Part B – Health Facility Briefing & Design

75 Emergency Unit and Urgent Care Unit



iHFG

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Table of Contents

75 Emergency Unit and Urgent Care Unit 3
1 Executive Summary 3
2 Introduction 5
3 Functional and Planning Considerations 5
4 Design Considerations 28
5 Components of the Unit 35
6 Schedule of Equipment (SOE) 37
7 Schedule of Accommodation 39
8 Further Reading 52
9 Sample Plans 53

75 Emergency Unit and Urgent Care Unit

1 Executive Summary

The Functional Planning Unit (FPU) covers the requirements of the Emergency Unit (ED) as well as Urgent Care Unit. Emergency unit may be referred to by different names such as:

- Emergency Department (ED)
- Accident & Emergency (A&E)
- Emergency Room (ER)
- Casualty Department
- Urgent Care Unit (for Triage Categories 3 to 5 only)

The main function of the Emergency Unit is to provide safe and high quality patient care as soon as possible. Patients may arrive at the Unit via Ambulance or private vehicles. Patients intended for inter-hospital transfers may also enter via the Emergency Unit.

Quick access to Triage for initial assessment is required to:

- Determine the destination of the patients brought in via ambulance
- Determine the destination of transfer patients
- Prioritise the ambulant patients according to 5 levels of triage category
- Stream the patients to the correct area of the Emergency Unit

Emergency Unit may incorporate a Short Stay area for patient monitoring up to a maximum of 24hours. After this period, the patient should be admitted to the hospital as an inpatient, transferred to a more suitable hospital or discharged.

The Emergency Unit should have quick access to the Medical Imaging Unit, Operating Unit and Intensive Care Unit. If the Hospital has a Catheter Laboratory, quick access to the Cath Lab is also required. At RDL 4 to 6, at least one mental health assessment room is required.

Emergency Unit can be provided for hospitals from RDL 4 to 6 based on the operational policy of the facility. It is not necessary to provide an Emergency Unit in all hospital types such as Specialised hospitals which may only cater to one or 2 medical specialties. Emergency Departments are recommended only for hospitals which have comprehensive supporting services such as a fully capable 24/7 Medical Imaging Unit and Laboratory. They should have the capacity to perform surgery and admit patients to ICU or Inpatient Unit if necessary.

Any hospital which does not have such facilities should not provide an Emergency Unit as this can be misleading and confusing for the general public. It also compromises the safety of the patients. Hospitals which do not qualify for the provision of an Emergency Unit and Hospitals at RDL3 may instead provide the optional Urgent Care Unit (or Urgent Care Centre).

The main public ambulatory entrance to the Emergency Unit requires high visibility from a distance but located in such a way that it cannot be confused with the main entrance to the Hospital. A drop-off zone and short stay carpark area is essential for ambulant patients. Public entrances shall lead to reception and waiting areas only. Ambulance entrance should be separated and not shared with the public ambulant patient entrance. Ambulance entrance also requires provision for quick triage upon the entry of the patients via stretchers.

Urgent Care Units (also referred to as Urgent Care Centre or UCC) are intended for a lower level of service than a full Emergency Unit and are suitable for Triage Categories from 3 to 5.

Urgent Care Units may be provided in different settings:

- Attached to Hospitals (for example at RDL3) as a low triage category of an Emergency Unit
- Attached to Medical Centres (Polyclinics)/ Primary Care
- Fully stand-alone but with the required supporting services

Urgent Care Units should be able to undertake basic resuscitation, stabilisation and minor treatments with medical services provided by General Practitioners or Physicians supported by Registered Nurses and supporting staff.

Where Urgent Care Units are attached to hospitals or Clinics, the supporting rooms and services can be shared. The Urgent Units operate 24 hours per day to serve local communities. These are highly desirable where Emergency Unit access cannot be provided within 15 minutes. These facilities should have clear signs referring to Urgent Care Centre or similar which cannot be confused with a full-service Emergency Unit. Centralised ambulance services should avoid delivering critical patients at triage categories 1 and 2 to Urgent Care Units as they are not capable of providing the required level of specialised workforce, equipment and follow-up care. This can result in a waste of time due to the need for patient transfer to other facilities and therefore the loss of the Golden Hour (the maximum time period where the patient survival and likelihood of recovery is good).

The Urgent Care Units should have links to a wider network of health services so that patients requiring more specialised care would be transferred to a higher-level hospital-based emergency unit, whether public or private.

Urgent Care Units should have access to an ambulance or ambulance service when patient transfers to more specialised facilities are necessary.

The Functional Relationship Diagrams provided indicate the ideal external relationships with other key departments and hospital services. This includes relationships with units such as Medical Imaging, Laboratory, Operating unit, Intensive Care Unit, Inpatient Units. Optimum internal relationships are demonstrated in the Functional Relationship Diagrams under several models from small to large according to the functional zones whilst indicating the important paths of travel and requirements for observation.

Design Considerations address a range of important issues including visibility, finishes, clearances and building services requirements.

The Schedule of Accommodation is provided using references to Standard Components (typical room templates) and quantities for typical units at Role Delineation Levels (RDL) 1 to 6 as follows:

- RDL 2 and 3 Small Unit (Urgent Care Unit)
- RDL 4 (Medium Unit)
- RDL 5-6 (Large Unit)

The actual size of each Emergency or Urgent Care Unit depend on each facility's Clinical Service Plan.

Further reading/reference material is suggested at the end of this FPU document, but none are mandatory.

2 Introduction

The function of the Emergency Unit and Urgent Care Unit is to receive, stabilise and manage patients (adults and children) who present with a large variety of urgent and non-urgent conditions whether self or otherwise referred. The Emergency Unit may also assist in the reception and management of disaster patients as part of the Unit's role within each region.

Emergency Units may also incorporate Trauma facilities and act as a designated Trauma Centre. Alternatively, a dedicated Trauma Unit can be provided separately from the Emergency Unit but in close proximity. In some circumstances a fully independent Trauma Centre may be provided, but with additional built-in services such as operating theatres and ICU.

Refer also to the separate FPU – Trauma Unit in these Guidelines

It is recommended that Hospitals not providing an Emergency Service display a prominent exterior sign at the main entrance stating this and giving the location of the nearest Hospital with an Emergency Service.

3 Functional and Planning Considerations

Operational Models

The Emergency and Urgent Care Units may be configured in a number of models that are aimed at improving efficiency of treatment and may influence facility design. The majority of Emergency Units will have a number of these models in operation.

Triage and Registration

On arrival, patients shall first undergo rapid clinical assessment by the triage nurse to determine acuity and immediate care needs. Administrative registration shall occur after triage in a collocated but separate area to avoid delays in urgent treatment.

There are two zones for Triage as explained below.

Visual Triage

Visual Triage, or External Triage is a monitoring station located just outside the Emergency Unit. Visual Triage shall be activated only during declared pandemics or airborne infectious disease emergencies, as mandated by the relevant public health authority (e.g., WHO, national ministry of health, or local health department with jurisdiction over the facility) and deactivated upon formal declaration that the emergency has ended. Under normal operation, all patients shall proceed to the internal triage areas inside the Emergency Unit.

Upon arrival from outside, the signage will direct the patients to the Visual Triage. At this point the Triage Nurse may remotely take the patient temperature and ask questions about any symptoms. The Triage Nurse will not physically examine or touch the patient, whilst keeping a reasonable distance across a counter. If the Triage Nurse suspects an infection, the patient and any accompanying family or carers will be directed to the Isolation Area entrance of the facility. If infection is not suspected, then they will be directed to the normal Emergency Unit entrance.

Internal Triage

Patients who are not suspected of airborne infections during pandemic periods and all patients during non-pandemic periods will typically be directed to enter the main Emergency Unit. At this point prominent signage will point to the Triage area which is the first place the patient must visit without waiting for any clerical work. Family members may attend to the separate clerical reception for any registrations or insurance checks etc whilst the patient is seen by a Triage Nurse.

At the Triage room, the patient is rapidly assessed and assigned to the appropriate care zone according to the 5 internationally recognised triage categories as follows below:

- Category 1 - Resuscitation: People who need immediate treatment within 2 minutes. Patients under Triage Category 1 are in a critical condition, with a severe risk of death or permanent injury.
- Category 2 - Emergent: People who need treatment within 10 minutes, categorised as having an imminently life-threatening condition.
- Category 3 - Urgent: People who need treatment within 30 minutes, categorised as having a potentially life-threatening condition.

- Category 4 – Less Urgent: People who need to have treatment within one hour, categorised as having a moderately serious but not life-threatening condition.
- Category 5 – Non Urgent: People who need to have treatment within two hours, categorised as having a less urgent condition which can also be treated in a Family Clinic or Primary Care setting.

For patients who enter via the Isolation entrance, the conventional triage is replaced by a rapid confirmation assessment at the Isolation Reception counter followed by a quick transfer to one of several negative pressure isolation consultation/ examination/ treatment rooms.

A variation of this model includes a Senior Nurse to manage patients in the Waiting room to continually review patients who have been triaged and are awaiting treatment. This initiative may be implemented to improve patient safety and quality of care as the Nurse can escalate access to care as needed.

Patient Streaming

In this model the patient is first triaged and registered in a rapid triage model and transferred to a streaming zone for assessment by a senior Emergency Physician. In a Streaming zone a Nurse coordinates patients through the streaming area into an Early Treatment Zone. The Streaming zone shall be located close to the triage area, with adequate curtained bays or rooms to allow simultaneous assessment of multiple patients. Visual observation from a staff base shall be provided while ensuring audible and visual privacy.

Pit Stop/ Early Treatment Zone

The Pit Stop/ Early Treatment Zone is a separate clinical area where patients are managed for a short time and then moved to another area of the Emergency Unit such as Acute Care or Waiting area for patients waiting on results before discharge. This model works in conjunction with other models such as Acute Care, Non-Acute Care, Fast Track, Short Stay Units and Mental Health assessment.

Fast-Track

Specific patient groups may be assessed and treated via a separate ‘fast’ track process, separate from other Emergency Unit presentations and is intended for fast throughput and a reduction in waiting times. This may occur at the triage point, or immediately after triage but in a separate zone, adjacent to the waiting area so that patients do not have to enter the main Emergency Unit. Patient types suitable for this area are ambulant with non-complex conditions such as the common cold, very minor injuries and common paediatric illnesses. Fast Track area will typically incorporate conventional consult/ exam rooms similar to those found in Outpatient Clinics and may also involve a mix of Consult/ Examination rooms and bed bays for easier examination and rapid treatment such as very minor wounds. Its purpose is similar to urgent primary care. Assessment and treatment of patients at triage categories 4 and 5 may be carried out in the same Consult / Examination rooms, and the majority of patients are quickly discharged to home.

Grouping by Patient Acuity

Patients of similar acuity (urgency) or staff intensity may be treated in the same zone. Facilities for this model include separate areas for resuscitation, acute monitored beds, acute non-monitored beds and ambulatory treatment spaces. There may be separate entry-points (or triage points) for the different areas or one triage point for all. Staff may be separately allocated to different areas for each shift and may require separate Staff Stations and private workspace.

Examples of Grouping by Patient Acuity include:

Resuscitation and Trauma

This model sets out how resuscitation and trauma patients will be assessed and managed in order to streamline the process and ensure the correct team and diagnostic services are available. This model ensures that when emergency or trauma patients arrive, trained staff are available to attend immediately. Resuscitation is intended for the most serious patients who have recently deceased (typically on the way to the Emergency Unit) or are in imminent danger of death, requiring immediate resuscitation. Resuscitation rooms should be vacated as soon as the patient is sufficiently stabilised. Therefore, Resuscitation rooms should not become de-facto ICU for the longer-term patient treatment.

Trauma rooms are provided for the immediate treatment and stabilisation of trauma patients before transfer to other facilities such as Surgery, ICU or IPU. Trauma rooms may be regarded as a step-down from Resuscitation, where the clinicians work on the patient for a longer period of time.

Trauma care may be integrated within the Emergency Unit, which then operates as a designated Trauma Centre. Alternatively, it can be provided as a dedicated Trauma Unit adjacent to the Emergency Unit. It can also be delivered through a standalone Trauma Centre, separate from a Hospital, with its own operating theatres and ICU and other supporting services. Refer to the Trauma Unit FPU within these Guidelines for more information.

Acute Care

The Acute Care model is aimed at assessment and treatment of patients that are acute or unstable with complex illnesses. Acute Care may be provided in a separate zone or allocated beds that require a higher level of care and endeavours to improve the patient's access to specialist care and minimise delays. The acute care environment will typically use a standardised clinical environment for each treatment space, using the principles of lean thinking.

Sub-Acute and Non-Acute Care

Sub-Acute and Non-Acute Care involves assessment of the patient to determine their need for monitoring or interventional care. Patients in this category do not require acute care or monitoring but have complex conditions that require observation, investigation, discharge planning, or follow up and are not suitable for Fast Track care. Non-Acute Care patients are allocated to a separate treatment area or a Short Stay area. Acute, Sub-acute and Non-acute bed bays or rooms can be standardised in design but allocated by the management as needed.

