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Part 2: Hospital Facility Types
Chapter 2.2: Specific Requirements for General Hospitals
Section 2.2-3: Diagnostic and Treatment Facilities

2.2-3 Diagnostic and Treatment Facilities

2.2-3.1 Emergency Services

* 2.2-3.1.1 General

Facilities for emergency care range from basic emergency care units to emergency departments to freestanding emergency facilities. For requirements for freestanding emergency facilities, see Chapter 2.3 (Specific Requirements for Freestanding Emergency Care Facilities).

A2.2-3.1.1 Classification of facilities for emergency services. This section of the *Guidelines* is separated into requirements for a basic emergency care unit and requirements for a full emergency department.

A dedicated emergency department may be part of a state or American College of Surgeons (ACS) trauma system with a Level I–IV designation. Trauma-level designations are awarded based on the capabilities and services provided by the hospital. All emergency departments, regardless of trauma-level designation, need to be able to provide for the initial evaluation and stabilizing treatment of all trauma patients.

The following ACS reference provides detailed descriptions of Level I–IV trauma centers: “Descriptions of Trauma Center Levels and Their Roles in a Trauma System,” chapter 2 in *Resources for Optimal Care of the Injured Patient*. State designations have their own criteria but often mimic the ACS requirements for each level.

The extent and type of emergency services provided in an emergency department vary according to patient population and hospital capabilities. All hospitals need to provide assessment of presenting condition, stabilization and treatment, and transfer to higher level of care when the emergency is beyond the hospital’s capabilities.

At minimum, a hospital needs to provide a medical screening exam conducted by qualified medical personnel to determine if an emergency condition exists and, if required, stabilization and treatment within the capability of the hospital. If the patient’s condition requires further inpatient treatment, the hospital needs to arrange for admission to the hospital or transfer to an appropriate facility for additional treatment.

2.2-3.1.2 Basic Emergency Care

* **2.2-3.1.2.1 General.** Space for basic emergency assessment and stabilization shall be provided at every hospital.

A2.2-3.1.2.1 Facilities for basic emergency care. At minimum, basic emergency care includes provisions for emergency treatment for staff, employees, and visitors as well as for persons who may be unaware of or unable to immediately reach services in other facilities. This is not only for patients with minor illnesses or injuries who may require minimal care but also for persons with severe illnesses and injuries who must receive immediate emergency care and stabilization prior to transport to other facilities.

Facilities for basic emergency care should accommodate equipment needed for the services identified in the organization’s functional program and support 24-hour/7-day-a-week staffing to ensure no delay in medical screening, stabilization, and essential treatment.

2.2-3.1.2.2 Entrance

- (1) A well-marked, illuminated, and covered entrance shall be provided at grade level. The emergency vehicle entry cover shall provide shelter for both the patient and the emergency medical crew during transfer between an emergency vehicle and the building.
- (2) Ambulance entrances shall provide a minimum of 6 feet (1.83 meters) in clear width to accommodate gurneys for patients of size, mobile patient lift devices, and accompanying attendants.
- (3) Where lifts for patients of size are provided in the covered ambulance bay, they shall be positioned to provide assistance with patient transfers.

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2.2-3.1.2.3 Reception, triage, and control station. These areas shall be located so staff can observe pedestrian and ambulance entrances and public waiting areas and control access to the treatment room.

2.2-3.1.2.4 Public waiting area

- (1) Provisions shall be made for a public waiting area, to include the following:
 - (a) Public toilet room with hand-washing station(s)
 - * (b) Access to public communications services

A2.2-3.1.2.4 (1)(b) Public communications services include provisions for telephone access, wireless internet connectivity, and distributed antenna systems to support cell phone use.

- (c) Access to drinking water
- (2) These provisions shall be permitted to be shared.

2.2-3.1.2.5 Communications center. Communication connections to local and other emergency medical service (EMS) systems shall be provided.

2.2-3.1.2.6 Treatment room

- (1) At least one treatment room shall be provided in accordance with Section [2.1-3.2](#) (Examination Room or Emergency Department Treatment Room) as amended in this section.
- (2) Each treatment room shall be sized to contain space for the medical equipment to be used in the room.

2.2-3.1.2.7 Patient toilet room. A patient toilet room with hand-washing station(s) shall be immediately accessible to the emergency care area.

2.2-3.1.2.8 Equipment and supply storage

- (1) Storage shall be provided for medical and surgical emergency care, including supplies, medications, and equipment.
- (2) Storage shall be located out of traffic and under staff control.

