A9.1.F
Community outpatient units should ideally be conveniently accessible to patients via available public transportation.

A9.2.A. Multipurpose room(s) should be provided for private interviews, conferences, meetings, and health education purposes. Where health education is accommodated, the room(s) should be equipped for audiovisual aids.

A9.2.A2.c. Consideration should be given to special needs of or between specific patient groups in a shared/general waiting area, such as separation of adolescent and geriatric patients.

A9.2.B1. Door swings should be oriented to provide patient privacy.

A9.2.B2. Door swings should be oriented to provide patient privacy.

A9.2.B3. Door swings should be oriented to provide patient privacy.

A9.2.B4. This is to permit close observation of patients. An examination room may be modified to accommodate this function. A toilet room with lavatory should be immediately accessible.

A9.2.C7. Stretchers should have ready access to and from other areas of the facility. Particular attention should be paid to the management of outpatients for preparation, holding, and observation. The emergency, surgery, cystoscopy, and outpatient clinics should be accessible to the imaging suite. Imaging should be located with consideration of ceiling height requirements, proximity to electrical services, and future expansion considerations.

A9.3.F.
Examination rooms and services as described in Section 9.2.B may be provided. In addition, offices and/or practitioner consultation rooms may be combined with examination rooms.

A9.5. Outpatient Surgery Facility
The unrestricted area includes a central control point established to monitor the entrance of patients, personnel, and materials. Street clothes are permitted in this area, and traffic is not limited.

The semirestricted area includes the peripheral support areas of the surgical suite and has storage areas for clean and sterile supplies, work areas for storage and processing of instruments, and corridors leading to the restricted areas of the surgical suite. Traffic in this area is limited to authorized personnel and patients. Personnel are required to wear surgical attire and cover all head and facial hair.

The restricted area includes operating and procedure rooms, the clean core, and scrub sink areas. Surgical attire and hair coverings are required. Masks are required where open sterile supplies or scrubbed persons may be located.

A9.5.A Recovery Care Centers
Outpatient "surgical" facilities now incorporate centers that perform both invasive and noninvasive procedures. The distinction between centers can now be better defined by the type of anesthesia that is used during the procedure. Even though most outpatient procedures do not require an overnight stay, some require extended patient observation for up to "23 hours and 59 minutes" of care. This extended care possibility should address the need for adequate sleeping, bathroom, and nutrition services for the

patient. A key element to housing patients is the communication system and the ability to obtain additional assistance as necessary.

Recovery care centers should have adequate waiting areas for family including children and adolescents, and privacy (noise barriers and sight barriers) for meetings between physicians and other professionals with family. The areas should be large enough for translators or have available translation equipment.

A9.5.D1. Such roof overhang or canopy should extend as far as practicable to the face of the driveway or curb of the passenger access door of the transport vehicle. Vehicles in the loading area should not block or restrict movement of other vehicles in the drive or parking areas immediately adjacent to the facility.

A9.5.E2. This room is exclusively for the inspection, assembly, and packaging of medical/surgical supplies and equipment for sterilization. The area should contain work-tables or counters and storage facilities for backup supplies and instrumentation. An area for a drying cabinet or equipment may be required. The area should be spacious enough to hold sterilizer carts, if used, for loading or prepared supplies for sterilization.

A9.5.F. Clinical Facilities

Provisions should be made to separate pediatric from adult patients. ~~This~~ Separate areas should include pre- and post-operative care areas and should allow for parental presence.

A9.5.F2.a. American College of Surgeons Classes of Surgical Facilities

(1) Class A–Provides for minor surgical procedures performed under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation. Excluded are spinal, epidural axillary, stellate ganglion blocks, regional blocks (such as interscalene), supraclavicular, infraclavicular, and intravenous regional anesthesia. These methods are appropriate for Class B and C facilities.

(2) Class B–Provides for minor or major surgical procedures performed in conjunction with oral, parenteral , or intravenous sedation or under analgesic or dissociative drugs.

(3) Class C–Provides for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions.

Those facilities meeting the guidelines for Class B procedures automatically qualify for Class A procedures, and those facilities meeting the guidelines for Class C automatically qualify for Classes A and B.

A9.5.F2.e. For surgeries dependent upon medical imaging, such as many orthopedic procedures, medical image viewers should be provided in each operating room.

A9.5.F3.a. In the absence of a qualified functional program, recovery positions should be provided at a ratio of one per Class A operating room, two per Class B operating room, and three per Class C operating room. Up to one-half of the total recovery positions may be provided in the Phase 2 recovery area.

A9.7.

The birthing center was conceptualized as small (intimate), home-like service units serving a population of healthy childbearing families approaching pregnancy and birthing as a normal family event and seeking care in a safe environment outside of, but with access to, the acute-care hospital setting when needed. The freestanding birthing center may be a separate outpatient facility.