Grouping by Specialty

Patients may be managed in different areas according to the specialty of service they require e.g., paediatric assessment, obstetric assessment and observation or mental health assessment, emergency care or those suffering from chest pain. Zonal separation of mental health patients, with its own segregated corridor, is required at RDL 5 and 6. At RDL 4, it is optional. The same requirements apply to zonal separation of paediatric patients. Patients may be triaged from a central arrival point, or from separate ambulance and ambulant entry points. Within each Functional Area, patients would be prioritised according to acuity and speciality. In this model, separate specialist staffing for each area is required, which would also include workspaces for staff.

Isolation Area

This is a group of rooms fully isolated from the main emergency department and intended for patients who are suspected of airborne infections. The Isolation zone is similar to a mini emergency department and kept under negative pressure. The Isolation Area will have direct access from the outside as well as a separate connection point to the main Emergency Unit interior. Patients who are identified at the Visual Triage are directed to the Isolation Zone from the outside. Patients who are discovered with infections inside the Emergency Unit are transferred to the Isolation Zone internally. After the initial assessment within the isolated Consultation/ Examination/ Treatment rooms patients may be transferred to other zones within the hospital such as Isolation Inpatient rooms, Isolation ICU, Medical Imaging or be held for transfer to dedicated isolation facilities.

Observation/ Emergency Short Stay Unit (ESSU)

In a typical Emergency Unit some bed bays/rooms need to be allocated to observation over an extended period of time, to assist with the diagnosis or decision on discharge or admission to the hospital inpatient areas. Observation may be from a few hours to full overnight stay. Observation beds may be within the body of the Emergency Unit or separated but linked. When a separate area is created, it is referred to as the Emergency Short Stay Unit (ESSU).

Emergency Short Stay Unit is also known as Emergency Medical Unit (EMU) or Clinical Decision Unit (CDU) and is either located immediately adjacent to or incorporated into the Emergency Unit or conveniently linked to it via corridors or lifts. Administrative, staff and support facilities can be shared. Patients suitable for the Short Stay Unit will require observation, diagnostic services, therapy or follow-up that may take up to 24 hours. These patients will typically be discharged home or admitted to an Inpatient Unit if their condition remains unresolved. Short Stay Units provide efficiency by improving the patient flow through the Emergency Unit and improving bed management in the hospital by avoiding short term inpatient admissions. Short Stay Unit should not be used as a substitute for an Inpatient Unit as that is likely to lead to bad practice and operational shortcuts.

Telemedicine

Telemedicine or tele-consultation can assist by providing specialized and remote healthcare services to manage complex patients and connect physicians at a central emergency department to physicians and patients at other emergency departments which are often smaller, remote or rural.

Application can also extend to providing paramedics with telemedicine support. It is recommended that telemedicine is provided in every Emergency or Urgent Care Unit.

Telemedicine facilities can be provided in dedicated rooms. However, increasingly Telemedicine can also be provided throughout the facility, in every room or area where a patient or physician may be present. This may require a distributed system or a number of mobile telemedicine stations.

Urgent Care Unit/ Urgent Primary Care Unit Urgent Care Centre

Urgent Care Units may be provided in different settings:

- In General Hospitals with a Role Delineation Level of 1 to 3, in place of an Emergency Unit, provided as an Urgent Care Unit (also known as an Urgent Care Centre)
- Attached to a Medical Centre (Polyclinic) or Primary Care Facility
- Fully stand-alone, but with the required supporting services

Such facilities shall be able to undertake basic resuscitation, stabilisation and minor procedures with medical services provided by local General Practitioners supported by Registered Nurses. The Urgent Care Unit model operates 24 hours per day. The Urgent Care Unit would have links to a wider network of health services so that patients requiring more specialised care would be transferred to a higher-level hospital-based emergency unit.

Urgent Care Units also require isolation facilities on a smaller scale than an Emergency Unit. In a similar manner to the Emergency Unit, such isolation facilities must have access from the outside of the unit as well as inside the unit, in order to be able to reasonably isolate the infected patients at an early state, during pandemics.

Remote Emergency Unit

In rural areas, more than 100km away from a city, remote emergency units provide access to emergency services to patients residing in remote areas. This unit is able to undertake basic resuscitation and stabilisation of patients and treatment with medical services provided by at least one Specialist in Emergency Medicine and Trauma. Access to a helipad and telemedicine is mandatory. The helipad shall be located as close as possible to the Emergency Unit, allowing a patient transfer time within 3 minutes. It shall have a dedicated, secure path for patient transfer. Telemedicine facilities shall be included with dedicated rooms with video conferencing equipment, high-speed internet and patient privacy provisions.

Hours of Operation

The Emergency Unit, Urgent Care Unit or Remote Emergency Unit will operate 24 Hours per day, 7 days per week.

Planning Models

The Emergency Unit or Urgent Care Unit should be located for efficient ambulant and ambulance access, ideally at ground level, with good access to public and private transport. The site planning should have provisions for the separation of public access from ambulance access both externally and internally.

Planning of the Emergency Unit or Urgent Care Unit will depend on the Operational Model/ Model of Care adopted, the patient mix and the Service plan which establishes the role delineation and size of the service. Planning should provide maximum flexibility of patient spaces to allow adaption to alternative models of care.

Within the facility, patients may be grouped by acuity, which is initially determined by the triage category. Alternatively, patients may be grouped by specialty. This is influenced by the physical size of the unit. In small to medium sized units, each patient zone may have multiple functions, determined by management decision and based on patient numbers or conditions encountered. In larger units, the patient types are increasingly separated into their own zones or pods which can be better managed by specialised staff. This increasing differentiation of zones for different patient types

are best demonstrated in the Functional Relations Diagrams which are shown separately for Small to Large Units.

The zones separated in small to medium size units include:

- Fast Track
- Treatment/ Observation
- Resuscitation
- Isolation Area

The zones separated in larger units may include:

- Fast Track for adults
- Fast Track for paediatrics
- Fast track for obstetrics
- Sub-acute Treatment
- Acute Treatment
- Observation/ ESSU/ EMU/ CDU
- Isolation Area
- Psychiatric Emergency Care Centre (PECC)

The local terminology used for the zones mentioned above may vary. However, the concept of grouping by patient type and condition can be applied regardless of the terms used.

Planning should provide a clear path of travel for each zone with a minimum of cross traffic, for maximum unit efficiency.

For small facilities, the support rooms serve the entire facility. For larger facilities the support rooms may have to be duplicated so that the different zones are served appropriately. Alternatively support rooms can be clustered and located between the zones so that they are easily shared whilst avoiding long travel distances.

Triage and Reception areas should be located to allow maximum visibility for incoming ambulant patients and waiting areas. Ideally the same triage area should be able to attend to the incoming patients via ambulance, using a different access door.

The Unit should provide an Isolatable Area for use in infectious outbreaks and pandemics. This Isolated Area should have access from the outside as well as inside the unit. Access to this isolated area may be directed via an external Visual Triage area at the entrance to the Unit during pandemic events. If a patient within the main Emergency Unit is later found to have an infection, they may be directed to the Isolation Area from inside the unit. The Isolation Area will have one or more negative pressure isolation rooms and other support rooms. The corridor system that serves the isolation area shall be separated from the interior of the main Emergency Unit by self-closing double doors. This corridor should also be maintained under negative air pressure.

Decisions regarding the site location have a major influence on the eventual cost and operational efficiency of the Emergency and Urgent Care Unit staff. The site of the Unit should, as much as possible, maximise the design flexibility for the layout. In particular, the options available on the site for the access points to the Unit must be carefully considered.

The Emergency or Urgent Care Unit should ideally be located on grade level for easy access by ambulant patients and ambulances. The entrances must be covered and provide shelter for ambulances and crew unloading and loading patients. Ambulance entrance point should be separated from the public entrance point. The public entrance should lead immediately to the Triage area whilst the Ambulance entrance should be directed to the interior of the Unit via the Ambulance Triage Bay.

The Emergency or Urgent Care Unit should be clearly identified from all approaches. Signposting that is illuminated is desirable to allow visibility at night. The use of graphic and character displays such as a white cross on a red background or locally acceptable and recognisable symbol is encouraged.

Functional Areas

An Emergency or Urgent Care Unit may include the following Functional Areas, according to the facility's agreed Service Plan:

- Entrance / Reception/ Waiting
  - Receiving of patients and visitors and administration
  - Patient waiting with areas for refreshments and amenities
  - Security room
  - Visual Triage room (external to the unit)
- Triage
  - Internal Triage Assessment for ambulant patients
  - Triage Assessment Bay for ambulance patients
- Patient Resuscitation/ Treatment Areas
  - Decontamination Shower
  - Resuscitation Bays
  - Trauma Rooms
  - Acute Treatment bays or rooms for assessment and treatment of severe conditions
  - Non-Acute treatment bays- or rooms for the assessment and treatment of minor conditions or patients awaiting test results
  - Treatment & Procedure Rooms
- Fast Track/ Consulting Area
  - Consult/ Examination rooms
  - Patient Bed / Chair Bays
  - Vital signs room
  - Staff Station
  - Access to patient amenities
- Support Areas
  - Bays for Handwashing basins, Linen, Mobile Equipment and resuscitation trolleys
  - Clean Utility and Medication rooms
  - Cleaners Room
  - Dirty Utility Room
  - Disposal Room
  - Cleaner's Room
  - Meeting/ Grieving Room; the room should be located in a private area away from the reception and waiting area
  - Store Rooms
- Staff Areas:
  - Change Rooms with toilets, shower and lockers
  - Staff Room
  - Offices and Workstations
  - Meeting rooms that may be used for education and teaching functions.

Optional Areas include:

- Paediatric Assessment/ Short Stay

- Obstetrics Assessment/ LDR Rooms; however, for remote emergency units serving populations without nearby obstetric services, at least one room capable of maternity assessment and delivery should be provided.
- Mental Health Assessment Rooms are optional for RDL 1 to 3; however, for RDL 4 to 6, at least one room is mandatory.
- Observation/ ESSU/ EMU/ CDU beds for patients requiring a period of observation or rest prior to admission or discharge. A designated area within the unit is highly recommended for RDL 4 to 6. Where space within the Emergency Unit is not available, a separate observation unit located elsewhere within the facility may be provided, provided appropriate access and operational connectivity to the Emergency Unit are maintained.
- Plaster Room
- Ambulance Base and facilities

In addition to standard treatment areas, depending on the service plan and models of care, some functions may require additional, specifically designed areas to fulfil special roles, such as:

- Streaming of patients to improve throughput and access to care which may require specialist areas such as Pit Stop/ Early Treatment Zone
- Management of paediatric patients
- Management of pregnancy complications and postnatal patients
- Management of major trauma patients
- Management of mental health patients
- Management of patients following sexual assault
- Undergraduate and postgraduate teaching
- Transport and retrieval services
- Tele-medical referral/ consultation service.

The inclusion of the above functional areas or specialist treatment zones will be dependent on the size of the unit and the Service Plan of the facility.

Entrance / Reception/ Waiting Areas

Entrance

The Emergency or Urgent Care Unit should be accessible by two separate entrances: one for ambulance patients and the other for ambulant patients. A separate path for infected patients is also required and managed by a visual triage room located outside the entrance. The visual triage room and separate path is optional for Urgent Care Units. It is recommended that each entrance area contains a separate lobby that can be sealed by remotely activating the security doors. Access to Treatment Areas should also be restricted by the use of security doors. The Ambulance Entrance should be visually screened as much as possible for sight and sound from the ambulant patient entrance. Both entrances should direct patient flow towards the Reception/Triage Area.

Patients delivered via ambulance stretchers must not enter from the ambulant entrance via the waiting area. They must enter from a separate ambulance entrance and move to the interior of the unit via the ambulance triage bay, without passing through the public waiting area.

The entrances to the Emergency or Urgent Care Unit should ideally be at grade-level, well-marked, illuminated, and covered. It shall provide direct access from public roads for ambulance and vehicle traffic, with the entrance and driveway clearly marked. A gentle ramp no steeper than 1:12 shall be provided for pedestrian and wheelchair access where necessary.

The ambulant entrance to the Emergency or Urgent Care Unit should be designed to allow discharge of patients from vehicles and ambulances. Temporary parking should be provided close to the entrance.

The external signage should not direct the general public towards the ambulance entrance. Similarly, family members for the patients should not be admitted through the ambulance entrance. Signage shall clearly indicate separate entry points.

Outside the public entrance (ambulant entrance), there should be provision for an external Visual Triage room which can be activated during pandemics. This room will have a window directly to the outside with provisions for a triage nurse to talk to the incoming patients and perform a temperature scan. If the triage nurse suspects an infection, the patient and their supporters will be directed to the Isolation Area of the Unit from the outside, without entering the main waiting area. During pandemics there should be clear signage to indicate that all incoming patients must first present to the Visual Triage before entering the main waiting areas.

