environment (PE)

Direct access to a patient toilet room

Radiant heat panels over bed

Available OR with temp of 95°



**CHANGES TO THE HOSPITAL *GUIDELINES*:
EMERGENCY SERVICES**

FSED removed from Hospital document!!

Trauma/Resuscitation

When not in use as T/R, can be subdivided with cubicle curtains

Low-acuity pods

40 SF clear floor area

5'-6" minimum clear

Human Decontamination Facilities

Room: increased from 80 to 100 SF

Exterior structures: No min. SF

BEHAVIORAL HEALTH CRISIS UNIT



Located in or readily accessible to the ED

Single patient observation room

- 100 SF
- 10 ft. clear dimension

Multiple-patient room

- 80 SF per patient
- 4' between recliners
- 3' clearance between walls or partitions

CHANGES TO THE HOSPITAL *GUIDELINES*: BEHAVIORAL AND MENTAL HEALTH HOSPITALS

- Added requirements for a Geriatric Patient Care Unit
- Added Transcranial Magnetic Stimulation (TMS) room
- Added Intensive Outpatient and Partial Hospitalization Program (IOP/PHP)
- New safety provisions: entrances, reception, and waiting spaces



CHANGES TO THE
2022 OUTPATIENT
GUIDELINES

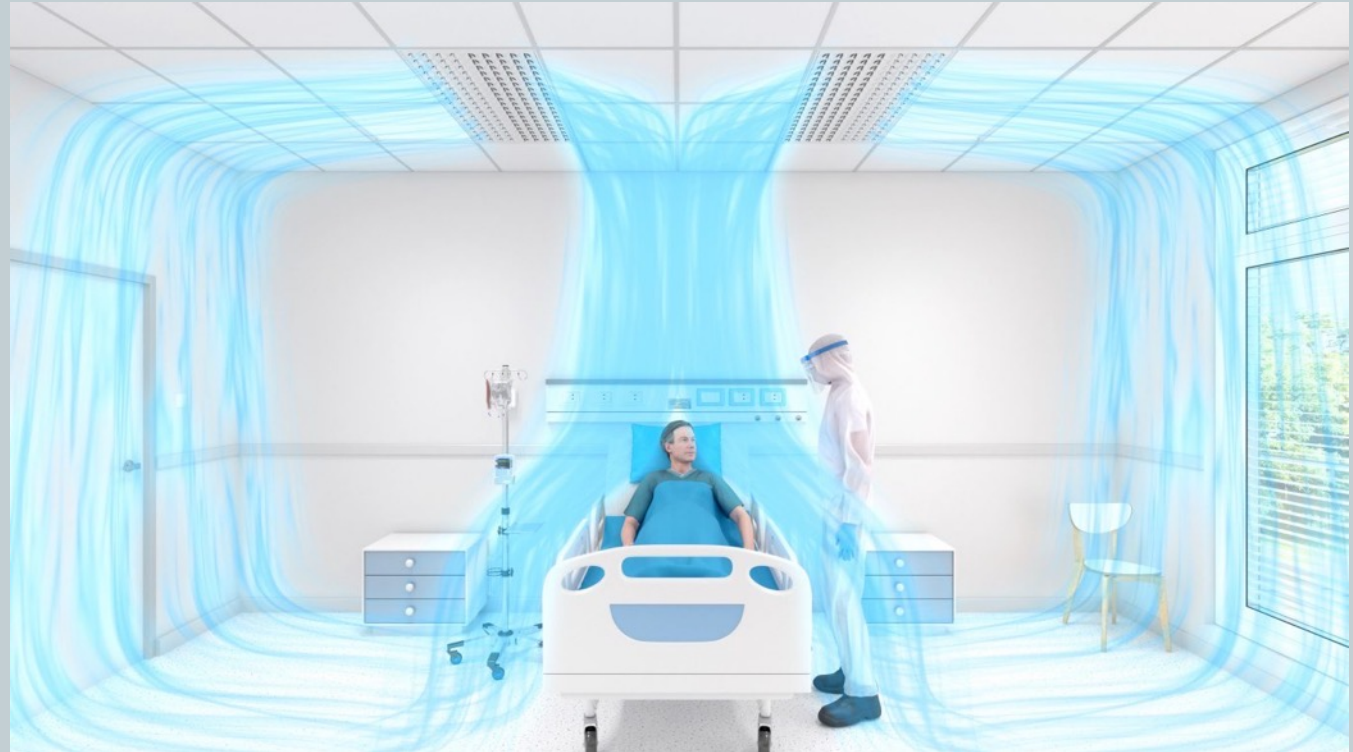
PDC & COMMISSIONING

Strengthened Functional Program requirements

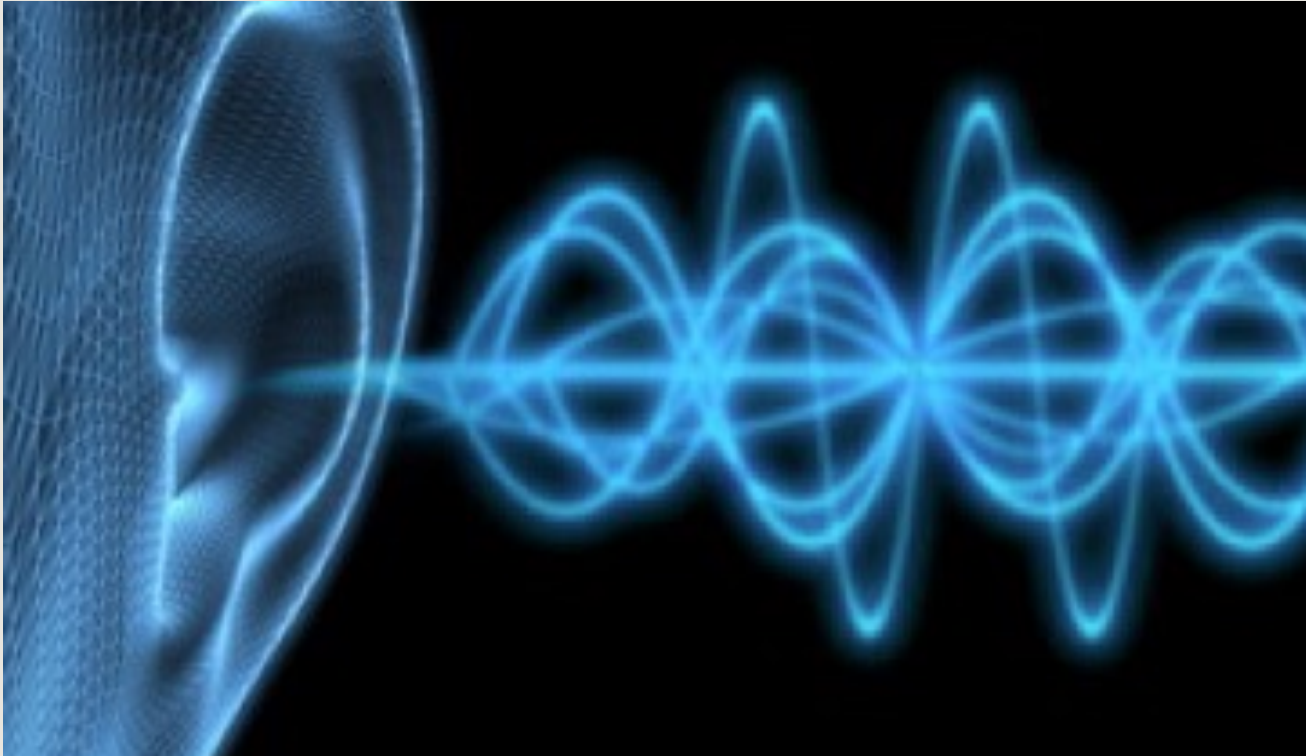
Airborne Infection Isolation room anteroom determined by ICRA

Considerations include:

- Define intended use
- Facility location
- Long-range infection prevention planning



PDC & COMMISSIONING



Acoustics

• Numerous room types have had an increase in sound absorption coefficients from 0.15 to 0.20 NRC:

- Exam
- Treatment
- Procedure
- Class 2 imaging
- Corridor

Added
Multipurpose/conference
room and telemedicine room

OUTPATIENT *GUIDELINES:*

COMMON ELEMENTS

Single-patient
exam/observation
room with dual
entry

Each room shall
have 100 sq. ft. clear
floor area

Min. clearance of 2'-
8" at each side of
the patient station
and at the foot



OUTPATIENT *GUIDELINES*: COMMON ELEMENTS

New section on hyperbaric oxygen therapy facilities

- Multiplace facilities
- Monoplace facilities
- Pre-procedure area
