Welcome everyone and thank you
for joining us on our
Session 3 of a four-part session
with the Office of Statewide Health
Planning and Development.
Today we have Mr. Richard Tannahill
once more
and we will be going over the
Building Code
Part 2, in all of its entirety with
that being said,
I want to ask you to hold your
questions until the end.
If you do have a question and you want
to make sure it gets answered please
type your question into the question
dialog box
within the go to webinar software and we
will try to answer all the questions at
the end,
in the order that we received them
today.
Again, once again thank you for
joining us and with that being said Mr.
Richard Tannahill please
proceed. Hello everyone
welcome back. If you've been here before
and welcome
to all first timers today we're going to
be going over the 2019
California Building Standard Code, Part 2
changes that were applied
back in January.
First, we're going to give you a real
quick update what's going on with
what we're doing with the coronavirus.
Actually, things have slowed down a lot
for OSHPD.
We've been assisting in getting some of
the temporary hospitals up and running
in
temporary conditions
available for any surge patients. I'm
happy to say that they're not being used
a lot right now.
Hopefully, that will continue. A lot of
the questions we're getting
are, if we're still doing plan review. And
yes, we are. Our
staff, most are working from home, they do
have equipment at home
but it's not at the same level of what
we have here. So, things are a little bit
slower.
You may see a little bit of delays on
your reviews but

so far, I think they've been pretty good
at keeping up.
With the 2019 timeline it went into
effect
January, 1st of this year
we have been doing a lot of outreach
training on the changes that were
coming both before it came into
effect and
up till now and then we'll continue to
do so
but here we are. We're out here
now,
and we're currently working on
the next iteration of this is the 2019
Triennial
Code Cycle. What we do when we
put codes together is, we take the
International Building Code
and the last cycle of the code, which
in this case the 2016 Building Code and
we take
any new additions or modifications
and scrunch those altogether. That
gives us our
new 2019 code
volumes.
Today we're going to be focusing on
Part 2, Building Code and
really just what has changed since the
last,
2016. My voice is a little dry today so
I'll be taking some sips of water as we
Go. So
Excuse me for that. We've already had, this is
session three
of four and we've already had Session
1 was the Intro to 1R
and Part 10 and Part 1 and two weeks
ago
Nancy Timmons, our Chief Fire Life Safety
Officer did Part 9.
And in two weeks, we'll be wrapping up
with the Electrical, Mechanical,
Plumbing, and Energy Code.
Here's the dates for the Session 1.
Just want to remind you again
to register for each session
independently. And, also, we understand a
lot of you are
watching this from home now and you will
have to
register individually, we have upped
the amount of participants on the
webinar.
But there still may be a maximum amount.

It's a first come first sign in basis
we are trying to work on that to get it
higher
and we've requested that, but it may or
may not be happening we may max out at
500.
Starting Session 3 I just want to
remind you that go ahead and
enter your questions into the chat and
we will answer those at the end as time
allows.
The Part 2 of the California
Building Code, this is
for me, is my workhorse. This is where
we spend most of our time as architects
and today we're going to be talking
about classification
alignment and some structural updates
just to start us off. One of the
things we did and we've
been talking a lot about especially
in the first two sessions,
we talked about that we added 1R,
and this is a hospital building removed
from general acute care services.
You'll be hearing a lot more about that
today because a lot of the revisions
that were made
throughout in all the volumes
had to do with adapting 1R to
our uses, we also,
back in 2016, we added psyched 1228,
psychiatric hospitals has their own
section
for stand alone psychiatric. This cycle we
added OSHPD 5
to designate that use.
Also note here just for clarification
OSHPD 1R is not an occupancy it is a
building type.
The reason behind that is that we
can track it in our system when these
buildings are removed they remain under
OSHPD jurisdiction
and when they're removed from acute care
service. We needed a way to track them.
The applications of code goes by the
occupancy
so, the OSHPD 1, 2, 3, 4 and 5.
In 1983 the Alfred E. Alquist
Act, as we call the Alquist Act
was developed to basically say that
hospital buildings that
house patients who are incapable of
self-preservation
that they must be reasonably

capable of providing
services to the public after a disaster.
And that's kind of how it’s
been our charge,
with OSHPD. Since then to develop these
codes
the way we do.
So, this will apply to general acute care
hospitals
as defined in the Health and Safety Code.
Again, I’m not going to read all this
stuff word for word, kind of just explain
it,
but it does not include buildings if
they provide skilled nursing or
psychiatric
services only. So, you can have skilled
nursing facilities and
psychiatric facilities as part of a
hospital and these will apply
but if they're not, the
requirements
are not the same.
So, the standards that were set up
basically, the charge was that we shall
design and construct to resistance as far
as practical
the forces generated by earthquakes,
gravity, and winds.
Okay, the Office shall propose proper
building standards for earthquake
resistance based on current knowledge
and provide an independent review of
design and construction of hospital
buildings.
Again, this is really the authority that
OSHPD has to
do what we do with hospitals.
Okay, OSHPD is obligated to use model
code whenever and wherever
possible. If we feel that these
requirements are not stringent
enough
for the requirements for California and
the special conditions within California,
with justification. We're allowed to
modify that model code
if it's deemed to be inadequate. And we
must show
evidence of that when we propose
revisions to the model ode.
Okay, the model code is for buildings
that do not house patients
and who have less than the capacity of
normal health,
normally healthy persons to protect