Waiting Areas

The Waiting Area should provide sufficient space for waiting patients as well as relatives/ escorts. The recommended area for Waiting is 1.5 m^2 per 1,000 attendances per annum or 15m2 as a minimum guide. The area should be easily observed from the Triage and/ or Reception areas. Seating should be comfortable and adequate. Space should be allowed for wheelchairs, prams, walking aids and patients being assisted. There should be an area where children may play.

Support facilities such as a television should also be available. Fittings must not provide the opportunity for self-harm or harm towards staff.

From the Waiting Area there must be access to:

- Triage and Clerical Reception Areas
- Toilets
- Baby Change Room
- Light refreshment facilities which may include automatic beverage dispensing machines and water dispensers
- Health literature
- During pandemics patients and their supporters can enter the main Waiting Area only after presenting to the external Visual Triage and being cleared by the Triage Nurse.

In large Units (30 beds or more), it is desirable to have separate Waiting Areas particularly for children. Child play areas shall provide equipment suitable for safe play activities, including a television. It shall be separated for sound from the general Waiting Rooms and must be visible to the Triage Nurse.

The area should be monitored to safeguard security and patient well-being.

All Waiting Area seats must be visible from the Reception or Triage Station(s).

Triage

This section refers to the Triage facility which is located inside the facility and off the waiting area. For the external Visual Triage, refer to the section under “Entrance” above.

Upon the entry of ambulant patients into the Emergency of Urgent Care Unit, Triage rooms must be easily visible and clearly signposted as the first point of contact.

The Triage may be immediately adjacent to the Reception desk and should have clear a vision to the Waiting Room and the ambulant entry point. The same triage rooms may have rear access to the ambulance entrance and ambulance triage area. The Triage nurse may interview patients, perform observations and provide first aid in relative privacy in a Bed Bay or Triage Cubicle. Triage must include an examination couch with appropriate privacy screening.

Reception / Clerical Areas

The Reception Area is required to accommodate:

- Reception of patients and visitors
- Registration interviews of patients
- Clinical records
- Printing of identification labels.

The counter should provide seating and be partitioned for privacy at the interview area. There should be direct communication with the Reception / Triage area and the Staff Station in the Acute Treatment / Observation Area.

The Reception/Clerical Area should be designed with due consideration for the safety of staff. This area requires a duress alarm easily accessible by staff and CCTV monitoring is recommended. The Reception desk should be located where staff can observe and control access to treatment areas, pedestrian and ambulance entrances, and public waiting areas. The Reception should have direct observation of Waiting areas and Paediatric play areas if provided.

Fast Track/ Consultation

If a Fast Track/ Consultation Service is to be provided according to the service plan, the following facilities may be provided:

- Consulting / Examination room/s – these may be generic or some of them may be specialised for common specialities such as ENT or Ophthalmology, as defined in the service plan
- Bed/ Chair Bays for patients as required and according to the size of the service
- Staff Station; dependent upon the size of the service
- Pathology Bay or Pneumatic tube for rapid transportation of samples to Laboratories, that may be located at the Staff Station

Fast Track consultation rooms are required in standalone Urgent Care Units.

Facilities that may be shared with the Emergency and Urgent Care Unit include

- Entrance and Reception; this may be a shared facility with the hospital or other specialty departments
- Waiting Area may be shared and a sub-waiting space may be provided
- Treatment Room/s
- Dirty Utility/ Disposal Room
- Storage; as required
- Staff Room
- Toilets and Change Rooms; may be shared with the Emergency Unit and the hospital

Consultation Rooms are to be provided according to Unit size and requirements for examination and treatment of ambulant patients. Consult Rooms are to comply with Standard Components - Consult Room.

Environmental Requirements: special attention is to be given to the visual and acoustic privacy of patients when being interviewed and also to the quality of light when being examined (the latter requires adequate natural light or colour corrected artificial lighting or task lighting)

Construction, finishes, design for disabled access, parking, signposting, etc. shall be in accordance with the other relevant sections of these Guidelines.

Fast Track is best located between the Emergency or Urgent Care waiting area and the interior of the unit. Ideally the rooms should have double access from the waiting area as well as a rear corridor within the unit.

Patient Resuscitation/ Treatment Areas

Decontamination Area

Emergency Units will require a Decontamination area for patients who are contaminated with toxic substances. This requirement is mandatory for Units at RDL 4 to 6. This area may be integrated with the Ambulance bay/s or directly accessible from the ambulance bay/s without entering any other part of the unit. The Decontamination area may consist of shower heads in a section of the Ambulance bay ceiling or a dedicated internal room with pass-through hatch access and a shower hose spray. For any hospital that may be called upon for major disaster management, consider providing large external decontamination area with deluge showers.

Additional requirements include:

- A retractable plastic screen to contain the water flow if located in an external area.
- A flexible water hose, floor drain and contaminated water trap; all water flowing out of such a decontamination area shall be treated as contaminated water and treated accordingly.

Resuscitation Area

The Resuscitation Room/ Bay is used for the resuscitation and treatment of critically ill or injured patients. The Resuscitation Room/ Bay requires:

- Space to fit a specialised resuscitation bed
- Space to ensure 360-degree access to all parts of the patient for uninterrupted procedures
- Circulation space to allow movement of staff and equipment around the work area
- Maximum possible visual and auditory privacy for the occupants of the room and other patients and relatives
- Easy access from the ambulance entrance and separate from patient circulation areas
- Easy access to the Acute Treatment/Observation area from the Staff Station
- A full range of physiological monitoring and resuscitation equipment
- Workbenches, storage cupboards, X-ray viewing facilities (or digital electronic imaging system) and computer access
- Access to dirty utility and disposal facilities
- Solid partitions between this and other areas are recommended.

Each Resuscitation Bay should be equipped with:

- Service panel, service pendants or pods to maximise access to patients
- Physiological monitor with facility for ECG, printing, NIBP, SpO^2, temperature probe, invasive pressure, CO^2 monitor
- A procedure light similar to a small, single arm operating light
- Equipment to hang IV fluids and attach infusion pumps
- Resuscitation patient trolley
- Wall mounted diagnostic set (ophthalmoscope/ auroscope)
- Clinical scrub basin with paper towel and soap fittings

Imaging facilities should include:

- Overhead X-ray or mobile digital x-ray
- X-ray screening (lead lining) of walls and partitions between beds
- Patient resuscitation bed/ trolley with X-ray capacity

The exact number of Resuscitation bays should be based on the facility Service Plan and projected number of Emergency presentations per annum. As a general guide for the Service Plan, the following minimum numbers may be considered:

- Up to 15,000 presentations: 1 Resuscitation room
- Up to 25,000 presentations: 2 Resuscitation rooms
- Up to 50,000 presentations: 3 to 4 Resuscitation rooms
- Up to 100,000 presentations: 4 to 5 Resuscitation rooms
- More than 100,000 presentations: It is best to provide a separate Emergency Unit to serve the community within the recommended access time of 15 minutes.

In hospitals designated or specialised as a Trauma Hospital, consider one more resuscitation room added to each of the above numbers.

It should be noted that at the time of design and before the facility reaches its maximum operational maturity, the exact number of presentations per annum cannot be guaranteed. Therefore, this is only a Service Planning guide, not a guide that can be verified at the time of design.

Trauma Rooms

Trauma rooms are required for the immediate treatment of trauma injuries which do not require resuscitation. Such trauma treatment requires maximum privacy and therefore Trauma rooms must

be fully enclosed but with glass front for observation. They shall be located close to the ambulance entrance and resuscitation bays.

Trauma room requirements are as follows:

- Bedroom to fit a standard mobile bed
- Solid side and rear walls; glazed front wall with glazed sliding or swing doors
- Storage space for essential equipment and supplies used at the bedside
- Fixed monitors
- Service panel with medical gases, power and data
- Examination light; the examination light must be a high standard focused light with a power output of 30,000 lux, illuminate a field size of least 150 mm and be of robust construction
- Wall mounted sphygmomanometer
- Waste bins and sharps containers
- Patient call and emergency call facilities.
- Hand Wash Basins

Acute, Sub-Acute and Non-Acute Treatment Areas

Acute Treatment Areas are used for the management of patients with acute illnesses. Non-acute Treatment Bays are provided for patients who are not critical but require observation or investigation prior to discharge. Requirements are as follows:

- Bed Bays to fit a standard mobile bed; either solid walls or privacy curtain separation. It is recommended that at least 50% of the treatment bays be enclosed.
- Storage space for essential equipment and supplies used at the bedside
- Space to allow monitoring equipment to be housed

The allocation of bays as non-acute or acute treatment bays shall be determined based on the daily patient volume and acuity. This allows clinical capacity to be optimised for real-time reassignment to match shifting operational demands and patient needs.

All Treatment bays including Triage, require the following:

- Service panel with medical gases, power and data
- Examination light: the examination light must be a high standard focused light with a power output of 30,000 lux, illuminate a field size of least 150 mm and be of robust construction
- Wall mounted sphygmomanometer
- Waste bins and sharps containers
- Patient call and emergency call facilities

Patient Toilets/ Showers

The following Patient Toilet facilities will be required (gender separated where required to accommodate cultural requirements):

- Up to eight treatment bays – one Patient Toilet
- Between nine and 20 treatment bays – two to three Patient Toilets
- Between 21 and 40 treatment bays – four to five Patient Toilet
- More than 40 treatment bays – six Patient Toilet
- At least two of the above Toilets to be Accessible for wheelchairs

Support Areas

Support areas include Clean and Dirty utilities, Disposal room, Bays for linen, handwashing, mobile equipment and resuscitation trolley and Store Rooms to comply with Standard Components as identified in the Schedule of Accommodation.

Staff Station/s

The Staff Station/s should have an uninterrupted vision of the patients. It should be centrally located and may be constructed with an enclosed area to ensure confidential information can be conveyed without breach of privacy and to provide security to staff, information and privacy. It shall be ergonomically designed. The use of sliding windows and adjustable blinds can be used to modulate external stimuli and a separate write-up area may be considered.

Pathology Bay

A designated area for performing immediate laboratory investigations such as arterial blood gas analysis and microscopy should be considered in Units of Role Delineation Levels 4 to 6. This shall be separate from patient care areas. Mechanical or pneumatic tube transport systems for specimens and electronic reporting of results are recommended.

Medication Room

A Medication Room is required for the storage of medications used within the Emergency Department. Entry should be secure with a self-closing door. The area should be accessible to all clinical areas and have sufficient space to house a drug refrigerator for the storage of heat sensitive drugs. The drug refrigerator should be temperature monitored and alarmed. Controlled or dangerous drugs must be kept in a secure cabinet within the medication room. Access shall be restricted to authorised staff via keypad or swipe card.

Isolation Area

The Isolation Area is a relatively self-sufficient area with dual access from inside and outside the Unit. The Isolation Area will have the following components:

- Isolation Consultation/ Examination/ Treatment rooms
- Anteroom to the Isolation room
- Ensuite bathroom with access from the Isolation room
- Isolation Reception
- Waiting area
- Accessible public toilets
- Clean Utility
- Dirty Utility
- Store

Optional Areas

Inclusion of the following optional areas is dependent on the clinical services plan.

Paediatric Assessment / Short Stay

This dedicated paediatric area is also referred to as the Paediatric Pod. A separate zone must be provided at RDL 5 and 6 hospitals but optional in RDL 3 and 4 hospitals. The area shall be customised for paediatric patients with:

- Controlled access for the safety and security of paediatric patients
- Paediatric play area, within the zone
- Paediatric Consult rooms
- Bed/ cot bays and chair bays for nebuliser therapy
- Staff Station with direct visibility to all treatment bays and areas
- Support areas contained within the zone for staff convenience.

Maternity Assessment/ LDR

This area is devoted to providing emergency maternity care. A separate zone is optional in RDL 3 to 6 hospitals. The area shall compromise of:

- Obstetric assessment rooms, with early labour evaluation
- Labour, Delivery and Recovery (LDR) rooms

- Controlled access for the safety and security of neonates
- Staff Station with direct visibility to all treatment bays and areas
- Support areas contained within the zone for staff convenience

For remote emergency units serving populations without nearby obstetric services, at least one room capable of maternity assessment and delivery shall be provided.

Acute Mental Health & Behavioural Assessment Area

The patient suffering from an acute psychological or psychiatric crisis has unique and often complex requirements. An Emergency Unit should have adequate facilities for the reception, assessment, stabilisation and initial treatment of patients presenting with acute mental health problems.

It is not intended that this be used for prolonged observation of uncontrolled patients. The main purpose of such an area is to provide a safe and appropriate space to interview and stabilise patients. Acute mental health presentations have the potential to disrupt the normal operation of an Emergency Unit. Conversely, the busy environment of an Emergency Unit may not be conductive to the care of patients with acute mental health crises.

Patient flows should be separated where possible to maximise privacy and minimise disruption. A separate secure entrance for use by community emergency mental health teams and police may be desirable. Patients should be continuously observable by staff either directly or via closed circuit television.

The designated area should be within close proximity of other continuously staffed areas of the department, with ready access to assistance when required. As far as possible, the facility should not contain objects that could be thrown at staff. There should be two separate exits to allow the exit of staff if one exit is blocked by an aggressive patient. The exit doors should open outwards, and should be lockable from the outside but not from the inside. If a window is incorporated, any drapes or blinds shading the window should be operable from outside. All areas should have easily accessible duress alarms.