A9.8.A.
The range of services provided in these facilities is very dynamic and growing, including diagnostic cardiac catheterization, general radiography, fluoroscopy, mammography, CT scanning, magnetic resonance imaging (MRI), ultrasound, radiation therapy, and IV therapies. Facilities may specialize in only one of these areas or may provide a mix of services.

A9.9A. Visual and acoustical privacy should be provided by design and include the registration, preparation, examination, treatment, and recovery areas.

A9.9.F. [Proposal has asterisk, but no appendix text that I can find. Sent query to author 7/30.]

~~**A9.9.A1.** Wall outlets should be planned to minimize exposed power cords and cables. Monitors should be located for optimal visualization by practitioners.~~

A9.12.B22. All installed reverse osmosis water and dialysis solution piping should be accessible.

A9.30.C2.d When incinerators are used, consideration should be given to the recovery of waste heat from on-site incinerators used to dispose of large amounts of waste materials.

A9.30.C2.e Incinerators should be designed in a manner fully consistent with protection of public and environmental health, both on-site and off-site, and in compliance with federal, state, and local statutes and regulations. Toward this end, permit applications for incinerators and modifications thereof should be supported by ~~E~~environmental ~~A~~assessments and/or ~~E~~environmental ~~I~~impact ~~S~~statements (EISs) and/or ~~H~~health ~~R~~risk ~~A~~assessments (HRAs) as may be required by regulatory agencies. Except as noted below, such assessments should utilize standard U.S. EPA methods, specifically those set forth in U.S. EPA guidelines, and should be fully consistent with U.S. EPA guidelines for health risk assessment. Under some circumstances, however, regulatory agencies having jurisdiction over a particular project may require use of alternative methods.

A9.31.A1. Remodeling and work in existing facilities may present special problems. As practicality and funding permit, existing insulation, weather stripping, etc., should be brought up to standard for maximum economy and efficiency. Consideration should be given to additional work that may be needed to achieve this.

Insofar as practical, the facility should include provisions for recovery of waste cooling and heating energy (ventilation, exhaust, water and steam discharge, cooling towers, incinerators, etc.).

Facility design consideration shall include recognized energy-saving mechanisms such as variable air volume systems, load shedding, programmed controls for unoccupied periods (nights and weekends, etc.), and use of natural ventilation, site and climatic conditions permitting. Systems with excessive installation and/or maintenance costs that negate long-range savings should be avoided.

Use of mechanically circulated outside air does not reduce the need for filtration.

A9.31.A3. It may be practical in many areas to reduce or shut down mechanical ventilation during appropriate climatic and patient care conditions and to use open windows for ventilation.

A9.31.D6. See *Industrial Ventilation: A Manual of Recommended Practice*, published by the American Conference of Governmental Industrial Hygienists (www.acgih.org), for additional information.

A9.31.D9. One way to achieve basic humidification is with a steam jacketed manifold type humidifier, with a condensate separator that delivers high-quality steam. Additional booster humidification (if required) can be provided by steam jacketed humidifiers for each individually controlled area. Steam to be used for humidification may be generated in a separate steam generator. The steam generator feedwater may be supplied either from soft or reverse osmosis water. Provisions should be made for periodic cleaning.

A9.31.E3.c.
There are several ways to treat domestic water systems to kill *Legionella* and opportunistic water-borne pathogens. Complete removal of these organisms is not feasible, but methods to reduce the amount include hyperchlorination (free chlorine, chlorine dioxide, monochloramine), elevated hot water temperature, ozone injection, silver/copper ions, and ultraviolet light. Each of these options has advantages and disadvantages. While increasing the hot water supply temperature to 140°F (60°C) is typically considered the easiest option, the risk of scalding, especially to youth and the elderly, is significant. Additional consideration should be given to domestic water used in bone marrow transplant units. See CDC, ASHRAE, and ASPE documentation for additional information.

A9.31.E4.e. Floor drains in cystoscopy operating rooms have been shown to disseminate a heavily contaminated spray during flushing. Unless flushed regularly with large amounts of fluid, the trap tends to dry out and permit passage of gases, vapors, odors, insects, and vermin directly into the operating room. For new construction, if the users insist on a floor drain ~~is insisted upon by the users~~, the drain plate should be located away from the operative site, and should be over a frequently flushed nonsplash, horizontal-flow type of bowl, preferably with a closed system of drainage. Alternative methods include (a) an aspirator/trap installed in a wall connected to the collecting trough of the operating table by a closed, disposable tube system, or (b) a closed system using portable collecting vessels. (See NFPA 99.)

A9.32.D1. Light intensity of required emergency lighting should generally comply with the IES recommendations. Egress and exit lighting should comply with NFPA 101.