- Support areas for staff
- Support areas for patients



OUTPATIENT *GUIDELINES*: COMMON ELEMENTS

Security

Environmental service rooms

- A means of securing each room from unauthorized access

Mechanical and electrical equipment installed outside the building shall be secured from unauthorized access.





FREESTANDING EMERGENCY CARE

New optional spaces in FSEDs

- Trauma/resuscitation room can be subdivided (as in the Hospital)
- Low-acuity pods are permitted
- Flexible secure treatment room (allows conversion from a treatment room to secure holding)
 - Hand-washing station can be located outside the room
 - Room shall have a max. wall length of 12 feet
- If provided, the behavioral health crisis unit would be equivalent to that in the *Hospital Guidelines*.



URGENT CARE FACILITIES

At least one care station shall be a single-patient exam/treatment room.

- Triage area
 - Access to language translation services
 - Means to alert staff or local authorities
- Multiple-patient exam/treatment room
 - Where bays or cubicles face each other – min. 5-foot aisle required independent of the foot clearance



DIALYSIS FACILITIES

Patient care station space requirements

- Removed min. clear floor areas
- 2'-0" clearance at the foot of the dialysis chair when the chair is fully extended

DIALYSIS FACILITIES

Dedicated room for patients with special precautions (removed All room and added contact transmission)

- Single-patient room; min. 120 sq. ft. clear floor area
- Direct observation of patient's face AND insertion point
- Hand-washing in each room
- Fluid disposal sink
- Storage for PPE
- Door and walls need to extend to the floor—but not the ceiling



DIALYSIS FACILITIES

Nurse station

Direct visual observation of the patient's face and vascular access

Casework/obstructions no higher than 3'-8" in sightlines that impair visual observation

Hand-washing station can be placed at the nurse's station

Corridors: Meet NFPA or local building codes; at least one exit route sized to accommodate transporting a patient by gurney/stretchers.