As far as possible, the area should be free of heavy or breakable furniture, sharp or hard surfaces which could injure an uncontrolled patient and should incorporate tamper resistant electrical fittings. It should also incorporate interior design features that promote calmness, such as muted colours and soft furnishings and appropriate lighting. Patient tracking devices may enhance security.

The Acute Mental Health & Behavioural Assessment Area should be separate enough from adjacent patient care areas to allow privacy for the mental health patient and protection of other patients from potential disturbance or violence. There should be acoustic and visual separation from adjacent clinical areas, but ready access for staff in the event of an urgent need for intervention. The incorporation of sound-insulating material is recommended.

Ideally the area should contain at least two separate but adjacent areas:

- Interview Room (Mental Health) with:
  - Two exit doors, swinging outward and lockable from outside, to allow for the escape of staff members when one exit is blocked; one door should be large enough to allow a patient to be carried through it; consideration should be given to solid core doors with safety viewing glass.
  - Design that permits observation of the patient by staff outside the room at all times; this may be backed up with closed circuit television for the safety of staff.
  - Acoustic shielding from external noise
  - Soft furnishings with no hard edges
  - No patient access to air vents or hanging points
  - Smoke detectors fitted
  - Duress alarm at each exit.
- Treatment room (Mental Health) with the following features:
  - The room should be immediately adjacent to the Interview room and should contain adequate facilities for physical examination of the patient; however, the inclusion of

unnecessary and easily dislodged equipment should be avoided; a lockable retractable door or panel to services is recommended.

- If operational policy dictates that intravenous sedation is to occur in this area, the room should include appropriate facilities and monitoring equipment, mounted out of reach of a potentially violent patient. The room should contain the minimum of additional fittings or hard furnishings that could be used to harm an uncontrolled patient. It should be of sufficient size to allow a restraint team of five people to surround a patient on a standard Emergency Unit bed and should be at least 14 m2 in floor area.

Emergency Observation/ Emergency Short Stay Unit (ESSU) / Emergency Medical Unit (EMU)/ Clinical Decision Unit (CDU).

This facility may be provided either within or adjacent to the Emergency Unit for the prolonged observation and ongoing treatment of patients leading to a decision to discharge (directly from the Emergency Unit) or admission to the hospital inpatient areas. The Unit may also be situated separately to the Emergency Unit, although functionally linked and easily accessible via corridors or lifts.

Patients may be kept in this Unit for diagnosis, treatment, testing or for medical stabilisation. The length of stay in the Unit is generally between 4 and 24 hours, although Unit policy may allow longer stays.

According to the service plan, dedicated beds for short stay are separately designated and staffed. The types of patients planned to be admitted to this Unit will determine the number and type of beds provided, and the design of associated monitoring and equipment. Staff Stations, work and storage and other support areas will need to be available and may be shared if the unit is located physically close to other treatment areas. The unit shall maintain appropriate staff to patient ratios and provide continuous observation, either through line of sight or remote monitoring. Physiological monitoring equipment shall be available at each bed.

Satellite Medical Imaging

Many Emergency Unit patients will require a Medical Imaging scan. Depending on patient volume and to avoid disrupting the outpatient appointment booking system there may be a need to establish a satellite medical imaging facility within the Emergency Unit. The most commonly required imaging modality is X-ray.

Ambulance Service Requirements

Specific requirements of the Ambulance Service(s) serving the area shall be obtained and complied with. These requirements relate to areas such as ramp gradients (if any), ambulance parking/ unloading area gradients, height clearance and ambulance bay dimensions.

Specific information about emergency vehicles and ambulances that will be used for the facility should be acquired from local public and private Ambulance Services.

The following consideration shall be given while designing the Ambulance areas:

- Access for Ambulances shall not conflict with other vehicular or pedestrian traffic
- The Ambulance access shall be located away from public entrances and shall be reasonably screened from public view; a separate entrance is required and cannot be shared with the Main Public Entrance
- The Ambulance access is to be directly connected to the Emergency Unit; an air lock shall be provided between the inside and the outside; Ambulance access to the Emergency Unit shall not be via hospital corridors that are open for public access.
- The Ambulance collection/ drop off points must be discreet and shall be covered
- A lockable storage cupboard or room no less than 2 m^2 shall be provided for Ambulance supplies. The cupboard or room shall have adjustable shelves and be lockable with a separate key or keypad lock.
- A hose cock with attached hose shall be located close to an Ambulance bay for washing down the vehicle or trolleys; it is recommended that the hose cock and hose be located in a discrete cabinet or recessed bay.
- An intercom system shall be provided between the Ambulance door and the Emergency Unit Reception/Clerical Area, Triage Area or Staff Station; the Intercom system shall be integrated

with a security CCTV system located to clearly show those requesting entry.

- All Ambulance Bays shall be clearly marked and sign-posted; the external signage system shall direct ambulances and vehicles carrying emergency cases to the Ambulance Bays. These signs shall be clearly visible at the entrance to the Hospital and/or any major change of direction. Signs directed to ambulance bays intended for emergency units or birthing units shall be permanently lit during the night. In order to avoid confusion, the signage system shall be designed in such a way that ambulant patients, including ambulant access to an emergency unit are not to be directed to the ambulance bay or ambulance door.
- All Ambulance Bays shall be covered to provide weather protection and infection control during patient transfer.
- In RDL 5-6 hospitals a Communications Room is required, for up to three ambulance officers to communicate between major hospital centres and the ambulance service for coordination of Ambulance movements; the communications base is also a critical co-ordination centre in the event of a disaster.
  - The room should be immediately adjacent to the Ambulance entry of the Emergency Unit with direct line of sight to incoming ambulance vehicles and the parking bays.
  - The room shall include workstation benches and chairs for 3 people, telephones, computer and radio communications systems.

Functional Relationships

A Functional Relationship can be defined as the correlation between various areas of activity which work together closely to promote the delivery of services that are efficient in terms of management, cost and human resources. Correct Functional Relationships are identified below for both Emergency Units and Urgent Care Units.

External

The Emergency Unit will require close and efficient access to the following units:

- Medical Imaging Unit: The Medical Imaging Unit is to provide general X-Ray diagnostic investigations and other diagnostic screening services such as fluoroscopy, ultrasound, mammography, computed tomography (CT), magnetic resonance imaging (MRI) and other interventional radiographic procedures and immediate access to those modalities are highly recommended for effective Emergency Unit's operational procedure. Medical Imaging may be provided as a satellite facility within the Emergency Unit dependent on patient volume.
- Clinical Information Unit – Patients' previous medical records are required to provide holistic care in Emergency Department. In order to minimise delays and labour costs, a mechanical or electronic record transfer system is recommended. 24 hours per day access to Clinical Information Unit is essential.
- Birthing Unit - for labour, deliveries and care for patients with antepartum complications
- Operating Unit – to transfer patients requiring emergency surgical procedures
- Cardiac Investigation Unit (particularly Cardiac Catheter Laboratories) – for patients who require further cardiac services consultation, diagnostic procedures, and interventional treatments
- Intensive Care Unit / Neonatal Intensive Care Unit/ High Dependency Unit/ Coronary Care Unit - for admission of patients with severe conditions requiring close monitoring or life support

Ready access is required to the following:

- Inpatient Accommodation Units – for admissions of medical and surgical patients
- Outpatients Unit - for patient follow-up and referrals for further investigation and ongoing review for non-admitted patients
- Service Units including:
  - Catering Unit – for providing meals, beverages, and snacks for patients
  - Mortuary – to transfer deceased patients for storage and undertaking post-mortem examination / autopsies

- Laboratory Unit – for sending patient specimen for testing and examination, this may be an automated link such as pneumatic tube system
- Pharmacy Unit – pharmacy services for dispensing medications for discharged patient and enabling prescriptions to be filled by patients
- Sterile Supply Unit – to obtain sterile equipment for surgical emergencies in Emergency Department

For Remote Emergency Units, X-Ray, CT and ultrasound are required on site within the facility, as well as basic blood bank services, a small laboratory with conventional testing or point of care testing capability, a designated area for paediatric patient assessment and treatment, at least one room capable of maternity assessment and delivery, mental health assessment and, if deemed required by local authorities, decontamination facilities.

These key external functional relationships are demonstrated in the diagrams below including the following:

- Separate entries are provided for ambulant and ambulance patients
- Public entry is in close proximity to urgent short-term parking
- Rapid and ready access to key clinical units such as Operating Unit, Birthing Unit, Cardiac Catheter Labs, ICU/ NICU/ HDU/ CCU for patient treatment and transfers via service corridor
- Ready access to Inpatient Units for patient transfer via service corridor
- Access to Outpatients Units via a public corridor
- Access to support untis including Clinical Information Unit, Supply, Sterile Supply Housekeeping, Catering Waste managmenent and Mortuary should be readily accessible for staff via a service corridor
- Access to diagnostic units such as Laboratory and Pharmacy via a service corridor and may be via a pneumatic tube or automated transport system.

Internal

Within the Unit, key functional relationships include the following:

- The design should allow for rapid access to every space with a minimum of cross traffic
- There must be close proximity between the Resuscitation / Acute Treatment areas for non-ambulant patients, other treatment areas for ambulant and non-ambulant patients, so that staff may be relocated at times of high workload
- Visitor and patient access to all areas should not traverse clinical areas
- Protection of visual, auditory and olfactory privacy is important whilst recognising the need for observation of patients by staff.

The optimal internal relationships are outlined in the diagrams below and include the following:

- Triage and Waiting located at the Public Entry of the Unit; Ambulance Triage located at the Ambulance Entry
- Direct link from Ambulance Entry, to Decontamination, Ambulance Triage and Resuscitation areas
- Close proximity of Resuscitation and Patient Treatment Areas
- Patient treatment areas divided into Fast Track, Acute/ Non-acute Care/ Observation, with the addition of specialist areas such as Paediatrics, Maternity, Mental Health and Short Stay Unit in larger Emergency Units
- Staff Station/s located centrally within Treatment Areas, with direct oversight of Resuscitation, Acute Treatment and Non-acute Treatment bays
- Access from all Patient Treament and Consult areas to the Integrated Medical Imaging facilities
- Support areas for Treatment zones located adjacent to the zones for ready access
- Staff amenities and Administration may be accessed externally from staff/ service corridors and located on the perimeter of the Unit

Urgent Care Units which are not attached to Hospitals or Clinics may use outsourced services for Sterile Supply Unit, Mortuary and various housekeeping functions. They may also partially outsource services for Medical Imaging, Pharmacy and Laboratory. Therefore, the external relationships remain, although not in the same facility or campus. The below external and internal relationships apply.

External

Urgent Care Units will require access to the following:

- Convenient access to drop off zone/ car park and Main Entry
- Outpatients Unit, where available as part of the facility, for patient follow-up and referrals for further investigation

The optimum external relationships are demonstrated in the diagrams below and include the following:

- Separate entries are provided for ambulant and ambulance patients
- Public entry is in close proximity to urgent short-term parking
- Access to Outpatients Units and Outpatient Pharmacy, where available, shall be via a public corridor

Urgent Care Units that are not part of a hospital facility will require access to the following:

- Other public healthcare facilities, such as local hospitals
- A service entrance for deliveries and waste removal
- Off-site healthcare services, such as Medical Imaging, Pharmacy and Laboratory, where these are partially outsourced. For medium-sized Urgent Care Centres, access to a small outpatient pharmacy may be provided
- Support services such as Sterile Supply Unit and Mortuary
- Access to support untis including Housekeeping, Waste Managmenent and Stores should be readily accessible for staff via a service corridor
- Access to deliveries should be via a service corridor

Internal

In the case of small Urgent Care Units, many rooms may have multiple functions. Some functions may also be outsourced as mentioned earlier. The internal planning of an Urgent Care Center shall include the following:

