Hospital Accessibility

by Kimberly Paarlberg, RA, ICC Senior Staff Architect

Hospitals are unique facilities in that their designs typically include high levels of accessibility in order to accommodate people who use wheelchairs or mobility aids. Understanding that building codes provide only minimum requirements, designers and owners often choose to exceed those requirements. For example, while the I-Codes specify accessible entrances for hospitals, they do not mandate automatic doors. However, they are often provided.

Following are some common accessibility questions related to hospitals. References cited are for the 2006 edition of the *International Building Code* (IBC) and the 2003 edition of ICC A117.1, *Accessible and Usable Buildings and Facilities* (A117.1).

Are all hospital patient sleeping rooms (i.e., 24-hour care) required to be accessible?

In hospital areas specializing in rehabilitation for conditions that affect mobility, 100 percent of the patient sleeping rooms must be accessible (IBC 1107.5.4) while only 10 percent of patient sleeping rooms are required to be so in other parts of the hospital (IBC 1107.5.3.1). Bathrooms associated with the 10 percent of accessible patient sleeping rooms within critical care and intensive care units are not required to be con-

structed in accordance with A117.1 because patients in these rooms typically need assistance in the bathroom, necessitating extra space around the fixtures to allow staff to help them to sit down or rise (IBC 1109.2, Exception 5). Also, some patients are so incapacitated that they are not able to use bathroom fixtures, so they are used only by staff to empty bedpans and wash their hands.

Type B units would not be required in a typical hospital. However, in specialized treatment centers like psychiatric hospitals or rehabilitation facilities where patients are committed for long-term care for issues other than mobility impairments, patient rooms are considered abodes and Type B units are required (IBC 1107.5.3.2).

Are all exam rooms (i.e., less than 24-hour care) required to be accessible?

All exam rooms are required to be accessible with respect to patients being able to approach, enter and exit independently (IBC 1103.1). The scheduling and use by doctors and patients, including emergency visits and consideration for special equipment that may only be available in certain rooms, does not allow for only a percentage of the exam rooms to be accessible. While the codes do not typically address portable equipment or furniture in these spaces, designers should accommodate for patients arriving in wheelchairs or gurneys and the need to transfer them to exam tables or for additional equipment that may be necessary in the room. However, if the storage area, equipment or lavatory provided in the exam room are only for the use of doctors and nurses, these elements are not required to be accessible because they are considered part of an employee work area (IBC 1103.2.3).

Are information counters or admission windows required to be accessible?

A variety of levels of access are required based on functions and services provided at admission counters and admission windows (IBC 1109.12.3).

For information or check-in counters or windows, the top of the counter or bottom of the window opening must be a maximum of 36 inches above the floor. If a side approach (i.e., knee and toe space not required) is provided, the minimum width is 36 inches (A117.1 904.3.1). If a front approach is chosen, the minimum width is 30 inches and knee and toe clearances must be provided (A117.1 904.3.2). This allows for the same face-to-face interaction and eye contact between the patient and volunteers, admissions clerks or nurses that any other person coming into the facility would have. Note that providing a low shelf on the front side of a higher counter is not an acceptable alternative.

In admission areas where patients fill out forms, requirements for work surfaces are applicable (IBC 1109.11). They must be located between 28 inches and 34 inches above the floor and allow for a front approach with knee and toe clearances (A117.1 902.2 and 902.3).

Privacy issues in a clinic area may result in separate locations for check-in and check-out. The check-out and waiting areas are often separated by a door, access of which is controlled by staff. Even when both service windows are monitored by the same staff members, both locations must be accessible.

At some windows, patients may be expected to write checks to pay for services. While this situation is not specifically addressed, there are provisions for check-writing surfaces associated with check-out aisles (A117.1904.4.3) at the 28-inch to 34-inch height (A117.1 902.3). This is a situation where a shelf provided on the front of a 36-inch-high service window may be appropriate. Note that given the small surface area required for check-writing, knee and toe spaces are not required.

Conclusion

Best practices for hospital design and customer needs will often exceed minimum code requirements. As the population in the U.S. ages, these design features will start becoming more common in all types of buildings. ◆