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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH DIVISION
BUREAU OF LICENSURE AND CERTIFICATION

Technical Bulletin
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Date: December 20, 2007
To: Health Care Providers and Architectural/Engineering Firms
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This bulletin provides notice that on December 7, 2007, the State Board of Health, pursuant to Nevada Administrative Code (NAC) 449.0105, approved the adoption by reference of the current 2006 edition of the *American Institute of Architects Guidelines for Design and Construction of Health Care Facilities* excluding the information contained in the appendix and specific sections which are outlined in the attachment to this bulletin.

The 2006 edition will be implemented January 1, 2008 with the following exclusions.

Exclusions:

Part 1 General; 1.2 Indoor Air Quality; Sections 3.1.5, 3.1.5.2 and 3.1.6; Page 20
Part 1 General; 1.5 Planning, Design, Construction; Section 3.4, Page 28
Part 1 General; 1.6 Common Requirements; Section 2.1.1; Page 31
Part 2 Hospitals; 2.1 General Hospital; Section 3.1.1.1; Page 40
Part 2 Hospitals; 2.1 General Hospital; Section 3.3; Page 46
Part 2 Hospitals; 2.1 General Hospital; Section 3.4.1.4(3); Page 48
Part 2 Hospitals; 2.1 General Hospital; Section 5.5.4.2(2); Page 85
Part 2 Hospitals; 2.3 General Hospital; Section 6.2.3.1(2); Page 155
Part 3 Ambulatory Care Facilities; 3.1 Medical Gas & Vacuum Systems; Section 7.1.4.1; Page 199

The attached chart provides comparison of the 2001 and 2006 requirements for the excluded sections and includes the rational for excluding the requirement from the adoption of the 2006 AIA Guidelines.

Typical patient rooms: The requirement for single bed rooms in hospitals, Chapter 2.1, section 3.1.1.1 and section 3.9.2, will be excluded from the AIA Guidelines requirements. Please note, however, that minimum room dimensions for hospitals will

still be required for new construction which appears in the AIA Guidelines in Chapter 2.1, section 3.1.1.2 under space requirements.

Plan Review Application Packet– Functional Program Requirement – Infection Control Risk Assessment (IRCA): The plan review application packet has been updated to include the attached chart of excluded sections. The functional program requirement and infection control risk assessment continue to be required components when submitting a plan review application to the Bureau of Licensure and Certification.

The 2006 edition of the AIA Guidelines contains physical environment standards that were developed by an interdisciplinary group of professionals for protecting the health and safety of patients in health care facilities. Emphasis was placed on designing a health care facility that promotes increased patient and staff safety, preventing facility-acquired infections, protecting patient privacy and providing an atmosphere that controls noise while contributing to improved patient health care outcomes.

These standards are considered to be minimal construction standards, and it may be necessary to exceed the requirements to be able to meet the overall intent of the AIA Guidelines for providing a health care facility that can support the safe delivery of medical services.

Requirements excluded from the adoption of the 2006 edition of the *American Institute of Architects Guidelines for Design and Construction of Health Care Facilities*

	Code	2006 Edition	Code	2001 Edition	Rationale for Modification or Exclusion	Comments at the Public Workshops
1	1.2-3.1.5, 3.1.5.2, 3.1.6	Indoor Air Quality. The impact of building design and construction on indoor air quality shall be addressed. Impact from both exterior and interior air-contamination sources shall be minimized. The environmental impacts associated with the life cycle of building materials shall be addressed.	2.1	Environment of Care. The importance of energy conservation shall be considered in all phases of facility development or renovation….The quality of the health care facility environment must, however be supportive of the occupants and functions served.	BLC does not have a method of testing to determine compliance with these requirements. The language does not include minimum air quality or environmental impact requirements to follow to protect public health and welfare.	Public comments indicated that the local jurisdictions address and provide oversight of these areas and support the BLC decision.

	Code	2006 Edition	Code	2001 Edition	Rationale for Modification or Exclusion	Comments at the Public Workshops
2	1.5 - 3.4	Planning, Design and Construction. 3. Renovation. Delete section 3.4 Nonconforming Conditions. It is not always financially feasible to renovate an entire existing structure in accordance with these Guidelines. Therefore, the Authority Having Jurisdiction (AHJ) shall be permitted to grant approval to renovate portions of a structure if facility operation and patient safety in the renovated areas are not jeopardized by existing features of sections retained without complete corrective measures.	1.3	This requirement was included in the 1999 and 2001 editions of the AIA Guidelines. In 1999, this section was excluded from adoption by the SBOH**;** however, it was not in the 2001 edition. Industry architects and builders reported experiencing confusion regarding the extent of a renovation, as well as which existing conditions had to be brought up to code during expansion projects, especially for emergency departments. Each case was independently decided upon by BLC staff, thereby making it difficult to ensure consistency throughout the state.	BLC recommends the deletion of this section as the NAC requires a facility to comply with the AIA guidelines for renovations and new construction. The SBOH has the authority to grant approval for variances to the AIA guidelines, if a facility does not wish to bring all conditions into compliance with current codes rather than BLC.	There were multiple comments received that indicated a need to clearly define when a remodeling or renovation project would require the area to meet current code requirements. The National Fire Protection Association (NFPA) 101 Life Safety Code, the International Building Codes (IBC) and our NAC have independent, industry specific requirements that address renovation, remodeling and reconstruction. BLC staff recommendation for deletion of this section would allow the NAC to take precedence and require current code for renovations and new construction.