themselves,
nor provide services to the public after
disaster.
So basically, there are health care
facilities that would not
meet the requirement of a hospital
providing services
for health. That's where the psychiatric
nursing observation units, things like
that would not come in.
model code will continue to apply for
any other use
other than the OSHPD 1 General Acute
Services.
Okay, now also the reasons we're kind of
including that here
these definitions not only give you the
history but also to
again, with the 1R, what can be used in
those
buildings. Once it becomes a 1R building
it does
go back to model code for plan review
and OSHPD will be doing those plan
reviews for
whatever it might be in those spaces.
In Chapter 16 the structural design
clarified at OSHPD 2 skilled nursing
facilities and immediate care
facilities are Risk Category III
and this includes all levels of skilled
nursing before it was
different if it was more than a
multi-story
it would fall under OSHPD 1 but
all skilled nursing
facilities now under OSHPD 2.
And then we're just showing here that
OSHPD 5 is for the acute psychiatric
hospitals.
The component importance factors for
skilled nursing facilities,
OSHPD 2 and psychiatric hospitals,
OSHPD 5
is 1.5 and this is for components that are
required for the safety purposes after
an earthquake
and for medical device components,
mechanical electrical components,
and components required for life support.
Such as
subacute beds in skilled nursing
facilities.
For this slide
basically, we removed the section for
occupancies having surgery as emergency

treatment facilities because that actually falls under
general acute care hospital buildings.
That's the only change here
under Risk Category IV.
We're going to talk a little bit more
about OSHPD 1R allowable services,
what's allowed to be
in OSHPD 1R building.
If they remain for healthcare, you have
to remember, the OSHPD 1R buildings
remain under the jurisdiction of OSHPD
but they also have all acute care
services removed from them.
So, what would be allowed in there,
basically, for OSHPD 1 would be
duplicative services under Section 1224,
in excess of those required for basic
and supplemental services.
So, if there's a certain amount things
that are required to be
part of the basic services within the
hospital if you exceed those,
those are allowed to go into the OSHPD
1R. You can also put outpatient
hospital services, the ones that are
listed under 1224.39 for outpatient
services,
can go in an OSHPD 1R.
OSHPD 2 and OSHPD 5 the skilled
nursing facilities and psychiatric
facilities can also go in a
OSHPD 1R because they do not have the
same seismic requirements
as the acute care facilities.
In addition to that almost any other
type of
occupancy can go into a 1R if it meets
the requirements
for the model code provisions and for
the
proper separations between the hospital.
So, you can have
food services you can have
administrative buildings,
or clinic spaces, or whatever it might be
and again, that will be reviewed under
model code.
When also doing an OSHPD 1R
Building you want to
consider what CDPH requires for
licensing.
Again, the duplicative services they'll
be looking at that
outpatient observation units are a good

example of what can go into a 1R Building,
but may be
restricted in the absence of acceptable evacuation
provisions and protocols. You need to look at the egress
from the spaces and make sure that they're not going back through the hospital.
Multiple provider arrangements are another thing that we're seeing a lot of where they'll lease out different floors
or different sections of a building
to different providers. Things that CDPH is looking at,
is how do you enter those separate provider offices or
separate suites or uses whatever they might be,
and you may have to demonstrate independent support
services separate from the hosting hospital.
So, they basically have to be self-supportive for their
uses.
Accessibility has to be considered when you're putting a new use,
if you're putting a skilled nursing facility in the 1R,
50% of those beds will have to be accessible
with accessible toilet rooms. That's up from 10% if it used to be a
med surge unit or similar use.
So, that needs to be considered. Existing non-accessible toilets
within nursing units when you convert them to staff offices,
we're seeing a lot of these patient floors being converted to offices and they
basically, end up having their own private toilets.
We have talked to DSA and a minimum of 10% of those
toilets because a lot of them, especially in the older buildings are
not accessible. A minimum of 10% will need to be
accessible or made to be accessible
and you must also have separate accessible common use toilet rooms
in the general area provided that would be within 200 feet.

And nursing unit conversions to family lodging suites
will be required to meet the provisions of transient lodging. So that would have to be looked at for the accessibility.
So, this is an example of Stanford Healthcare, we did a case study for one of our previous seminars
and they turned this building into a 1R Building and this is what they're proposing to do with the different floors.
The existing the previous use was all patient rooms and various uses.
They turned a lot of the rooms into doctor on-call
or physician on-call rooms.
Outpatient observation beds were added on the first floor.
An outpatient clinic space was provided on the second floor.
And their school of
medicine offices
were added on the third floor, as well as surgical pathology offices.
So, you have a lot of different varieties of uses and again, in some
cases, facilities may lease out these spaces at different
organizations. Here's another example of a case study we did
that same seminar and basically,
it's Loma Linda University, they're taking their central tower
and making it a 1R Building. And in this case
on the ninth floor, they're converting into psychiatric
space. In the areas in blue.
Basically, just designate the areas that had to be upgraded to accessibility
to their 10% accessibility, as well as the other blue spaces could be required functional spaces that required for psych that weren't required for
med surge.
If this was to be a skilled nursing floor, you'd probably see a lot more blue to make
50% of the beds accessible.
It's actually 50% of the rooms. Excuse me.
So, here's one more case study. This is in San Francisco and the part, you're looking at here
is actually the older 1R Building
and up on top here we have the new

hospital expansion. So, they want to reuse as much of this older building as possible.
So, this is the uses they put in, they have an existing loading dock, and they asked, can they continue to use that loading dock, now what they did provide a loading dock in the new hospital, much further to the north with a single bay truck. There is no requirement for how many trucks are required in the loading dock. So, they provided a single bay loading dock and they are continuing to use their existing loading dock which holds three to four trucks. Again, this is in excess of what's required by the code for basic services.
Another use they're doing is the outpatient oncology, they can see up to 25% inpatients in this area.
They have a duplicative lab. They have the lab that's required in the building code in the main hospital but they're providing lab services in the existing lab space that was used before. So, they didn't have to demolish or remodel any of this they continue to use it for but as a more of a support service to the hospital.
And also, they have duplicative locker Rooms. Again, they have the required number of locker rooms in changing areas in the hospital. This is just for like general staff changing they can use for whatever they'd like.
So, a lot of reuse here, is with zero construction for this area.
So, what if you're going to put mixed use into these spaces?
What we're looking at, is access, is it public versus patient access, or again, multiple providers or multiple uses.
Will they have their own entries? These are the things that you need to consider when doing this outpatient services, cannot traverse through inpatient nursing units. So, you can't have

