Key OR design, construction changes proposed

Key changes are being proposed in the OR design and construction guidelines that are used by the Joint Commission, federal agencies, and 42 states. OR leaders may wish to offer comments.

Comments are accepted until November 22, 2012, on the draft 2014 Guidelines for Design and Construction of Health Care Facilities from the Facility Guidelines Institute (FGI).

Among proposed changes related to surgery:
• OR design classifications based on infection risk, size of surgical team, quantity and size of equipment, and type of anesthesia
• updated guidance for pre and postoperative care areas
• new guidance for hybrid ORs
• deletion of office-based surgery chapter.

There are 7 significant areas of change, notes Ramona Conner, MSN, RN, CNOR, a member of the FGI committee to revise the guidelines. She is AORN’s manager of standards and recommended practices.

Elimination of ABC classifications
(General Hospitals 2.2-3.3.2)

The change with the most dramatic impact on ORs is the elimination of the ABC classifications for OR design, says Conner. They will be replaced with 2 classifications—operating room and procedure room.

The ABC classifications were based on the American College of Surgeons (ACS) Guidelines for Office Based Surgeries, which focused mainly on the type of anesthesia to be administered in the room.
• A classification was essentially for a standard operating room where general anesthesia was administered.
• B was a hybrid classification for rooms where general and local anesthetics were used.
• C was a classification for procedure rooms where no general anesthetic was administered.

These guidelines, no longer in publication, were written in the 1980s and were not intended to be applied to all surgical settings.

New classifications
The proposal for 2 classifications simplifies design issues.
• In a room classified as an operating room, any kind of anesthesia can be administered, whether local, general, or regional. Notable is that minimal dimensions for an operating room in an ambulatory surgery setting dropped from a floor area of 400 sq ft to 360 sq ft (Outpatient Facilities, 3.7-3.3.2.1). For inpatient operating rooms, minimum dimensions remain at 400 sq ft.
• Procedure room design requirements are less stringent than for an operating room with dimensions changed from a floor area of 400 sq ft to a minimum clear room
width of 18 ft. It doesn’t matter if the rooms are being built in an inpatient or ambulatory setting.
• The office-based surgery chapter was deleted from the proposed guidelines because with the new classifications, it doesn’t matter where a procedure is performed; requirements are the same (Outpatient Facilities 3.8).

Elimination of substerile rooms
(General Hospitals 2.2-3.3.6.14)

Substerile rooms are proposed for elimination. The rationale is that if sterile processing or decontamination is being performed in the surgical suite, there should be a satellite sterile processing area with the necessary equipment and space required for proper decontamination and sterilization practices.

The design of substerile rooms encouraged and almost required the placement of steam sterilizers between every couple of ORs, says Conner, noting that these sterilizers are expensive and take up lot of space.

In addition, the term “substerile” is archaic. “There is no such thing as substerile; either it is sterile or it is not,” says Conner.

New guidance for hybrid ORs
(General Hospitals 2.2-3.3.2.3)

Hybrid operating rooms are complex and challenging spaces to build. Because of the storage requirements and imaging equipment used, the proposed minimum size for a hybrid OR is 640 sq feet. Also included in the draft guidelines is the requirement for a computer room for each hybrid OR. The room is to be large enough to contain transformers, power distribution equipment, computers, and associated electronic and electrical gear.

A major emphasis is that there should be communication with the equipment manufacturer before the hybrid OR is designed, says Conner.

“We have run into a lot of problems with people designing a hybrid OR and then deciding what equipment they are going to put in it,” she says.

Team collaboration is emphasized, particularly between interventional radiology, the operating room, and equipment manufacturers.

Defining what a hybrid OR is was a challenge for the steering committee, says Conner. The draft guidelines include a proposal for a glossary term for hybrid operating rooms.

Elimination of central core terminology
(General Hospitals 2.2-3.3.1.1)

The proposed language eliminates the terminology of “central core” from the guidelines. Storage areas need to be designed with clean storage in mind, but having a central core would not be a requirement.

Elimination of anesthesia workrooms
(General Hospitals 2.2-3.3.6.15)

Anesthesia workrooms are proposed to be eliminated as areas for cleaning, testing, and storing equipment. Decontamination of anesthesia equipment should be performed in an area designed for decontamination, such as a satellite decontamination area, not a workroom that also is used for storage, says Conner.

The proposed guideline replaces anesthesia workroom with anesthesia storage—a space for storing and testing clean anesthesia equipment.
Requirements for unrestricted area moved
(General Hospitals 2.2-3.3.1.1)

The language was changed to divide the surgical suite into only 2 designated areas—semi-restricted and restricted. Unrestricted areas are still needed in the design for a surgical suite, but those requirements are found in the general requirements section of the guidelines (General 1.2-2.3.5.2).

The committee determined that unrestricted areas such as locker rooms and entrance areas where street clothes are worn apply throughout the health care facility, not just the surgical suite, says Conner.

Elimination of bariatric requirements in the OR
(General Hospitals Appendix A2.2-2.16)

Bariatric requirements in the operating room have been eliminated from the surgical suite guidelines and moved to the appendix. This still provides guidance for facilities that have bariatric patients as a large part of their patient population, but it is no longer a minimum requirement, says Conner. ♦

—Judith M. Mathias, MA, RN

An invitation to comment on the draft guidelines is at www.fgiguidelines.net/comments/
The proposed guidelines are at www.fgiguidelines.net/comments/draft.php