* **2.2-3.1.3 Emergency Department**

A2.2-3.1.3 Emergency departments

a. *Surge capacity for NBC hazards events.* When consistent with agreements between the organization and local and regional emergency preparedness planning agencies, acute care facilities with an emergency department can function as receiving, triage, and treatment centers during an unplanned event affecting the community. These facilities should have the capacity to handle anticipated types and numbers of patients above the current emergency department capacity and should designate specific area(s) for these functions.

Planning for a disaster should include identification of space at the facility or an alternate site to be used for triage and management of incoming patients. Utility support and additional capacity for these areas (e.g., oxygen, water,

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Areas identified for triage should be able to provide a negative pressure environment to help control aerosolized infectious particulate with 100 percent exhaust capability.

—If 100 percent exhaust cannot be achieved, appropriate proven portable technology should be used to reduce airborne particles by > 95 percent.

—If patient care areas in the hospital are to be used to house these patients, the route to the patient care unit should minimize the potential for cross-contamination.

—Existing smoke control areas could be used to meet ventilation requirements. Air-handling systems should be designed to provide required pressure differentials.

—Written protocols should be developed to assure proper performance of the means to accomplish intended goals.

Facilities may designate an area outside and adjacent to the emergency department to serve as a primary decontamination area, which should include appropriate plumbing fixtures (e.g., hot and cold water) and drainage. See appendix section A2.2-3.1.3.6 (8) (Human decontamination room) for more information.

—Use of screens and tents in these areas may be needed and should be accessible for rapid deployment.

—Other contingencies may require airborne infection isolation, removal of chemicals, and temporary container storage of contaminated materials.

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- Use of screens and tents in these areas may be needed and should be accessible for rapid deployment.
- Other contingencies may require airborne infection isolation, removal of chemicals, and temporary container storage of contaminated materials.
- Availability of hand-washing and shower capabilities and personal protective equipment (PPE) are key to controlling transmission of infectious agents to staff and others in the area.

b. *Security.* The design of the emergency department should promote an all-hazards approach to the safety and security of those working in, visiting, or seeking emergency services. The layout and design should provide secured access or the ability to lock down the emergency department. Specific security recommendations can be found in IAHS *Security Design Guidelines for Healthcare Facilities*—02.02 Emergency Departments.

2.2-3.1.3.1 General. Hospitals that offer more than basic emergency care services shall have facilities that meet the requirements in this section for the services they provide.

* **2.2-3.1.3.2 Entrance.** Entrances shall be provided in accordance with Section [2.1-6.2.1](#) (Vehicular Drop-Off and Pedestrian Entrance) except as amended in this section.

A2.2-3.1.3.2 Public vehicle access should be located a sufficient distance from the entrance to provide for safe movement of pedestrians and/or wheelchair traffic.

(1) The site design shall provide a signed route from public roads that directs ambulance traffic to the ambulance entrance to the emergency department and vehicle traffic to the public entrance.

*(2) Paved emergency access to permit discharge of patients from automobiles and ambulances shall be provided.

A2.2-3.1.3.2 (2) The paved emergency access should accommodate short-term parking close to the entrance of the emergency department.

(3) The emergency department entrance shall be clearly marked.

(4) Where a raised platform/dock is used for ambulance discharge, a ramp or elevator/lift to grade level shall be provided for pedestrian and wheelchair access.

(5) The emergency vehicle entry cover/canopy shall provide shelter for both the patient and the emergency medical crew during transfer between an emergency vehicle and the building.

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Part 2: Hospital Facility Types
Chapter 2.1: Common Elements for Hospitals
Section 2.1-2: Patient Care Units and Other Patient Care Areas

2.1-2 Patient Care Units and Other Patient Care Areas

2.1-2.1 General

*2.1-2.1.1 Application

The patient care unit and other patient care area requirements included in this section are common to most hospitals. For requirements specific to a hospital type, see the applicable hospital facility chapter.

A2.1-2.1.1 Accommodations to encourage patient mobility. Patient care units should be designed to enhance opportunities for patient ambulation, including provision of ceiling track systems that support a harnessed patient walking with assistance (e.g., in patient unit corridors, a physical therapy clinic, and other patient rehabilitation service locations). See Section [1.2-4.7](#) (Patient Immobility Assessment) for more information about patient immobility prevention as a component of the safety risk assessment.

*2.1-2.1.2 Patient Privacy

Provisions shall be made to address patient visual and speech privacy.