the public walking through an inpatient area to get to their outpatient service may require separate entrances if you have separate providers.
Again, these are things you want to talk about beforehand.
Do you need a new front door, or can you reuse the existing one?
Again, it depends on where it is on the building how access is gained.
Emergency egress, there's going to be, we're going to talk about a little bit more there are requirements for egress not going through the older buildings from the hospital.
Elevators may have limitations if you have a psychiatric on the ninth floor you may be required to provide a dedicated elevator just for those psychiatric patients.
You also have to continue to work with the locals for their zoning and land use.
Make sure that the use that you want to put in the building is permitted.
As well as, will it increase parking demand
depending on the use, the locals, that planning
department can work with you on those areas.
Also, keep in mind vacated spaces.
Again, we're trying to emphasize this when you're moving people out
or patients out of a space and into the new spaces
and you're ending up with vacated spaces, those
spaces need to be made safe
for nobody being in there. Basically, that you know there is where we did add some requirements
for vacated spaces in the code. There is more coming in the Intervening Cycle.
There's some clarification on that
Basically, you want to make it so that it's
safe with fire separation smoke detection and security.
Again, we talked a lot more about that in the first session
and just on a side note here the sessions that are previously
done, Sessions 1 and 2, as well as these next two
are being recorded and they will be posted shortly. We're working on getting

that done on the OSHPD website.
Now we're going into definitions
for equipment. We've added fixed
equipment, movable equipment,
and mobile equipment. This is
hopefully going to do a lot to clarify
the difference between the different
types of equipment and how they're
applied.
I would also recommend that you look at
the new PIN 68
that has been recently posted. You're
actually, going to see
seven definitions or seven
different types of equipment listed in
that PIN because that's coming in a
future code
modification but it can be used now.
We're going above and beyond the fixed
movable and mobile
but for the 2019 these definitions have
been added. They actually been relocated
from the Administrative Code
into the Chapter 2
of
the Volume 1 of Part 2. That
sounds
confusing but basically, they they've
added them, moved them from the
Administrative Code to the Building Code.
We added a definition for 1R again
just to repeat these are buildings that
previously had acute care services that
have been removed and remain under the
jurisdiction of OSHPD.
We discuss means of egress for the
hospitals
In addition to the requirements of 1003
means of egress to also
comply with Part 10 for Existing
Building Code in Section 308A.
That’s Section 34A
of the 2016 Building Code is no longer
there, that's the Existing Building Code.
It basically remodels,
repairs, and renovations,
that has all been moved into
Part 10 the Existing Building Code. So
you want to look at that if you're doing
any remodels
but basically. this section talks about
egress from those hospitals
not going through from the hospital
through these
1R Buildings. But you can go from the 1R
back

through the hospital.
Section 1003.1.2 is means of egress
for hospitals removed from acute care.
Kind of the same thing I just mentioned
in addition, the requirements of this, you
want to look at section 308 because now
the OSHPD 1R Buildings are no longer
considered hospitals, 308A is for
hospitals
308 is for everything else for Existing
Building.
For Chapter 12 means of egress
basically, just pointing you to Part 10.
Again, the Existing Building Code for
the requirements you're going to see a
lot of these that say the means of
egress or the utilities as you'll see in
the next slide will
shall only pass through structures that
are under the jurisdiction
of OSHPD.
That's not the only requirement, so you
do need to look at 308A.
They talk about, know where it
originates. There's other
requirements for that but they do have
to go through
a structure under OSHPD jurisdiction as
one of the primary requirements.
You'll see that with the service systems
and utilities as well,
pass through, or under shall
only originate in, pass through
or go under structure that are under the
jurisdiction of OSHPD.
And again, but you have to look at all
the pieces together to know exactly what
would be allowed there.
So, for some of the State Fire Marshal
changes that affect OSHPD or
acute care facilities is non-patient
care suites is back.
It's welcome to see that,
here's the requirements, they still need
the one-hour separation.
They're limited 10,000 square feet and
they must have automatic fire sprinklers
but what you want to look at is under
Chapter
10 is the…
excuse me, I've got some stuff popped up
on my screen here.
The definition of non-patient care suite
in a group
I-2 or I-2.1 occupancies.
A group of rooms or spaces within the

suite for use of administrative
business and professional offices. So
you're really limited in these
non-patient care suites
to a more administrative type function.
There's a lot of requests to put
pharmacies in there, they're not
considered patient care
but that would not fall under this
requirement of a non-patient care suite.
One of the other things that have
changed in Section 804,
there was a little break in the code
before where
we were identifying
locked psychiatric facilities at I-3,
that has been changed back to a
locked I-2 or
I-2 with restraint. One of the
requirements under the old I-3, if you
have restraint you are
only allowed to have non-combustible
floor finishes
which was very hard to meet especially
in the psychiatric facilities.
In the 2019 we have clarified that
you may use Class
1 where restraint is used and there
are conditions on that, that have to be
met.
We continue to update the words hand
washing fixtures to hand washing
stations. So, it's all inclusive
everything is required for
for hand washing including your soap and
paper towel dispensers.
And hopefully we caught them all this
time around.
And we also updated the proximity access
terminology and I'll go over those
because
we get a lot of questions on these we
deal with this a lot.
So directly accessible means it's
connected to the identified area or room
through a doorway or other opening
without going through an
intervening room or public space. So, this
would be basically,
you walk through the door here in the
directly accessible space.
Immediately accessible is available
either in the identified area or room
or directly accessible from a room or
area
located within the same department or