	Code	2006 Edition	Code	2001 Edition	Rationale for Modification or Exclusion	Comments at the Public Workshops
3	1.6 - 2.1.1	Section 1.6**:** Common Requirements for all facility chapters in the guidelines. Section 2 Building Systems and 2.1 Plumbing states that unless otherwise specified herein, all plumbing systems shall be designed and installed in accordance with the International Plumbing Code.	Same	In this edition of the guidelines the international codes were not in place. Several codes and publications were referenced in the guidelines including the building codes; therefore, a conflict did not occur.	The 2006 edition created a conflict between the Nevada Revised Statutes (NRS) 444.340 that require compliance with the Uniform Plumbing Code**,** not the International Plumbing Code (IPC) and the AIA Guidelines. BLC would like to exclude all references to the IPC throughout the AIA Guidelines. For example, the reference to the IPC in code 2.1-10.1.1 under the heading of Building Systems for general hospitals.	Public comments were in agreement with the BLC staff recommendation to delete this requirement from the 2006 edition of the Guidelines.

	Code	2006 Edition	Code	2001 Edition	Rationale for Modification or Exclusion	Comments at the Public Workshops
4	2.1 - 3.1.1.1	Typical Patient Rooms - Capacity (1) In new construction, the maximum number of beds per room shall be one unless the functional program demonstrates the necessity of a two-bed arrangement. Approval of a two-bed arrangement shall be obtained from the licensing authority.	7.2.A1	Patient Rooms - Maximum room capacity shall be two patients. Where renovation work is undertaken and the present capacity is more than two patients, maximum room capacity shall be no more than the present capacity with a maximum of four patients.	This is a new requirement for single bed rooms for medical or surgical units, LDR & LDRP rooms, and in hospital skilled nursing units.	Public comments received at the public workshops in July 2007 provided comments for and against this requirement. Additional public comment was received from the Nevada Hospital Association and Nevada Rural Hospital Partners. These organizations represent the urban and rural hospitals through-out Nevada. Concerns were expressed by both associations that private rooms are not cost effective due to the extremely high cost of construction in Nevada, and that ultimately this would have a negative impact on hospitals providing sufficient bed capacity to provide services to patients. BLC staff recognize that protecting patients and staff from hospital acquired infections, promoting a quiet

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5	2.1 - 3.3	Protected Units - Intermediate Care Units**,** sometimes referred to as step-down units, are routinely utilized in acute care hospitals for patients who require frequent monitoring of vital signs and/or nursing intervention that exceed the level needed in a regular medical/surgical unit**;** but is less than that provided in a critical care unit.	None	In the 2001 edition, intermediate medical care was provided to patients on a typical nursing unit without causing patient harm. In this edition, the maximum number of patients in a room was two.	This is a new section in the AIA Guidelines that creates a new Intermediate Care Unit in a general hospital that allows for four patients in one room. The BLC staff wish to exclude this section entirely as this type of patient could be treated on a nursing unit that allows a maximum of two patients per room (if the functional program requirement supports this concept and it is approved). Limiting the number of patients per room helps to control the spread of infections and protects patient privacy.	Public comments were in agreement with the BLC staff recommendation to delete this requirement from the 2006 edition of the Guidelines. Please note this does not affect current ICU or CCU units in hospitals. Deleting this new requirement would place a patient requiring this level of care in a private room on a nursing unit.

	Code	2006 Edition	Code	2001 Edition	Rationale for Modification or Exclusion	Comments at the Public Workshops
6	2.1 - 3.4.1.4(3)	Critical Care Units. Unit location. The following shall apply to all types of critical care units unless otherwise noted. (3) Space arrangement shall include provisions for access to emergency equipment from other departments.	7.3.A11	The 2001 edition only required space for emergency equipment storage. Space that is easily accessible to the staff shall be provided for emergency equipment such as a CPR cart. The facility was charged with the responsibility to determine if one crash cart met the needs of their patients.	BLC staff believe the ICU unit must have a department dedicated crash cart housed on its unit for patient use in critical/emergency situations.	Public comment suggested emergency equipment could also include a ventilator and other items, not just a crash cart. There was agreement from the public to require placement of this type of emergency equipment in the ICU unit for their exclusive use.