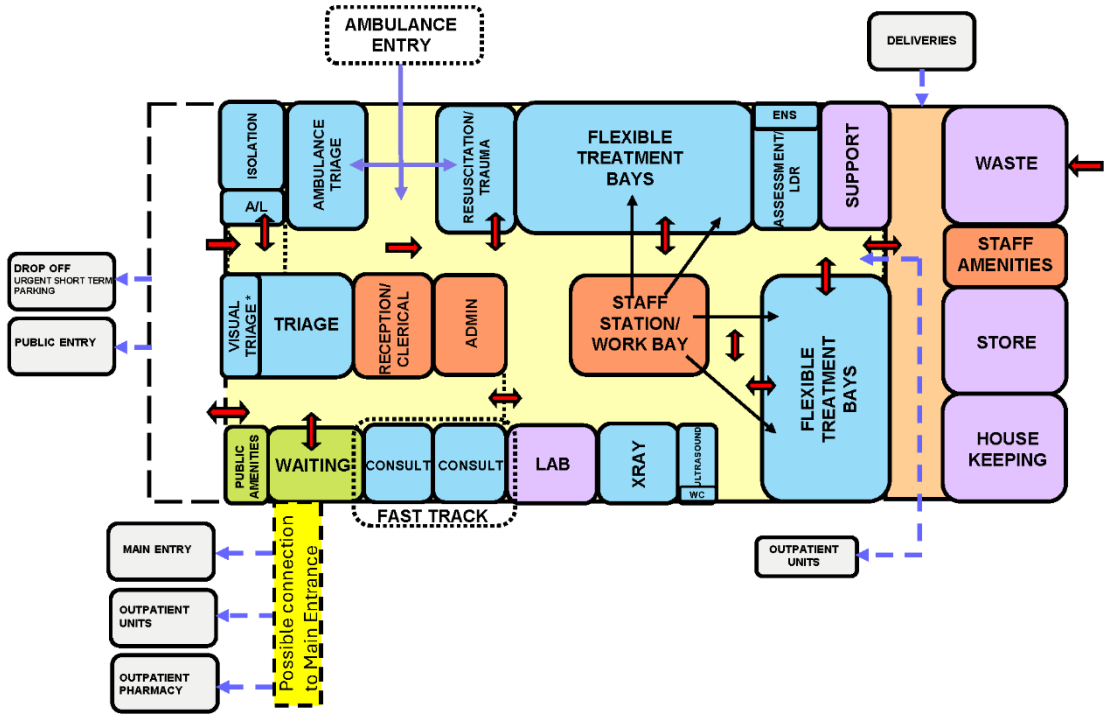
- Reception/ Clerical Areas should have a direct view of the entry and waiting areas and should be clearly visible to patients and visitors
- Triage and Waiting located at the Public Entry of the Unit; Ambulance Triage located at the Ambulance Entry
- Direct link from Ambulance Entry to Ambulance Triage and Resuscitation areas
- Close proximity of Resuscitation and Patient Treatment Areas
- Patient treatment areas divided into Fast Track and Flexible Treatment Bays to accommodate the assessment, treatment and observation of patients with both acute and non-acute conditions, as required
- Direct access to the isolation area from the outside with controlled access from inside the unit
- Staff Station/s located centrally within Treatment Areas, with direct oversight of Resuscitation and Treatment bays
- Access to support areas from the treatment zone
- Staff amenities and Administration may be accessed externally from staff/ service corridors and located on the perimeter of the Unit

Urgent Care Units that are not part of a hospital facility will also require the following internal relationships:

- At least one labour and delivery assessment room for labour, deliveries and care for patients with antepartum complications
- Access from all Patient Treament and Consult areas to X-ray and Ultrasound services
- Access to basic laboratory functions necessary to support the assessment and management of urgent care patients including point of care testing, basic haematology, chemistry and coagulation testing. It should also include specimen collection, storage, and transportation, with access to an external laboratory service for investigations that are not performed on site, with defined arrangements for specimen transport, result reporting, critical-result notification and clinical follow-up

Functional Relationship Diagrams

Urgent Care Unit – Standalone

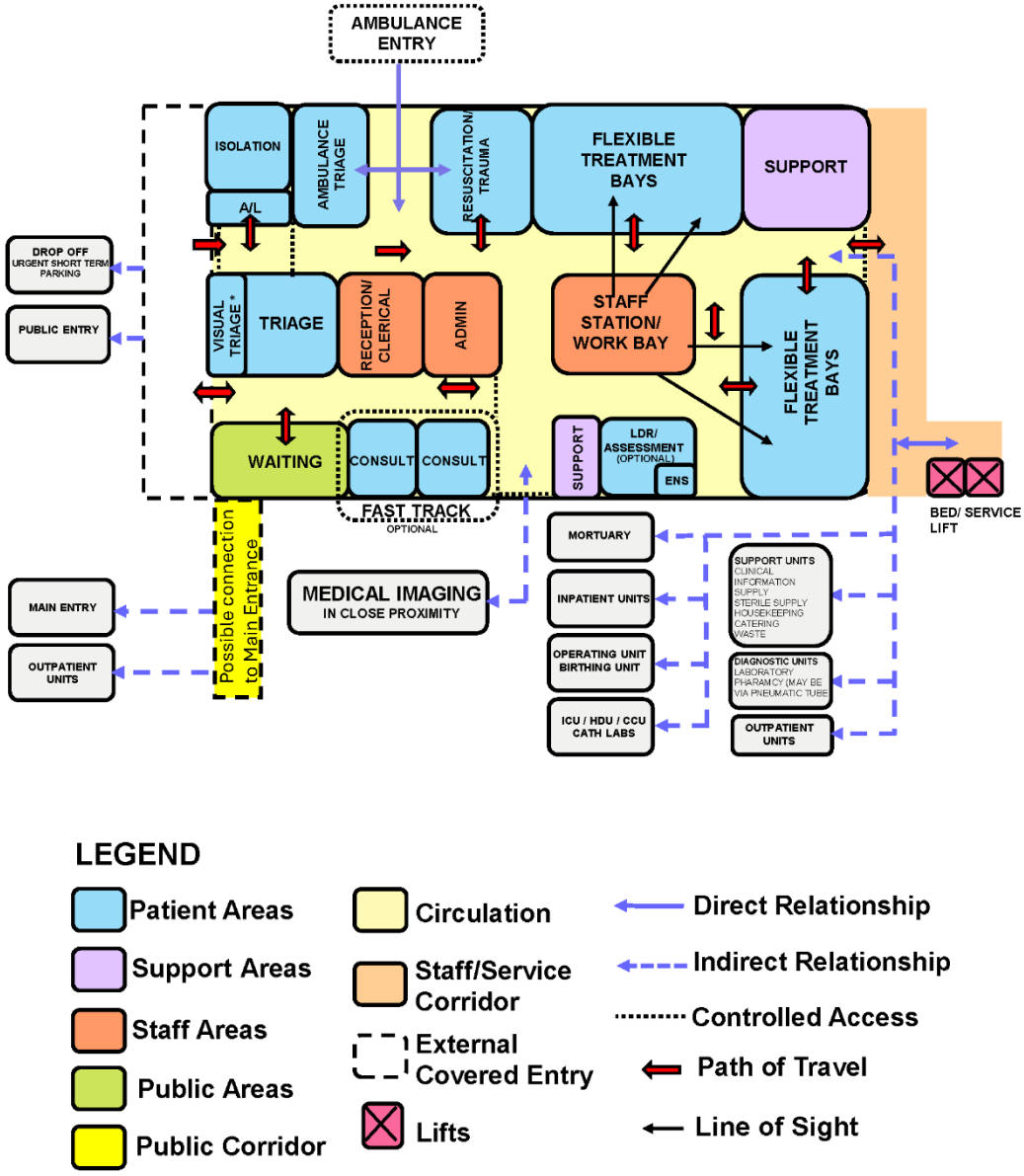


LEGEND

- Patient Areas
- Support Areas
- Staff Areas
- Public Areas
- Circulation
- Staff/Service Corridor
- External Covered Entry
- Public Corridor
- Direct Relationship
- Indirect Relationship
- Controlled Access
- Path of Travel
- Line of Sight

* Note: Visual triage, separate entrance and controlled corridor access for infectious patients is optional in Urgent Care Units

Urgent Care Unit within a Hospital



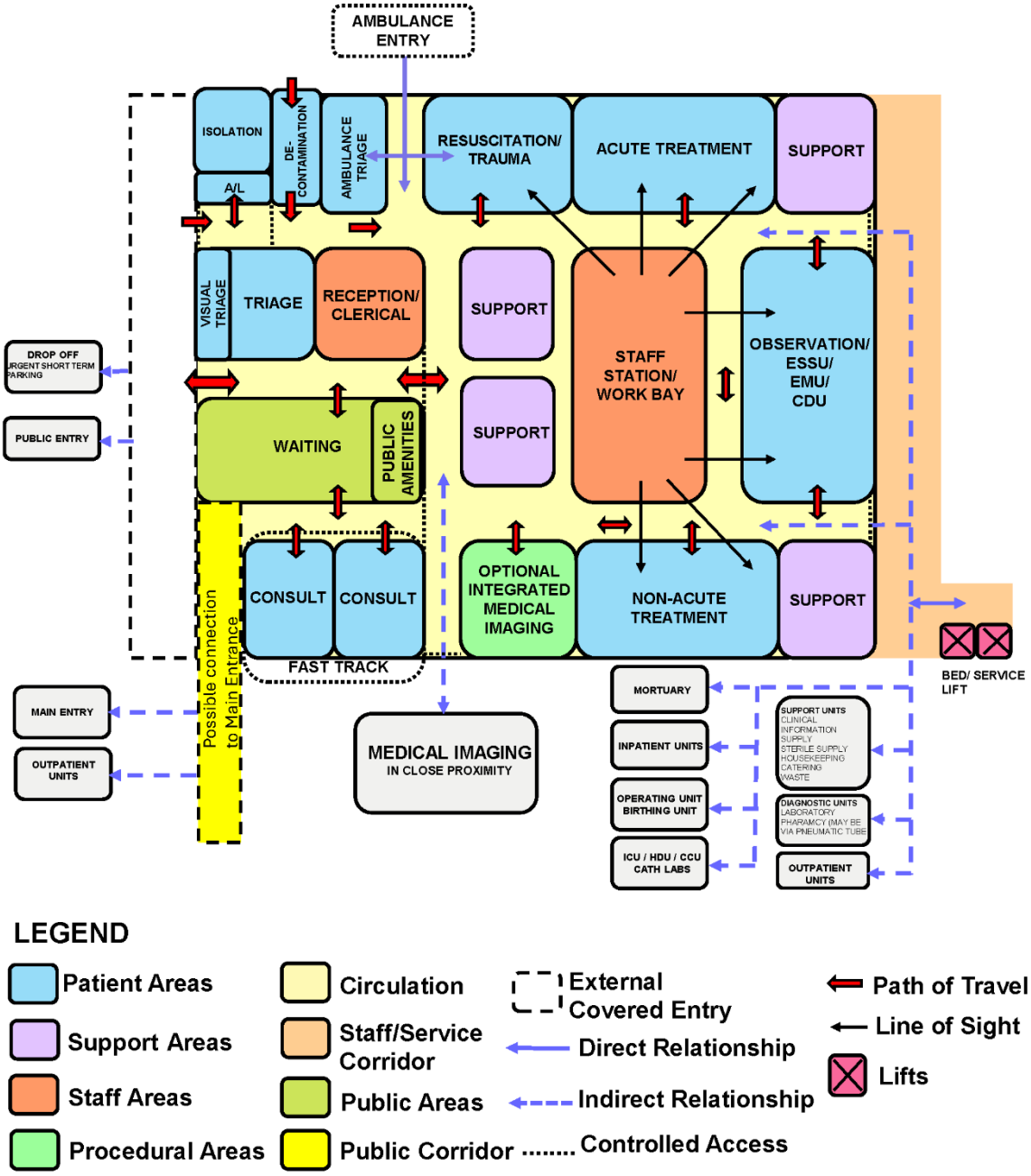
LEGEND

- Patient Areas
- Support Areas
- Staff Areas
- Public Areas
- Public Corridor
- Circulation
- Staff/Service Corridor
- External Covered Entry
- Lifts
- Direct Relationship
- Indirect Relationship
- Controlled Access
- Path of Travel
- Line of Sight