service space. So, it can be anywhere in the same department.
Say example, if you're required to put a toilet.
Have a toilet that's immediately accessible it can be in the same department.
And that doesn't mean across the corridor and somewhere else in another department, that means
just to clarify that it has to be within the same department or service space readily accessible is located within the same department
or service space as the identified area or
room or located in and shared with an adjacent
directly accessible unit the available on the same floor has gone away.
So,
this is what's important here to recognize that it has to be
located within the same department or service spaces, but it can be shared with an adjacent
unit, they cannot be on separate floors.
They have to be on the same floor but they have to be next to each other, you can't skip a
department. So, again we get a lot of questions on those so, hopefully this will help clarify it.
So, service space as shown here clouded,
it refers to the distinct area of a health facility where license basic service or supplemental services provided
and basically, you can look at these like sections of the code if it's under 1224.27.
Those requirements need to be met.
Are all grouped together so it shall include all the functional area requirements required to deliver the specific service.
Okay, so some general items for further clarification was added for departmental boundaries.
Again, it kind of goes back to what we were just talking about with the service areas
that everything that's functionally required for that department that's

listed has to be within the department boundary.
So, you may be asked to identify those boundaries.
You can have corridors go through departments but what you don't want is once a department ends
you have a piece of it somewhere else in the hospital.
We also, there's been some updates to this
the STC ratings. The sound transmission transmission ratings of walls between rooms.
The
patient room is actually dropped and the increase on the exam
rooms for HIPA reasons and they added more to the MRI room ratings because those things can be pretty loud.
Clarification of med station locations and observation for these are for the self-contained the Pyxis or other type units.
If provided
a MDU or self-medical dispensing unit shall be located
at the nurse's station in the clean utility room
or in an area where access to the self-contained
medical dispensary unit is under the monitoring and control of nursing staff.
So, they have to be in an area that they can be observed by the staff.
So, not in a patient room and it can be in a locked room that
staff only has access to, like you said a clean utility room.
Okay, and the self-contained medication dispensing
unit should be provided
with essential power and lighting. Again, we get a lot of questions on that, they want to throw in the corridor
and they don't have any essential power there that does need to be provided.
The nurse call table has been restructured. This is only a portion of it I would just recommend that you look at the code to see what applies to your project.
I know there's a lot of questions on clinic spaces
and where that's required that is still the same as it was previously, but we are

working on
making that clearer.
So, now we're getting to 1224.
This is a big one for a lot of people
that have required that the nursing
units
not share everything, and this identifies
what can be shared and what's
required to be in each unit.
So, required in each nursing unit is a
nurse station,
an office for the nurse or
supervisor,
a clean and soiled utility room, or clean
linen, a med station
equipment storage facilities for the
different types of equipment,
a nourishment and an ice machine per
unit. What can be shared
is staff toilet rooms, housekeeping
rooms, and
the special bathing facilities, that's
the roll in shower,
or the gurney shower.
Optional services may be shared with
other service bases exam
treatment rooms are optional.
Multi-purpose rooms aren't optional but
they can be shared between departments
and this it says in each area that
should be identified now if they can be
shared or if they must be per unit.
another to me a good clarification,
the code used to say that the locker
rooms for changing for OR's
should be, should ensure
or what you would say, it was
encouraged to be one-way traffic. And now
it says to shall ensure that you'll have
one-way traffic.
So, when someone comes into a locker
room off the street, they'll come in,
change their clothes, and go out on the
other side of the red line.
So, that has been clarified we've been
practicing that for quite a while so, it
shouldn't be a big deal for most people
but that has been clarified in the
language
because the previous language was, is
encouraged
the clinical lab space has been
rewritten. There
previously was only a few items that
were actually required to be in the lab
that has been expanded.

I'm not going to read through all of these but you're going to have refrigerated storage facilities terminals for sterilization radioactive material handling if required as well as special specimen collection facilities and administrative areas.
When we're looking at the 1R all of these requirements are now required to be in the hospital building.
So, the 1R would be any duplicative services of this or anything additional that would want to be added can be done in the non-acute care portions.
In pharmaceutical we did the A2 Guide I think it's been a couple years now it's been out.
It is still in effect but we basically transferred all the information in the A2 Guide working with CDPH and the board of pharmacy and we put that into the code now under 1224.19.
So, all these options are listed there we worked a lot with, like I said CDPH and Board of Pharmacy and used other standards to put this together.
Even though currently USP 797 is still the new release version is temporarily on hold.
They are applying it per the new requirements that are forthcoming and 800 was approved but it basically, depends on 797 to be there. But the A2 Guide is still required to be used.
You still required to submit the checklist and the Appendix B is really critical when we're getting CDPH reviews of these. So, I would encourage you to continue to use that.
A new one updated one of these will be posted. There's not a lot of changes in it, just a lot of clarifications or a few clarifications will be posted probably in the next week or two.
But in the code, we've added a lot of the requirements that were, you've seen in the compounding guides