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5	2.1 - 5.5.4.2(2)	Diagnostic X-ray: tomography, radiography/fluoroscopy rooms. (1) Separate toilets with hand washing stations shall be provided with direct access from each fluoroscopic room so that the patient can leave the toilet without having to reenter the fluoroscopic room. (2) Rooms used only occasionally for fluoroscopic procedures shall be permitted to use nearby patient toilets if they are located for immediate access.	7.10.G4	Support Areas. Patient toilet rooms. Separate toilets with hand washing stations shall be provided with direct access from each radiographic/fluoroscopic room so that a patient can leave the toilet without having to reenter the R & F rooms. Rooms used only occasionally for fluoroscopic procedures shall be permitted to utilize nearby patient toilets if they are located for immediate access.	Delete subsection (2). BLC believes that toilets must be available for patient use only to help assure availability in times of emergency. Toilets may be occupied by other patients if shared for multiple areas.	Patient toilet rooms in diagnostic x-ray units. Exclusion of subsection 2 of this new section of the guidelines would then require a patient toilet with direct access from each fluoroscopic room so the toilet is always available for patients undergoing this type of procedure. Public comment was in agreement that patient toilet rooms should be accessible to each fluoroscopic room.

	Code	2006 Edition	Code	2001 Edition	Rationale for Modification or Exclusion	Comments at the Public Workshops
~~7~~	~~2.1 – 7.1.3~~	~~Public Waiting Areas. All public waiting areas serving more than 15 people shall include toilet room(s) equipped with hand-washing stations. These toilet rooms shall be located near the waiting areas and may serve more than one such area.~~	~~7.19B3.~~	~~Administration and Public Areas. The following shall be provided: Lobby with public toilet facilities. Public Waiting Areas~~	~~This is a new requirement in the 2006 edition that allows hospitals with 15 or less beds to eliminate the public toilet requirement. BLC would like to exclude this new paragraph which would have the effect of requiring toilets in public waiting areas regardless of the number of beds the facility is licensed for. This will allow public access to toilets without having to use patient toilets.~~	The public comments suggested leaving this requirement as it appears in the 2006 edition of the Guidelines. BLC staff are in agreement and will not recommend deletion. BLC, therefore, has indicated this is a change from the information provided on December 8, 2006 at the BOH meeting by stricking through this requirement.

	Code	2006 Edition	Code	2001 Edition	Rationale for Modification or Exclusion	Comments at the Public Workshops
8	2.3 - 6.2.3.1(2)	Psychiatric Facility - Finishes. Ceilings. In patient bedrooms where acoustical ceilings are permitted by the functional program, the ceiling shall be secured or of sufficient height to prevent patient access. This would allow for drop-in ceiling tiles.	11.1.F Environment in a Psychiatric Hospital	Special design considerations for injury and suicide prevention shall be given to the following elements: Ceilings, ventilation grills, and access panels in patient bedrooms and bathrooms.	Currently, patients may be able to lift a drop-in ceiling tile, even when secured and cause possible harm. BLC would like to exclude this paragraph so that drop-in ceiling tiles will not be permitted.	One written public comment indicated that lay-in ceilings can be acceptable provided that the walls between patient rooms are constructed full height. Ultimately there was agreement with BLC staff recommendation to require hard ceilings, but also stressed the importance of security and sound transmission control between patient rooms. An additional public comment stressed the importance of providing tamper-proof light switches and ceiling lights, as well as not having exposed grills in psychiatric patient sleeping rooms to protect the patient.

	Code	2006 Edition	Code	2001 Edition	Rationale for Modification or Exclusion	Comments at the Public Workshops
9	3.1 - 7.1.4.1	Medical Gas Systems. If piped medical gas is used, the installation, testing, and certification of nonflammable medical gas and air systems shall comply with the requirements of NFPA 99. Station outlets shall be provided consistent with need established by the functional program.	9.9A3	The medical gas installation requirements in the 2001 edition were inconsistent between endoscopy centers and ambulatory surgery centers (ASC). There was a requirement for piped-in medical gasses in endoscopy centers but not for ASC's.	It is the position of BLC that medical gas installations shall be piped into installations in accordance with the table requirements (Table 3.1-2, page 207) rather than by the functional program requirements only. If procedures change that may require additional gasses, a facility would have the option to install additional gasses at that time. BLC prefers to exclude "Station outlets shall be provided consistent with need established by the functional program". The intent is to meet the table requirements for piped in medical gasses as a minimum standard and meet NFPA 99 requirements.	Public comment supported BLC staff recommendation to follow the table guidelines.