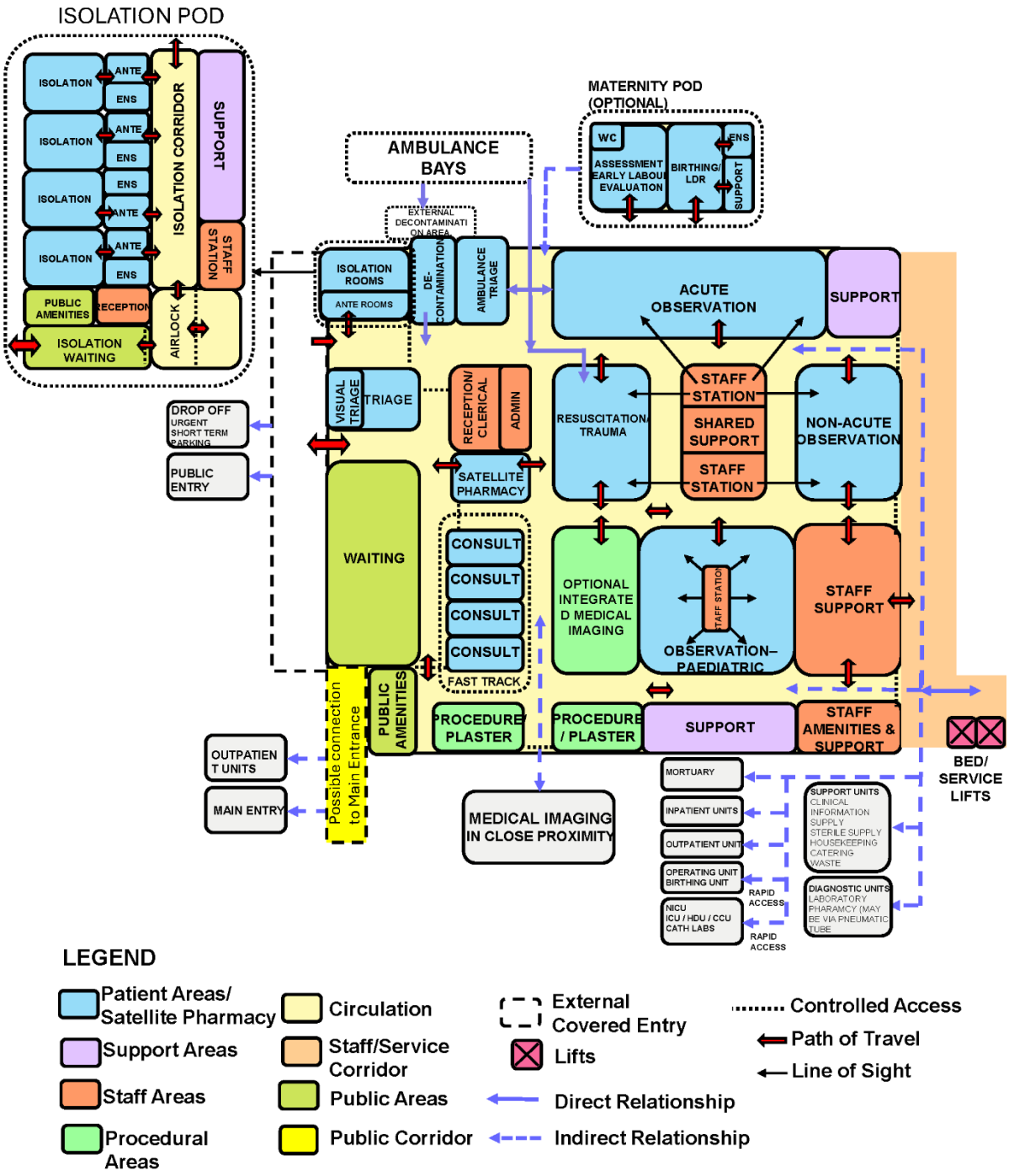
* Note: Visual triage, separate entrance and controlled corridor access for infectious patients is optional in Urgent Care Units

Emergency Unit - Small: (nominal 5 to 10 Treatment spaces)

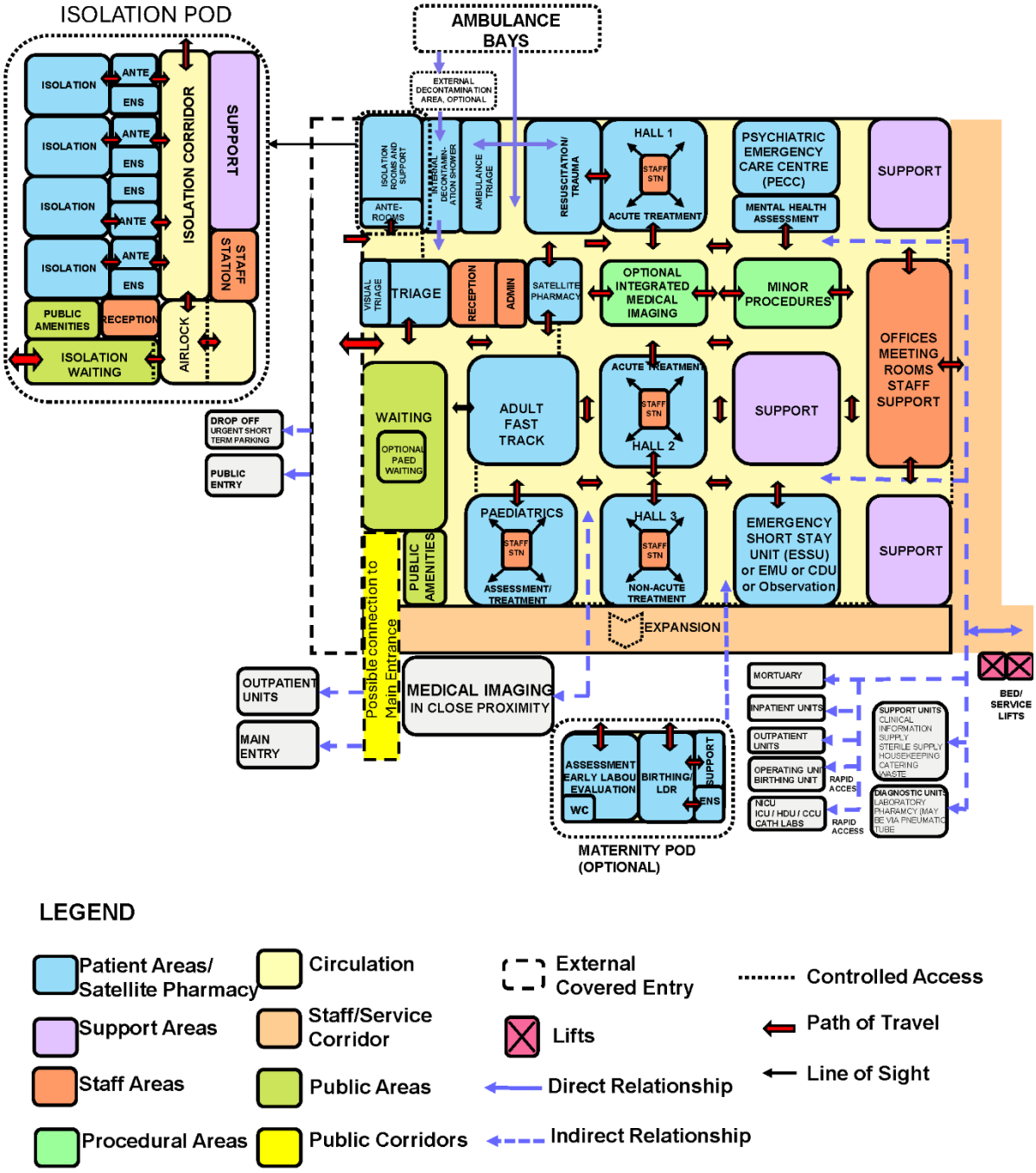
Services at RDL 1 - 3 are classified as Urgent Primary Care and may be delivered in an Urgent Care Centre



Emergency Unit - Medium: (nominal 11 to 35 Treatment spaces)



Emergency Unit - Large: (nominal 40 to 100 or more Treatment spaces)



4 Design Considerations

General

External Signposting

The emergency unit should be clearly identified from all approaches. Signposting that is illuminated is desirable to allow visibility at night. The use of graphic and character displays such as a white cross on a red background is encouraged.

Car Parking

Car parking should be close to the Entrance, well-lit and available exclusively for patients, their relatives and staff. Parking areas should be available close to the Emergency Unit for urgent call in staff.

The number of parking spaces shall be determined in accordance with the applicable local planning, municipal, and transportation authority requirements.

Undercover, weather-protected car drop-off should be available for:

- Ambulance drop-off for the Emergency Unit or patients transfers to other part of the facility
- Taxis and private vehicles that drop off/pick up patients adjacent to the ambulance entrance.

Taxis and private vehicles drop-off should not be combined with the ambulance drop-off. They should be physically and visually separated.

Adequate ambulance drop-off bays should be provided. This is based on the estimated case load and the availability of ambulance access to other parts of the hospital for non-emergency patients or transfers.

A guide for the number of ambulances drop-off bays required by the number of Emergency beds is as follows:

- Up to 8 beds – 1 ambulance bay
- Up to 15 beds – 2 ambulance bays
- Up to 25 beds – 3 ambulance bays
- Up to 35 beds- 3-4 ambulance bays
- Up to 45 beds- 5 ambulance bays
- Up to 55 beds- 6 ambulance bays
- 65+ beds- based on traffic assessment

In this context, the bed count includes:

- Acute beds
- Sub-acute and non-acute beds
- Resuscitation bays
- Trauma beds
- LDR beds
- Observation/ ESSU/ EMU/ CDU beds

The following are not counted as a bed:

- Triage beds
- Fast Track consultation beds

Patient Treatment Areas

Patients must be situated so that healthcare providers have direct visualization, as far as possible. This permits the monitoring of patient status under both routine and emergency circumstances. The preferred design is to allow a direct line of vision between the patient and the Staff Station. In large Emergency Units, treatment bed areas may be designed in clusters with a centralised staff station with maximum direct visibility of patients.

Treatment spaces may be fully or partially enclosed to ensure that confidential information can be conveyed without breach of privacy and to provide security to staff.

Treatment bed spaces should be designed as acuity adaptable - to suit any patient acuity in order to provide maximum flexibility for patient placement within the Unit.

Paediatric Treatment Zone

Paediatric assessment and treatment should be designed as a separate zone and have restricted access for safety and security of paediatric patients.

Paediatric Bed Bays should be provided at the same size as adult bed bays in order to provide future flexibility.

Environmental Considerations

Acoustics

Clinical Areas should be designed to minimise the ambient noise level within the Unit and the transmission of sound between adjacent treatment areas. Consideration should be given to the location of noisy areas or activity, preferably placing them away from patient bed bays.

The following areas will require acoustic consideration:

- Consult/ Interview and triage areas for discussions / interviews with clients
- Bereavement rooms
- Seclusion and psychiatric assessment rooms
- Treatment and Procedure Rooms
- Waiting areas
- Staff Stations
- Staff rest areas
- Toilets

Refer to Part G – Acoustics of these Guidelines for more information.

Natural Light

The use of natural light should be maximised throughout the Unit. Windows are an important aspect of sensory orientation and psychological well-being of patients and staff.

Natural light should be favourably considered when planning the Emergency and Urgent Care Unit in patient areas and is desirable in other support areas such as waiting and family areas.

Privacy

The design of the Emergency and Urgent Care Unit needs to consider the contradictory requirement for staff visibility of patients while maintaining patient privacy. Unit design and location of staff stations offer varying degrees of visibility and privacy. The patient acuity and their correlating treatment zones are a major influence.

Each treatment space shall be provided with bed screens to ensure privacy of patients undergoing treatment in both private and shared areas. Refer to the Standard Components for examples.

The following features shall be integrated to the design of the Unit:

- Doors and windows to be located appropriately to ensure patient privacy and not comprise staff security
- Discreet spaces to enable confidentiality of discussions related to a patient and storage of patients' medical records
- Privacy screening to bed and chair bays
- Consultation, Interview bays, Resuscitation bays and Patient bed bays should not be visible from public or waiting areas; examination couches should not face the door.

Space Standards and Components

Accessibility

Design should provide ease of access for wheelchair bound patients to Reception desks, Staff Stations, Consult Rooms and Interview/ Meeting Rooms. Waiting areas should include spaces for wheelchairs and suitable seating for patients with disabilities or mobility aids.

Doors & Corridors

Doors used for bed transfer to Operating Unit, Medical Imaging Unit, Critical Care Units and Inpatient Units, must be appropriately positioned and sized. A minimum of 1350mm clear opening (ideally 1400mm clear opening) is recommended for doors requiring bed/trolley access.

Corridor width in the Emergency Unit must allow the passage of two hospital beds without difficulty. There should be adequate space for trolleys to enter or exit Treatment, Procedure and Consult Rooms. Corridors should not be used for storage of equipment and bays provided for storage should not impede Corridor access.

Also refer to Part C - Access, Mobility and OH&S of these Guidelines.

Ergonomics/ OH&S

Consideration should be given to ergonomic functionality in the Unit. Benches and recording workstations should be provided at suitable working heights.

Refer to Part C – Access, Mobility, OH&S of these Guidelines for more information.

Size of the Unit

The size of the Emergency or Urgent Care Unit will be determined by the Clinical Services Plan establishing the intended services scope and complexity.

Schedules of Accommodation have been provided for typical small, medium and large facilities along with the typical Role Delineation that may apply to that size. Small, medium and large facilities are nominally defined as follows:

- Small: 5 to 10 treatment spaces (not including Procedure and Treatment Rooms)
- Medium: 11 to 30 treatment spaces
- Large: 31 to 100 or more treatment spaces.

Bed Spacing / Clearance

In open plan treatment bed areas there should be at least 2.4 metres in width per curtained bed bay, and a minimum of 900mm clear space at the foot of each bed.

If solid walls are used, then the minimum should be 2800 centre to centre of walls.

Drug Storage

Controlled or dangerous drugs must be kept in a secure cabinet with alarm according to operational and drug storage policies. The room should be secured with staff only access and may include CCTV surveillance.

A lockable refrigerator or a refrigerator located within a lockable room is required to store restricted substances.

Safety and Security

The Emergency Unit receives a large number of patients and their visitors, many of whom may be distressed, intoxicated or involved in violence. The hospital has a duty of care to provide for the safety and security of employees, patients and visitors. Both policies and structures should be in place to minimise injury, psychological trauma and damage or loss of property. The precise details of security features should be designed in conjunction with a security risk assessment for the specific site.

Security issues are important due to the increasing prevalence of violence in Emergency Departments and health care facilities.

The arrangement of spaces and zones shall offer a high standard of security through the grouping of like functions, control over access and egress from the Unit and the provision of optimum observation for staff.