talk about dispensing facilities,
non-sterile compounding area,
storage non-hazardous sterile
compounding… I'm not going to read
through all of these
but these are the requirements for the
non-hazardous workstations
buffer rooms anterooms and if you're
doing an SCA
it's going to comply with 1250 it's that
graded compounding area,
as well as hazardous drugs the
requirements for that.
And then the support areas that are
required for pharmacies
are identified. Again, the multi-purpose
room can be shared with other
departments
staff toilet rooms and lockers have to
be part of the pharmacy.
And then as before there was always a
clause
in the code that stated if the hospital
has less than 100 beds,
previously it stated that a pharmacy is
not required
which still holds true. But what it
failed to say before that if you don't
have the pharmacy you do
are required to have a drug,
a drug room permit in lieu of a hospital
pharmacy.
We've seen a couple facilities get into
some sticky situations because
they met the requirement of not
being 100 beds but they put the pharmacy
in the outpatient with no
drug room or any area for distribution
within the hospital itself.
So, these items are still required even
if you don't have the pharmacy you have
to at least have a receiving area hand
washing station and storage for those
drugs.
Basically, it's a breakdown area and
distribution area.
For kitchens
just identified and this again, more
clarification food and nutrition
facilities shall be provided support
food services
for staff visitors and patients and
should have adequate space for
preparation and serving of
food shall be provided. Equipment shall
be placed so that

the aisles are sufficient to permit
easy movement and personnel
mobile equipment and supplies when
you're doing a kitchen, I would recommend
this is not
doing anything but I would recommend you do
a functional program specifically for
the dietetic space
because when the functional programs are
sent to CDPH, if they're mixed in with a
much larger project like a hospital,
a lot of the stuff's overlooked. If we do
the pharmacy and dietetic
separately they get reviewed very
quickly. A lot more attention is paid to
them because they have
special units that only work on dietetic
or the pharmacy unit
and they turn these around pretty
quickly for us. So,
I would just recommend you do a
functional program separately
too, for the dietetic and the pharmacies.
Also see here about the infant
formula requirements,
there are some clarifications for
those in those sections
under 1224.29. Which is a NICU
and basically, what it says is the
nourishment room is not required for
NICU's.
Senate bill 1076 was
Approved, it's been a couple years now
which required observation services for
outpatient services
to be added to an emergency department
area that would be considered outpatient.
We did provide a new code for 1224.39.6
and what it basically says is that a
outpatient observation unit can be in a
a
conforming or non-conforming
hospital building.
So, it can be in a 1R Building and
it may be relocated
and it, but the catch here
is the must have a corridor system that
connects to
all the basic services and supplemental
services of the hospital. So, it has to
have a
direct corridor system, so it can't be a
building across the parking lot
even if it's outpatient there should be
a corridor that connects them.
Okay, patient access to this unit should

not pass through public lobbies waiting areas or other
departments and that doesn't mean they can't come into the waiting room which means if you're assigning them to go to the observation unit. They shouldn't have to
if you have patients, they shouldn't have to go back out into the public areas and back
into their more clinical space.
And they shall have the support spaces for the waiting room, public toilets, telephone, and drinking fountain.
And getting closer to the end here Section 1225
for skilled nursing facilities and psychiatric under 1228.
Again, we talk about egress, this again goes back, it's
been added because of the 1R, we're talking about egress through these spaces
not going through a building that's not under OSHPD jurisdiction.
And again, with the skilled nursing facilities,
all of them are now under
OSHPD 2 before if it was
a multi-story it was under OSHPD 1
is now under OSHPD 2.
As I mentioned earlier Chapter 34A no longer
exists. So, you will go to
the appropriate 3A, 4A or
5A for
those items for the existing structures.
That's again for remodels
and also 1225.2.2
egress requirements
include multi-story that's what I just said that they are now
again, the egress is still the same requirements.
Okay, for OSHPD 2 subacute care if you're putting subacute into skilled nursing facilities they do need essential power
electrical power at those beds.
Okay, construction
if you're really, this is just a note that's been relocated from 1705, but construction documents for OSHPD 2 Buildings without subacute beds, so, explicitly state that skilled nursing facility or Intermediate Care Facilities

do not admit patients
needing sustained electrical life
support equipment.
Basically, you're saying we're not
going to be putting subacute patients
in here.
I just want something to document that
because if you do add subacute later
there are requirements
and there's also a CAN that will help
you do that if you're going to do that
later.
Again, with skilled nursing facilities
the system services are utilities
that originate in, pass through or
under structures
unless they're in the jurisdiction of
OSHPD as well as the egress will not
pass
through structures that are not under
the jurisdiction of OSHPD.
Again, look at all the requirements when
you're doing this
this is just for information right now
CMS has changed their bed requirement
for skilled nursing facilities not to
have
more than two residents per room,
current code allows for four if you
provide four right now they may not get
reimbursement for those rooms.
Now, we are changing this in the
Intervening Cycle to
for a maximum bed of number of beds to
two rooms
in the new upcoming Intervening Cycle
to align with this. But as of now
this is
just a note you can still do it but
there may be issues getting
reimbursement down the road.
Okay, moving on to acute psych
hospitals.
The requirements again previously
introduced in the 2016 code
are now 1R they're tailored for
standalone
acute psychiatric hospitals. So, hopefully
we don't need all the AMC's to
do these projects now.
The common elements that can be shared
with acute
care hospital are still located in 1224
and they'll be referenced from one
to another.
So, that they're not repeated over and

Over.
Acute psychiatric basic services
currently do not have general
acute care services. If you do have
medical services
then you're going to apply the
requirements of a hospital under OSHPD
1.
Again, we're talking about utilities the
same thing as skilled nursing facilities
not originate pass through or under a
structure unless it's under OSHPD and
the same with egress
not going through a structure unless
it's under OSHPD jurisdiction.
Also, you want to look at the
requirements for locked I-2 units,
there are a list of requirements that
have to be met to have a I-2
with restraint or locked facility.
Moving on to clinics.
Just added some clarification for the
specialty clinics,
in addition to primary care being
surgical,
chronic dialysis, alternative birthing
clinics,
and rehabilitation clinics. They also
added psychology clinics,
the requirements for that and
this section should also apply to
outpatient clinic services of a hospital
when provided in a freestanding building.
Freestanding building has been added to
the definition
under OSHPD jurisdiction. So, that you
can have these services in a
freestanding building
and still be under OSHPD jurisdiction
but again, there's a bunch of conditions
that have to apply,
the duplicative services or the
outpatient services.
This is big for the clinics they have
to be
continuous functions, just like in the
hospital where everything has to be in
the same department
the same thing applies now with clinics.
If you have various functions including
to
but not limited to reception, waiting
staff support areas, such
toilets, storage and lounge may be
located outside of the clinic suite
for the approval with the approval CDPH.