OP BEHAVIORAL AND MENTAL HEALTH CENTERS

Changes are consistent with what was changed in Behavioral and Mental Health unit in the Hospital *Guidelines*.

BIRTH CENTERS

The required size of a birthing room in birth centers has been **reduced from 200 to 120 sq. ft.** This change was influenced by a national study of birth centers which found that enough existing birth center rooms were less than 200 sq. ft. to have us reevaluate the minimum.

Emergency safety plan for building systems is required.





DENTAL FACILITIES

Space requirements

- Removed min. floor area of 80 sq. ft.
- Retained min. clearance of dental chairs of 2'-8"

HVAC requirements for laboratory

Room and pressure shall meet the requirements of ASHRAE 170.

CHANGES TO THE
2022 RESIDENTIAL
GUIDELINES

RESIDENTIAL *GUIDELINES*



Reorganized to match structure of Hospital & Outpatient



Safety Risk Assessment content updated, expanded, and aligned



Lighting coordinated with IES recommendations



Sustainability updated to refer to existing standards where possible



RESIDENTIAL *GUIDELINES*

- Design criteria for palliative care added
- Accommodations for telemedicine services expanded to address privacy, acoustics, lighting, skin tone rendition, and mobile telemedicine services
- Telecommunications requirements updated to reflect current technology

NURSING HOMES

Single-resident room

121 sq. ft.

Min. clear dimension 11'

Multiple-resident room

108 sq. ft. per bed

Min. clear dimension of 9'-6"

*Clearances must accommodate arrangement of furniture.



NURSING HOMES

Renovation

- Multiple-resident rooms max. capacity is 4 residents, with no more than 2 sharing a sink and toilet

Dialysis services added

- Chair station has min. clear floor area of 80 sq. ft. with min. headwall length of 8 ft.
- Privacy screens or cubicle curtains required
- Handwashing stations within 25 ft.



INDIVIDUALS OF SIZE



Single-resident
room

With fixed
overhead lift:
• 200 SF CFA

Without fixed
overhead lift
• 219 SF CFA

Multiple-resident
room

With fixed
overhead lift
• 197 SF CFA
per resident

Without fixed
overhead lift
• 216 SF CFA
per resident

—All require clear dimension of 13'-2"—
Clearances must accommodate resident
furniture and resident mobility and
transfer.

HOSPICE FACILITIES



- Hospice room is single-occupant unless need for double-occupancy is justified during planning phase.
- Hospice patient rooms in must have min. clear floor area of 153 sq. ft. to accommodate a family support zone of 33 sq. ft.
- Design criteria also provided for individuals receiving palliative care in other facility types.

STANDARD

ANSI/ASHRAE/ASHE Standard 170-2021
(Supersedes ANSI/ASHRAE/ASHE Standard 170-2017)
Includes ANSI/ASHRAE/ASHE addenda listed in Appendix F

Ventilation of Health Care Facilities

See Appendix F for approval dates by the ASHRAE Standards Committee, the ASHRAE Board of Directors, the ASHE Board of Directors, and the American National Standards Institute.

This Standard is under continuous maintenance by a Standing Standard Project Committee (SSPC) for which the Standards Committee has established a documented program for regular publication of addenda or revisions, including procedures for timely, documented, consensus action on requests for change to any part of the Standard. Instructions for how to submit a change can be found on the ASHRAE® website (<https://www.ashrae.org/continuous-maintenance>).

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ISSN 1041-2336



RESIDENTIAL
GUIDELINES:

ASHRAE 170-
2021

PREPARING FOR
THE 2026
GUIDELINES
REVISION CYCLE

2026 REVISION CYCLE — DATES TO KNOW

- February 1, 2023 Public proposal period begins
- June 30, 2023 Proposal period ends
- July 1, 2024 Public comment period begins
- September 30, 2024 Comment period ends
- April 2026 2026 *Guidelines* published

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To submit a proposal any of the 2018 FGI *Guidelines for Design and Construction* documents, please follow these steps.

1. Click All Proposals from the column at left to review proposals already submitted.
2. If you find someone else has submitted a proposal identical to one you were considering submitting, we suggest you enter an opinion with substantive reasons for supporting that proposal rather than submitting another, identical proposal. (This will simplify review by the Health Guidelines Revision Committee.)
3. Click Submit a Proposal to enter your own proposals. Before writing a proposal, however, please take time to review the [tips for writing proposals](#). You can [download this file](#) to keep it handy for reference as you prepare your proposals.
4. Click My Proposals to see the proposals you submitted during other sessions and to review opinions others have posted about them.

For more information about the FGI *Guidelines* documents and the 2022 revision cycle, visit the [Facility Guidelines Institute](#) website or read the proposal period [press release](#). Questions may be addressed to info@fgiguidelines.org.



QUESTIONS
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