The location of an office for security personnel near the entrance should be considered; security should be adjacent to the Emergency Unit; and the office may also be used by the police. This room should be positioned so that it allows Security Staff a clear view of the Waiting Room, Triage and Reception Areas. Immediate access to these areas is essential. Remote monitoring of other areas in the department by CCTV and of staff duress/personal alarms should also occur from this area.

Perimeter Access Control

Ambulatory and Ambulance entrances should be separate, with electronically operated locks. Access from the Waiting Areas to the treatment areas should be controlled. There should be restricted access from the remainder of the hospital into the Emergency Unit.

Reception / Triage Areas

The interface between the Waiting Areas and the Reception / Triage Areas should be carefully designed so as to permit communication and reassurance to distressed patients or visitors and yet provide safety and security for staff.

Counters should be of sufficient height and depth to minimise the possibility of them being jumped over or reached over.

The Reception Area should be designed so that staff may sit at eye level with standing patients or visitors. The Reception / Triage area should have an unobstructed view of the entire Waiting Area.

Fixed and/or personal duress alarms should be positioned in suitable areas as suggested by the security risk assessment, particularly Reception and Staff stations. Uniformed security personnel may be required at very short notice to assist with a safety or security issue.

Relatively secluded or isolated areas should be monitored electronically (for example, by closed circuit television), with monitors in easily visible and continuously staffed areas.

Finishes

In all areas where patient observation is critical, colours shall be chosen that do not alter the observer's perception of skin colour. The following additional factors should be considered in the selection of finishes:

- Acoustic properties
- Durability
- Ease of cleaning
- Infection control
- Fire safety
- Movement of equipment and impact resistance

Floor Finishes

The floor finishes in all patient care areas and corridors should have the following characteristics:

- Non-slip surface
- Impermeable to water, body fluids
- Durable
- Easy to clean
- Acoustic properties that reduce sound transmission
- Shock absorption to optimise staff comfort but facilitate movement of beds

Office/s, Tutorial Rooms, Staff Rooms, Clerical Areas and the Distressed Relatives' Room may be carpeted.

Wall Protection

Hospital beds, ambulance trolleys, and wheelchairs may cause damage to walls. All wall surfaces in areas which may come into contact with mobile equipment should be reinforced and protected with buffer rails or similar.

Refer to Part C and Part D of these Guidelines and Standard Components for more information on wall protection, floor finishes and ceiling finishes.

Fixtures, Fittings and Equipment

Window Treatments

Window treatments should be durable and easy to clean. Consideration may be given to use double glazing with integral blinds, tinted glass, reflective glass, exterior overhangs or louvers to control the level of lighting.

Privacy bed screens must be washable, fireproof and cleanly maintained at all times. Disposable bed screens may also be considered.

Clocks

Accurate tracking of time within the ED is critical. Wall clocks shall be provided and clearly visible in all clinical and waiting areas. Clocks in clinical areas shall be large digital clocks displaying time in a 24-hour format. All clocks within clinical areas shall be synchronised and centrally controlled through a master time system that is synchronised with the Electronic Medical Record (EMR) system, ensuring that the displayed time corresponds exactly to the time recorded by the EMR. Additionally, clocks in resuscitation areas shall be capable of displaying elapsed time.

Building Service Requirements

Mechanical Services (HVAC)

The Emergency Unit shall have appropriate air conditioning that allows control of temperature and humidity within each functional zone.

All HVAC units and systems are to comply with services identified in Standard Components and Part E – Engineering Services.

Medical Gases

Oxygen, medical air and suction will be required to each Acute Bed Bay, Non-acute bed Bay, Resuscitation Bay, Triage Bays, Procedure Rooms, Treatment Rooms, Consult Rooms for treatment and resuscitation. Oxygen/ nitrous oxide used in the Birthing Suite will require scavenging suction.

Information Technology (IT) and Communications

Emergency Units are high volume users of telecommunications and information technology. The following items relating to IT/ Communication shall be addressed in the design of the Unit:

- Electronic Medical Records (EMR) and Hospital Information Systems (HIS)
- Hand-held tablets and other smart devices
- Date entry scripts and investigation requests
- Picture Archiving Communications Systems (PACS)
- Paging and personal telephones replacing some aspects of call systems
- Public Address system and Paging system for staff and emergencies
- Duress systems, personal mobile duress systems may be considered
- Supply and records management systems including bar coding for supplies
- Wireless network requirements
- Videoconferencing and telemedicine requirements
- Communications rooms and server requirements

Nurse Call / Emergency Call / Staff Call

All patient spaces and clinical areas, including beds, toilets, bathrooms, treatment areas, patient day areas and lounges should have access to an emergency call facility so staff can summon urgent assistance. A patient call system should also be provided to allow for patients to alert staff in a discreet manner at all times.

All calls are to be registered at the Staff Stations and must be audible within the service areas of the Unit including Clean Utilities and Dirty Utilities as well as Staff Rooms etc. If calls are not answered the call system should escalate the alert accordingly. The Nurse Call system may also use mobile paging systems or SMS to notify staff of a call.

Telephones should be available in all offices, at all staff stations, in the clerical area and in all consultation and other clinical rooms. The use of multi-function, wireless communication devices should be considered. A dedicated telephone to receive admitting requests from outside medical practitioners is desirable.

Direct telephone lines bypassing the hospital switchboard should be available for use in internal and external emergencies or when the hospital PABX is out of service. The Staff Station should have a dedicated inward line for the ambulance and police services.

Patient Information Systems

An electronic Emergency Unit Information System may be installed to support clinical management, patient tracking and departmental administration. Sufficient terminals should be available to ensure that queuing does not occur, even at peak times. Workspace design should include sufficient bench-widths or suitable suspension devices for terminals, keyboards, drives and printers. Additional computer terminals, software and peripheral devices should be installed to enable other departmental functions.

Public Address System

An intercom or public address system that can reach all areas of the Emergency or Urgent Care Unit should be considered.

Telemedicine

Emergency and Urgent Care Units using telemedicine facilities can have a dedicated, fully enclosed room with appropriate power and communications cabling provided. However, this is not mandatory as a dedicated room is no longer required. Instead, telemedicine may be built into every space and data system. Furthermore, Telemedicine may be a mobile station, allowing it to move around to any space or patient. If this dedicated room is provided, it should be of suitable size to allow simultaneous viewing by members of multiple service teams and should be close to the Staff Station. The room shall provide acoustic and visual privacy, with sound attenuating construction.

Pneumatic Tube Systems

The Emergency or Urgent Care Unit may include a pneumatic tube station system, as determined by the facility Operational Policy. If provided the station/s should be located in close proximity to the Staff Stations within the treatment clusters or under direct staff supervision. Stations shall not be accessible to the public.

Radiation Shielding

Where diagnostic or interventional imaging is planned, a radiation protection assessment shall be undertaken by a certified medical physicist or other qualified expert as required by the relevant radiation and nuclear safety agency. The radiation protection assessment will specify the shielding requirements including the type, location and amount of radiation protection required according to the final equipment selections and layout. These requirements shall be documented and incorporated into the final specifications and building plans. Final certification of shielding shall be obtained from the relevant regulatory authority prior to commissioning.

Infection Control

Handbasins

Handbasins for hand-washing should be located in close proximity to each treatment bay and must be included in each enclosed bay or treatment room. Hand basins should be accessible without traversing any other clinical area. All handbasins in clinical areas should be the surgical type with

hands-free activation (Type A). Dispensers for non-sterile latex gloves should be available in the vicinity of each handbasin and each treatment area.

Refer to Part D - Infection Control in these Guidelines for ratios of basins required in clinical areas.

Antiseptic Hand Rubs

Antiseptic hand rubs should be located so they are readily available for use at points of care, at the end of patient beds and in high traffic areas.

The placement of antiseptic hand rubs should be consistent and reliable throughout facilities. Antiseptic hand rubs are to comply with Part D - Infection Control, in these guidelines.

Antiseptic Hand Rubs, although very useful and welcome, cannot fully replace Hand Wash Bays. Both are required.

Isolation Rooms

Isolation Rooms should be provided at the following ratios:

- Urgent Care Centres not based in hospitals – 1 negative pressure isolation room
- RDL 3 Emergency Unit or Urgent Care Centres – 1 negative pressure isolation room
- RDL 4 Emergency Unit or Urgent Care Centres – At least 2 negative pressure isolation rooms
- RDL 5 hospitals Emergency Unit – At least 4 negative pressure isolation rooms
- RDL 6 hospitals Emergency Unit – At least 6 negative pressure isolation rooms

The need for any additional negative pressure isolation rooms can be determined by risk assessment and the service plan of the facility.

All Isolation Rooms including Isolation rooms within the Emergency Unit require an Anteroom and an Ensuite Bathroom, both under negative pressure.

Isolation rooms should be accessible from inside the Unit as well as from outside the unit. The corridor off the Isolation rooms should be separated from the interior of the Unit via double doors and be kept under negative pressure.

Refer also to Part D - Infection Control in these Guidelines.

5 Components of the Unit

Standard Components

The Emergency Unit will consist of Standard Components to comply with details described in these Guidelines. Refer to Standard Components Room Data Sheets and Room Layout Sheets.

The Room Data Sheets are written descriptions representing the minimum briefing requirements of each room type, described under various categories:

- Room Primary Information; includes Briefed Area, Occupancy, Room Description and relationships, and special room requirements)
- Building Fabric and Finishes; identifies the fabric and finish required for the room ceiling, floor, walls, doors, and glazing requirements
- Furniture and Fittings; lists all the fittings and furniture typically located in the room; Furniture and Fittings are identified with a group number indicating who is responsible for providing the item according to a widely accepted description as follows:

Group	Description
1	Provided and installed by the Builder/ Contractor
2	Provided by the Client and installed by the Builder/Contractor
3	Provided and installed by the Client

- Fixtures and Equipment; includes all the serviced equipment typically located in the room along with the services required such as power, data and hydraulics; Fixtures and Equipment are also identified with a group number as above indicating who is responsible for provision.
- Building Services; indicates the requirement for communications, power, Heating, Ventilation and Air conditioning (HVAC), medical gases, nurse/ emergency call and lighting along with quantities and types where appropriate. Provision of all services items listed is mandatory.

The Room Layout Sheets (RLS's) are indicative plan layouts and elevations illustrating an example of good design. The RLS indicated are deemed to satisfy these Guidelines. Alternative layouts and innovative planning shall be deemed to comply with these Guidelines provided that the following criteria are met:

- Compliance with the text of these Guidelines
- Minimum floor areas as shown in the schedule of accommodation
- Clearances and accessibility around various objects shown or implied
- Inclusion of all mandatory items identified in the RDS

The Emergency and Urgent Care Unit consists of Standard Components to comply with details described in these Guidelines. Refer also to Standard Components Room Data Sheets (RDS) and Room Layout Sheets (RLS) separately provided.

Non-Standard Components

Non-Standard rooms are identified in the Schedules of Accommodation as NS and are described below.

Visual Triage Room

Visual Triage, or External Triage is a monitoring station located just outside the Emergency Unit, where trained nurses can evaluate walk-in patients via a quick visual assessment (eyeball triage). The room includes:

- Desk with computer and chair for staff
- Observation window to Emergency Department entrance

Work Bay

The work bay is an open bay collocated with the staff station for staff to work. The bay includes:

- Laminate bench at standing height
- May include under bench cupboards for added storage

- May include pigeonholes to store worksheets

6 Schedule of Equipment (SOE)

This Schedule of Equipment (SOE) below lists the major equipment required for the key rooms in this FPU.