But all the other
services that are required for the
functional use of that space have to be
within the same suite.
So, you can't send somebody out of the
corridor to get to another
area to continue their treatment, it
should be
continuous.
Again, they're making the exceptions that
if you're in a shared building you can
share reception,
toilets, waiting room, things like that.
If the toilets and drinking fountains
serving the public
are provided for the entire building
they can be shared
in the central area and also these
allow some of the services such as
storage laundry and housekeeping and
waste management to be shared with other
tenants.
Correctional treatment centers, all we
did was add
an allowance that gooseneck spouts may
be used in appropriate locations
basically, where there
are no inmates.
So, if you're interested in code, we would
ask that
you get involved. We do have
Hospital Building Safety Board,
we have the Academy for
Healthcare Architecture that we work
with.
We're interested in hearing what you
have to say,
if you have issues with the code, how
it's written. We'd like you to get involved.
Let us know, we
can't correct it unless we know
there's a problem.
Attend those meetings as well getting
involved as you're
interested. We welcome your attendance, we
welcome your input.
So, with that we're going to go on to Q
and A,
before Cesar
starts this and… I always get a timer on
this slide and keeps changing on me
there. I just want to call your attention
to the
email addresses shown underneath the
photo here.
If you have further questions or if

you don't get your question answered today you can email us at regsunit@oshpd.ca.gov or fddwebinar@oshpd.ca.gov and we'll try to get an answer to you as soon as we can on your specific question. With that I'm turning it back over to Cesar.

Great thank you Richard. Thank you for that a lot of good information, I hope everyone is enjoying the presentation in the series.

With that being said, please know that we've received a lot of questions that are specific to projects, so we're going to go ahead and try to limit the the questions we answer over the webinar to a more generalized question and answer type, so with that being said.

Richard, I have the first question for you.

Dealing with OSHPD 1 and 1R question is, can a 1R be reclassified in the future as a 1?

Yes, it can but you'd have to do all the requirements of a 1.

Most of the 1R's are being taken out of service because they're not meeting the SPC 1 or 2 requirements or the NPC requirements. It would have to be brought up to full code compliance and it can be brought in back to 1.

Now we do have a couple instances where we do have SPC 3 buildings that are just voluntarily being removed from acute care services. Again, you'd have to go through and justify that you're meeting the current code requirements at that time when you decide to bring it back to a 1.

Perfect and thank you for that.

I have another question from the audience also dealing with OSHPD 1 and 1R.

Can duplicative surgery suites be located in 1R?

If they're considered outpatient, just to clarify duplicative service for surgery, there is outpatient surgery and if they're connected to the building through the right requirements they can

do
25% of inpatient, but
they have to meet the requirements of an
outpatient
facility. Okay, very good,
here's a more generalized question
dealing with IOR or inspector of
record
inspections for projects. Does the
remodel work in an
OSHPD 1R require IOR inspection and
OSHPD field oversight?
You should be able to answer that. We
are working on that,
it is going to be a different
requirement for inspections
from what I understand, once the
plans will be
reviewed
there's going to be a different set of
requirements for that, actually do you
Cesar,
I defer that to you. If you know how those
are going to be handled yet?
No, you're right Richard, we are working
on that, it's the OSHPD 1R is
is something that you know it's
more of a complicated nature but
if the building of the
structure remains under our jurisdiction
then we would require the IOR inspection,
right.
Yes, but we're not going to be going to
the same level so that is something
we're working on it'll probably have
an abbreviated TIO Test Inspection
Observation,
it will not have the same requirements
as the hospital.
so, I guess the answer to that is, yes
Possibly, but more to come
on that. Next question still dealing
with one
and 1R, what is your best guess for
when
CAN 2-11B can be reissued?
This relates to conversions of OSHPD 1R
and the 10%
toilet room noted on your slide just
before the Stanford example.
It's in the works we have about a
couple more things we're working on
with leadership to get approval on. I
would say it will probably be posted
within the next three to four weeks.
That's a realistic answer, it may not be

what you want to hear
but it is going to be, we just have some
final things we're wrapping up and it'll
be posted. We have to
also, make everything accessible and
unfortunately, it takes a little bit of
time to do that as well.
Yes, the accessibility requirements are
quite involved too.
So, those of you listening, if just to
give you a little bit of background on
that,
to make any kind of document that a
agency, a state agency puts on a public
website, we need to make it,
make sure that it's accessible and
there's a lot involved to do that.
And that's why the previous
sessions have not been posted yet either.
That's all we're waiting on is getting them
converted to
be accessible. Perfect so switching gears
on to OSHPD 2 or OSHPD 5,
question is, can a dementia,
is a dementia or Alzheimer's OSHPD 2 or
OSHPD 5
and how do you determine which one it is?
It's an OSHPD 2. An OSHPD 5 is going
to be a psychiatric
acute care hospital and OSHPD 2 is a
skilled nursing
facility that you are allowed to
control the patient population for
Alzheimer's and dementia patients
and you are allowed to lock the
doors.
Again, there's requirements to do so and
if you
want to talk to us more about that
we can set up a meeting or you can
contact us but yes, they would be in OSHPD
2. We get them all the time.
Perfect sticking with the same
OSHPD 2, OSHPD 5
subject can a SNF for an acute psych
be done in
1R under the hospital's license without
providing separate entrances
or infrastructure? Can you repeat that
please?
Can a SNF or an acute psych be done
in a 1R under the hospital's license
without providing separate entrances
or infrastructure?
I missed it I apologize I was coughing.
It's okay, SNF's