A2.1-2.1.2 Patient privacy

- a. *Visual privacy.* Visual privacy can be achieved using various means, including cubicle curtains, blinds, and electronically controlled vision panels. In single-patient rooms, the entry room door can be used to achieve visual privacy provided the door is solid or has non-transparent glass. Where doors with vision panels or transparent glass are used, provisions for visual privacy should be made.
- b. *Speech privacy.* Speech privacy should be addressed. Use of full-height partitions and/or sound-masking can enhance speech privacy.

* 2.1-2.2 Patient Room

A2.1-2.2 Equipment and architectural details for the patient room

- a. *Standing assists.* Aids to help patients stand from seated positions (e.g., bedrails, grab bars, and extended chair armrests) should be available.
- b. *Orientation of TV.* Space should allow for at least one television screen to be viewed from the patient chair, recliner, wheelchair, or other such device.
- c. *Access to controls and communications.* Patient control of the environment should be accessible to the patient in a bed, patient chair, recliner, wheelchair, or other such device.
- d. *Trip hazards.* Chair legs should not extend laterally or forward beyond the chair seat.

2.1-2.2.1 General

2.1-2.2.1.1 Capacity. See facility chapters for specific requirements.

2.1-2.2.1.2 Fall-safe provisions. Where indicated by the safety risk assessment (SRA), fall-safe provisions such as handrails and grab bars shall be included in the patient room, patient toilet room, and patient care unit corridors. See sections 2.1-7.2.2.9 (Grab bars) and 2.1-7.2.2.10 (Handrails) for information.

* 2.1-2.2.2 Space Requirements

A2.1-2.2.2 Space considerations for patient mobility. Patient rooms should be sized, arranged, and furnished to maximize safe patient mobility, mobilization, weight-bearing exercise, and ambulation potential while minimizing risk to caregivers. This should apply for patients of all sizes and conditions described in the functional program.

Clearances should be provided and maintained to accommodate safe patient mobility and mobilization of patients. Designated clearances should not be obstructed by any object that does not qualify as movable according to appendix section A1.4-2 (Equipment Classification). Particular attention should be given to the following:

- a. *Provision of bed clearances to support patient safety*

- armrests) should be available.
- b. *Orientation of TV.* Space should allow for at least one television screen to be viewed from the patient chair, recliner, wheelchair, or other such device.
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- a. *Provision of bed clearances to support patient safety*
- Medical/surgical patient rooms: 36 inches on far side, 48 inches on transfer side, 36 inches at foot of bed
- Critical care patient rooms: 54 inches on far side, 66 inches on transfer side, 60 inches at foot of bed, 18 inches at head of bed
- Rooms for patients of size: 60 inches on far side, 72 inches on transfer side, 60 inches at foot of bed
- b. *Furniture and equipment size.* Furnishings and equipment (e.g., beds, exam tables, exam chairs, gurneys) impact clearance requirements. As furnishings and equipment vary based on clinical needs, patient size, manufacturer, and model, it is important that furnishings and equipment be selected for planning purposes by the operator of the facility.
- c. *Sizing of patient rooms to accommodate clearances for patient chairs, etc.* The size of patient rooms should allow unimpeded clearance on at least one side and at the front of any patient chair, recliner, wheelchair, or other such device. The clearances should equal, at minimum, those recommended just above for the far side and foot of the bed and may share bed clearance space.

2.1-2.2.2.1 Area. Minor encroachments (including columns and corridor door swing) that do not interfere with functions as determined by the AHJ shall be permitted to be included when determining minimum clear floor area requirements for a patient room.

2.1-2.2.2.2 For other space requirements, see facility chapters.

2.1-2.2.3 Windows

See Section 2.1-7.2.2.5 (Windows in patient rooms) for requirements. For psychiatric hospital and psychiatric patient care unit requirements, see Section 2.5-7.2.2.5 (Windows).

2.1-2.2.4 Patient Privacy

For requirements, see Section 2.1-2.1.2 (Patient Privacy).

2.1-2.2.5 Hand-Washing Station in the Patient Room

2.1-2.2.5.1 Location. A hand-washing station shall be provided in the patient room in addition to that in the toilet room.

- (1) This hand-washing station shall be located at or adjacent to the entrance to the patient room with unobstructed access for use by health care personnel and others entering and leaving the room.
- (2) When multi-patient rooms are permitted, this station shall be located outside the patients’ cubicle curtains.

2.1-2.2.5.2 Design requirements. See Section 2.1-2.8.7.2 (Hand-Washing Station—Design requirements).