or acute psych, can they be done
in a 1R under the hospital license
without providing
a separate entrances? Yes, it would be the
same as having a distinct part SNF
or a psych in a hospital building itself.
If you have the 1R you can have the same
access to it through the hospital
again, you have to look at the egress
you cannot
exit the hospital through either of
those uses
but they can actually have the
egress coming from the SNF or the
psych
through the hospital I wouldn't
recommend the psych coming through the
hospital
but those options are available.
But yes, it would be treated just as it
would a distinct part
of a hospital service but it would be
under, you can have
both of those service under the hospital
license in a 1R Building.
All right, thank you for that. The
next question we have is
something that would I that I would
anticipate is going to be a very
generalized question dealing with old
facilities
wanting to bring them back into service.
So, the question reads
how is a building defined if it was
taken out of acute care
approximately 10 years ago and the
facility now wants to utilize this
building for multiple uses including
SNF and outpatient services
to bring this facility back into
jurisdiction would it be considered a
1R Building or an OSHPD 2?
There would be a lot depending on that
if you're taking a building out of
service 10 years ago and you lose a
license
actually, the CDPH requirement for a new
license would be bringing it up to
the current
code standards. If you're bringing in a
skilled nursing facility it can be a
standalone skilled nursing facility.
Now, if it was removed from service
and made a 1R
you just can convert it to the SNF
used just as you would

any other SNF type project. So,
but like I said there's a lot of variations to
this question
a lot of answers that would go with it
but basically your
your design would have to meet the code
requirements for the new use just like
you would for any remodel
and the building type again it wouldn't
be a 1R
unless it was removed from acute care
service and made a1R.
You're not going to bring an old
building and assign it a 1R if it wasn't
already there.
Perfect I have another question from the
public
dealing with renovations, the
question is
many SNF's are being renovated and
turned into subacute,
there are no code section or sections
dedicated to this
only that captures some of the
requirements in OSHPD 1 facilities
can you help with this?
Yes, we actually have a CAN I believe
it's a CAN that i don't know the number
off hand.
And that CAN deals with converting to
subacute, it talks about all the
electrical, mechanical, and architectural,
requirements to do. So,
check our website if you can't find it
go ahead and send us an email
at regsunit@OSHPD.ca.gov and we can answer, get
you a copy of that.
But you're correct, it's not specifically
addressed in the code
and that's actually when we mentioned
the subacute in there
we did add subacute to
critical care for electrical code,
and we are adding it, we did add the
definitions of subacute and the
requirements for electrical to be looked
at
as we went over earlier. Very good I have
another remodel
question dealing with Section 1224.7
17.3, question is
will remodeling an existing lab, trigger
a requirement
to add the new functions in Section
1224.17.3?
Depends what you define as remodel, if

you're replacing a piece of equipment
no, if you're completely gutting it
and rebuilding it, you're probably going to
have to meet with us and see what would
be required because the
previous requirements for a lab were
minimal at best
and so that is something
that if you're doing a new lab yes, you
have to meet all those requirements.
If you're remodeling it's going to,
it's really going to depend on the
extent
of the remodel and what's being done. you
know, we see a lot of
the new Remodel CAN, we talk
about equipment replacement
which we see a lot of labs just doing
equipment replacement.
But once you start about remodeling,
you're going to need to meet the
functional requirements
of that new lab but again, it's going to
really depend on the extent
of the remodel. So, again that would
probably be a meeting
ahead of time to find out actually
what's going to be required.
Perfect thank you for that. This next
one is more of a clarification
asking for clarification as opposed to a
question.
The comment is, can you clarify
needing to provide
separate functional program for dietary
services?
Yes, that's actually something that’s again
it's optional.
It's not required. You do all projects
are pretty much required, most projects
require having a functional program.
I’ve found personally that if I’m doing
a hospital project,
if I get a separate functional program
that only addresses
the pharmacy requirements such as with
the A2 Guide, if you're just doing a
pharmacy upgrade you would
submit a functional program just for the
pharmacy or if
you're doing a kitchen only, you're
require to do a functional programming
kitchen.
I would also do the same thing if you're
doing a say a hospital project,
do the full functional program and then

submit the pharmacy and the kitchen
in addition to, not instead of, the other
functional program
but in addition to. This just helps
the review process.
Just from my working with CDPH you're
going to get a much
better response, and much better comments
based on that. So, again it is not a
requirement
but the pharmacy one is, but the dietary
is not. I just
found from personal experience if you
have a separate
dietary functional program in addition
to your normal functional program
we can get it pushed through a lot
faster and get comments turned around.
And to be honest most of the new
kitchens that we've been seeing
CDPH is requesting a meeting
to go over it and review it with you. So,
like I said that we're getting a lot of
attention
from the pharmacy and the kitchen
services it's a welcome
attention and it's just a way that I
have found
to help expedite the process and get you
the information you need
sooner. All right
next question deals with the four bed
skilled nursing rooms.
Question is, do you know if the
reimbursement problem
for four bed skilled nursing rooms apply
to existing licensed facilities?
I'm not, again we're not CMS I'm not sure
how they work. I know that
it came into effect 2018 and typically
you have 10 years to comply.
I do not know if it's retroactive or not
but we are going to be requiring that
future
skilled nursing facilities be limited to
two beds. And we're just
kind of giving what we call blue note
comments now
if we're seeing that, my guess is that
the older facilities will be allowed
but I cannot say that for sure. You'd
have to check with CMS
or your licensing. And I wanted to make
sure that, that
we point them to CMS and
then make sure that.

Yes, CDPH would probably be a better one to ask that question of because we're seeing this with high-rise buildings as of 2028 have to be sprinklered and that's also a CMS requirement, has to be fully sprinklered and that is retroactive it doesn't that does not grandfather you into anything. So, they take different positions on that and we would have to check with CMS.

And this next question deals with remodeling and not being able to comply with with new code so, daylight and NICU are there alternative methods of compliance for existing facilities that need to be remodeled and can't comply with a direct window? That one we get a lot of questions on. What I would suggest that you meet with us ahead of time and see what allowances there are for that. I know a lot of the older facilities they used to put the NICU's in the center of the building with no windows and it's near impossible to get lighting out and I'm sure there's going to be some allowances or alternate methods of compliance to deal with existing conditions.

And again, we're going to be looking at the extent of the remodel, if you're expanding or completely gutting the NICU, we're going to have to look at the space and see what would be reasonable. That's our key word this year reasonable, but that would definitely be something that you would want to meet with us about. I've been getting questions about that recently.

Another question for you. This is a good question since the acute care regulations don't carry into OSHPD 5 is there future consideration of not requiring medical airborne infection isolation rooms since psychiatric hospitals don't admit patients

with those medical needs and transfer patients once they have these medical issues?
There is no current plans to make modifications to the requirements of isolation rooms because they actually are used.
All right next question.
Does the USP 800 apply to medication room
inside a nursing unit? does the what?
Does the USP 800 apply to medication room inside a nursing unit? Only for compounding in there.
800 is for compounding hazardous drugs.
There are other requirements on 800 for Hazardous,
Sterile, non-sterile, things like that.
But no, it wouldn't be for your med room.
You shouldn't be doing any of that in the med room.
Great, I got a design question for you.
Maybe a little involved,
for an outpatient dialysis as an I-2.1 under OSHPD 3
is this facility considered as essential facility with
an important factor of 1.25?
It would still fall under OSHPD 3 Requirements.
All right we do have some more questions that are more specialized and require a more specific, I should say that require a little more research.
So, with that being said I… on that last question though I just wanted to, I didn't directly answer the question about the
value because to be honest I'd have to look it up but it would be,
it's not considered an essential services as
such as a hospital would be. What we're looking at, is a place that you would go after an emergency,
after an earthquake, or in an event, is this somewhere you would go. That's why SNF's and psych
hospitals are excluded as well. So,
what you're describing as an I-2.1 would not be a place you would go for
after an emergency and they would not have the same level requirements.
So, it would have, you'd have to look at the code to see what was required for that type of service for that,

that facility and it's probably not
going to be at the hospital level.
Alright good, I believe I have one more question.
And you may or may not know this off
the top of your head.
What is the definition of restraint
in an I-2? There's a long definition I
can,
it's basically for an I-2 it's going to
be you're either locked in a room or an
area or you're physically restrained
with a soft…
Again, I should probably look up the
actual definition.
But in I-2 you can restrain someone to a
bed or in a seclusion room
only and that room can be locked and
secured.
It doesn't make it a locked I-2. But
once you get into a unit or
you're restricting
somebody's ability to move
more as in the patient and psychiatric
type condition
I would say I would recommend you
look at the definition,
It's under in
Chapter 2 and I can look it up as
you're
going to the next question if you want
but it's basically there's
it's very clear what would be considered
restraint and what would apply and also
if you're
doing any type of lockdown facility
you're going to have to do a
risk assessment for the types of
patients are being seen and that will also
distinguish
or determine the level of
security that you'd have to provide. Yes,
and that's a good example of
something of a question that's
specific and we can provide an answer to
that question
in your individual replies that we
send back to you to those similar
questions.
So, with that being said we are a
little past the hour
on our webinar. I have the definition
here if you want. Yes. I can
read it really quick
like I said it's a little long it's
actually, three paragraphs, I'm not going
to go into the whole thing.

But restraint is the physical
retention of a person within a room cell
or cell block holding cells temporary
holding cell
room or area holding facility secure
interview rooms
courthouse etc.… just goes
into all these lists
by means of a locked door or within the
exterior walls of the building.
And let me go on to the other definition
Basically, if you're locked in
is one.
And says facilities employing the use of
soft ties however shall be classified as
a building used to house non-ambulatory
persons, non-ambulatory persons restraint
shall not be
practiced in licensed facilities
classified as,
basically are
unless constructed to the group I-3
occupancy.
And then it refers you. There's again,
there's a lot of definitions
in Chapter 2 under definitions of
restraint.
Again, if you have a special circumstance
you're curious about go ahead and send
an email but we're seeing a lot of
questions like if you have an
ED with a seclusion room where you put
your psychiatric
patients in there that is not, that is
restraint but there's
allowances for that. Thank
you for that Richard. A lot of
good information and we
we here at OSHPD hope that you enjoyed
the webinar presentation.
Again, if you do have any more questions
or you have a
specific question or a project
you want to discuss
please feel free to email
regsunit@oshpd.ca.gov or
fddwebinar@oshpd.ca.gov
and a quick reminder we do have our
fourth session
coming up May 7th, Session 4
which is going to deal with the
California Electrical Code,
Mechanical Code, Plumbing Code, Energy
Code,
how to remove acute care services from
the building

and a little bit more information of
what we have coming up.
Again, thank you for joining us and we
hope that you've enjoyed the
presentation today.