Room Name		
Triage Cubicle, Room Code (cub-tri-i)		
Air flowmeter	Oxygen flowmeter	Suction adapter
Light: examination	Scale: patient, with stadiometer	
Monitor: physiologic, vital signs	Stretcher: procedure/ recovery	
Patient Bay - Resuscitation, Room Code (pbtr-r-i)		
Air flowmeter	Infusion pump: single channel	Stretcher: radiography/ trauma
Analyser: blood gas (optional)	Infusion pump: syringe	Suction adapter
Cabinet: storage, medication, narcotics	Light: surgical	Supply unit: ceiling
Defibrillator: with monitor	Monitor: physiologic, critical care	Ultrasound scanning unit: point-of-care (optional)
Diagnostic set	Pump: suction/ aspirator, portable	Ventilator: transport
Infusion pump: rapid, blood/ solution warming	Refrigerators: drugs	
Patient Bay - Acute Treatment, Room Code (pbtr-a12-i)		
Air flowmeter	Light: procedure	Stretcher: procedure/ recovery
Diagnostic set (optional)	Monitor: physiologic, acute care (optional)	Suction adapter
Infusion pump: single channel	Oxygen flowmeter	
Patient Bay - Non-Acute Treatment, Room Code (pbtr-na-i)		
Air flowmeter	Light: examination (optional)	Suction adapter
Diagnostic set (optional)	Oxygen flowmeter	
Infusion pump: single channel	Stretcher: procedure/ recovery	
Patient Bay - Enclosed, Isolation - Negative Pressure, Room Code (pbhe-is-n-i)		
Air flowmeter	Light: procedure	Stretcher: procedure/ recovery
Infusion pump: single channel	Monitor: physiologic, critical care	Suction adapter
Infusion pump: syringe	Oxygen flowmeter	
General X-ray, Room Code (genxr-i)		
Air flowmeter	Suction adapter	X-ray unit: general purpose
Oxygen flowmeter		
Procedure Room, Room Code (proc-20-i)		
Air flowmeter	Monitor: physiologic, acute care	Stretcher: procedure/ recovery
Infusion pump: single channel	Oxygen flowmeter	Suction adapter
Light: procedure	Refrigerator: drugs (optional)	
Plaster Room, Room Code (plst-14-i)		
Air flowmeter	Monitor: physiologic, vital signs (optional)	Suction adapter
Cast cutter: with vacuum	Oxygen flowmeter	
Light: examination	Stretcher: procedure/ recovery	
Treatment Room, Room Code (trmt-14-i), Treatment Room - Paediatric, Room Code (trmt-p-i)		
Air flowmeter	Light: examination	Refrigerator: drugs (optional)
Diagnostic set (optional)	Monitor: physiologic, acute care	Stretcher: procedure/ recovery

Room Name		
Infusion pump: single channel	Oxygen flowmeter	Suction adapter
Consult Room - Room Code (cons-i)		
Air flowmeter	Monitor: physiologic, vital signs (optional)	Table: examination/ treatment
Diagnostic set	Oxygen flowmeter	
Light: examination (optional)	Suction adapter	
Consult/ Exam Room - Ophthalmology, Room Code (cons-opt-k)		
Air flowmeter	Lensometer: automatic	Slit lamp: digital, with camera
Auto refractometer/ keratometer	Ophthalmoscope: indirect, binocular	Stand: examination/ treatment, ophthalmic
Chart monitor: ophthalmic	Oxygen flowmeter	Suction adapter
Diagnostic set: ophthalmic	Phoropter: digital	Tonometer: applanation
Consult/ Exam Room - ENT, Room Code (cons-ent-k)		
Air flowmeter	Diagnostic set: ENT	Suction Adapter
Chair: ENT	Oxygen flowmeter	Treatment unit: ENT
Examination/ Assessment Room - Birthing, Room Code (exas-b-i)		
Diagnostic set (optional)	Monitor: physiologic, antepartum, fetal (CTG)	Suction adapter
Doppler: fetal	Oxygen flowmeter	Ultrasound scanning unit: OB/ GYN
Light: examination	Stretcher: OB/ GYN (or Birthing bed)	
Birthing Room - LDR, Room Code (birm-i)		
Air flowmeter	Infusion pump: epidural	Oxygen flowmeter
Bassinet	Infusion pump: syringe	Suction adapter
Bed: birthing, electric	Light: examination/ procedure	Table: overbed
Chair: recliner, electric	Locker: bedside	Warmer unit: neonatal, with resuscitation
Infusion pump: double channel	Monitor: physiologic, intrapartum, maternal/ fetal	
Treatment Room - Secure Assessment (Mental Health), Room Code (trsa-i)		
Air flowmeter	Diagnostic set (optional)	Suction adapter
Bed: inpatient, electric	Oxygen flowmeter	
Examination/ Assessment Room - Mental Health, Room Code (exas-mh-i)		
Table: examination/ treatment		

7 Schedule of Accommodation

The Schedule of Accommodation (SOA) provided below represents generic requirements for this unit. It identifies the rooms required along with the room quantities and the recommended room areas. The simple sum of the room areas is shown as the Sub Total. The Total area is the Sub Total plus the circulation percentage. The circulation percentage represents the minimum recommended target area for internal corridors in an efficient and appropriate design.

Within the SOA, room sizes are indicated for typical units and are organised into the functional zones. Not all rooms identified are mandatory therefore, optional rooms are indicated in the Remarks. These guidelines do not dictate the size of the facilities such as the total number of Treatment Bays. Therefore, the SOA provided represents a limited sample based on assumed unit sizes. The actual size of the facilities is determined by Service Planning or Feasibility Studies. Quantities of rooms need to be proportionally adjusted to suit the desired unit size and service needs.

The table below shows five alternative SOA's for different role delineations; a small urgent care unit with 4 treatment spaces suitable for RDL 1-2, a larger urgent care unit with 11 treatment spaces suitable for RDL 3, Medium sized units with 20 treatment spaces and 36 treatment spaces for RDL 4 and a large unit with 60 or more Treatment Bays suitable for RDL 5 & 6.

Any proposed deviations from the mandatory requirements, justified by innovative and alternative operational models may be proposed within the departure forms included in Part A of these guidelines for consideration by the health authority for approval.

Emergency Unit located within a health facility

ROOM/ SPACE Unit Size	iHFG Standard Component Room Codes	RDL 1 - 2 Qty x m² 4 spaces			RDL 3 Qty x m² 11 spaces			RDL 4 Qty x m² Medium-20 spaces			RDL 4 Qty x m² Medium-36 spaces			RDL 5-6 Qty x m² Large-65 spaces			Remarks (spaces only, not including procedure rooms)
Entry/ Reception/ Waiting		Urgent Care			Urgent Care												
Airlock - Entry	airle-10-i	1	x	10	1	x	10	1	x	10	1	x	10	1	x	10	Optional; May be shared with Main Entry; Ambulance entry may require separate Airlock
Waiting	wait-20-i wait-25-i wait-30-i similar wait-50-i	1	x	10	1	x	20	1	x	25	1	x	35	1	x	50	May be separate Male/ Female/ Family areas
Reception	rec-e-i similar	1	x	10	1	x	10	1	x	15	1	x	20	1	x	20	Staff to observe & control access
Play Area - Paediatric	plap-10-i similar				1	x	8	1	x	8	1	x	10	1	x	10	Adjoining Waiting area
Bay - Vending Machines	bvm-3-i bvm-5-i										1	x	3	1	x	5	Optional
Bay - Wheelchair Park	bwc-i similar	1	x	2	1	x	2	1	x	4	1	x	4	1	x	6	Wheelchairs & trolley holding
Parenting Room	par-i										1	x	6	1	x	6	May be shared with Main Entry
Police/ Security Room	secr-10-i similar							1	x	10 *	1	x	12	1	x	12	* Optional
Toilet- Accessible	wcac-i	1	x	6	1	x	6	1	x	6	1	x	6	1	x	6	May also include facilities for baby change; Where gender-separated toilet facilities are required to meet cultural requirements, an additional accessible toilet may be provided
Toilet - Public & Patient	wcpt-i							2	x	4	4	x	4	6	x	4	For waiting patients and support persons
Triage																	
Triage - Nurse	rece-i	1	x	6	1	x	6	1	x	6	2	x	6	2	x	6	May include with Reception
Triage Cubicle/s	cub-tri-i							1	x	10	2	x	10	4	x	10	Includes exam couch and write-up desk, may be enclosed
Ambulance Triage	ambtr-i							1	x	10	1	x	12	2	x	12	1, 2 & 4 bays respectively
Visual Triage	NS							1	x	7	1	x	7	1	x	7	Optional in RDL 1 - 3 (Urgent Care)
Resuscitation/ Treatment Areas		3 spaces			8 spaces			15 spaces			20 spaces			38 spaces			
Decontamination Shower	shdec-i							1	x	8	1	x	8	1	x	8	May be external with ambulance bays
Change - Staff	chst-10-k similar							1	x	4	1	x	4	1	x	4	For decontamination staff

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ROOM/ SPACE Unit Size	iHFG Standard Component Room Codes	RDL 1 - 2 Qty x m² 4 spaces			RDL 3 Qty x m² 11 spaces			RDL 4 Qty x m² Medium-20 spaces			RDL 4 Qty x m² Medium-36 spaces			RDL 5-6 Qty x m² Large-65 spaces			Remarks (spaces only, not including procedure rooms)
Store - Supply	stgn-8-I similar							1	x	6	1	x	6	1	x	6	For decontamination supplies, may be a cupboard
Patient Bay - Resuscitation	pbtr-r-i similar	1	x	35	1	x	35	1	x	35	3	x	28	4	x	28	35m² room has 2 bays, includes handbasin within
Patient Bay - Trauma	pbte-12-i													4	x	12	Qty according to service plan. Must be an enclosed bay
Patient Bay - Acute Treatment	pbtr-a12-i	2	x	12	3	x	12	6	x	12	8	x	12	14	x	12	Qty according to service plan; arranged in clusters of up to 12 beds
Patient Bay - Non Acute Treatment	pbtr-na-i				3	x	10	6	x	10	8	x	10	14	x	10	Qty according to service plan; arranged in clusters of up to 12 beds
Seclusion Room	secl-i							1	x	14	1	x	14	2	x	14	Optional; for patients in distress, fully enclosed room with acoustic glass front
General X-ray Room	genxr-i										1	x	30	2	x	30	Optional; for CT scanning & Control room additional area will be required.
Change Cubicle - Patient	chpt-2-i										1	x	2	1	x	2	Optional, for X-Ray if provided
Procedure Room	proc-20-i										1	x	20	2	x	20	Qty according to service plan. May include plaster/splint facilities
Plaster Room	plst-14-i										1	x	14	1	x	14	Optional
Treatment Room	trmt-14-i							1	x	14	1	x	14	1	x	14	
Meeting Room - Small	meet-9-i										1	x	9	2	x	9	May be used as Interview, Grieving room or as Telemedicine consult
Shower - Patient	shpt-i							1	x	4	1	x	4	2	x	4	May be combined with Toilet-Patient. May be gender separated where required
Toilet - Accessible	wcac-i	shared			shared			1	x	6	2	x	6	2	x	6	May be shared with Fast Track, if located close by
Toilet - Patient	wcpt-i	1	x	4	1	x	4	2	x	4	2	x	4	4	x	4	May be shared with Fast Track, if located close by. Where gender-separated toilet facilities are required to meet cultural requirements additional toilets may be provided where required
Isolation Area		1 space			1 space			2 spaces			4 spaces			6 spaces			

ROOM/ SPACE Unit Size	iHFG Standard Component Room Codes	RDL 1 - 2 Qty x m² 4 spaces			RDL 3 Qty x m² 11 spaces			RDL 4 Qty x m² Medium-20 spaces			RDL 4 Qty x m² Medium-36 spaces			RDL 5-6 Qty x m² Large-65 spaces			Remarks (spaces only, not including procedure rooms)
Airlock - Entry	airle-6-i							1	x	6	1	x	6	1	x	6	
Airlock	airle-6-k similar							1	x	6	1	x	6	1	x	6	from internal corridor
Reception/ Clerical	recl-5-i							1	x	5	1	x	5	1	x	5	Staff to observe & control access
Waiting	wait-sub-i wait-10-i wait-15-i							1	x	5	1	x	10	1	x	15	May be separate Male/ Female areas
Toilet- Accessible	wcac-i							1	x	6	1	x	6	1	x	6	May also include facilities for baby change; Where gender-separated toilet facilities are required to meet cultural requirements, an additional accessible toilet may be provided
Bay - Vending Machines	bvm-3-i							1	x	3	1	x	3	1	x	3	Optional
Patient Bay - Enclosed, Isolation - Negative Pressure	pbhe-is-n-i	1	x	12	1	x	12	2	x	12	4	x	12	6	x	12	includes hand basin within; Qty according to service plan
Anteroom	anrm-i	1	x	6	1	x	6	2	x	6	4	x	6	6	x	6	For isolation room (s)
Ensuite - Standard	ens-st-i	1	x	5	1	x	5	2	x	5	4	x	5	6	x	5	For Isolation room (s)
Staff Station	sstn-5-i sstn-10-i similar	shared			shared			1	x	5	1	x	10	1	x	10	
Cleaner's Room	clrm-6-i	shared			shared			shared			1	x	6	1	x	6	
Clean Utility/ Medication - Sub	clum-8-i	shared			shared			shared			1	x	8	1	x	8	
Dirty Utility - Sub	dtur-s-i	shared			shared			shared			1	x	8	1	x	8	
Bay - Pneumatic Tube	bpts-i	shared			shared			shared			1	x	1	1	x	1	Optional
Store - Equipment/ General	steq-6-i	shared			shared			shared			1	x	6	1	x	6	May include recharging of equipment
Fast Track/ Consulting					2 spaces			3 spaces			5 spaces			8 spaces			**Optional for RDL 1-2**
Consult Room	cons-i				2	x	14	3	x	14	3	x	14	6	x	14	
Consult - Ophthalmology	cons-opt-i										1	x	14	1	x	14	Qty according to service plan
Consult - ENT	cons-ent-i										1	x	14	1	x	14	Qty according to service plan
Vital Signs Room	vsr-i				1	x	8	1	x	8	1	x	8	1	x	8	Optional
Bay - Handwashing, Type B	bhws-b-i							1	x	1	1	x	1	1	x	1	to staff station

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ROOM/ SPACE Unit Size	iHFG Standard Component Room Codes	RDL 1 - 2 Qty x m² 4 spaces			RDL 3 Qty x m² 11 spaces			RDL 4 Qty x m² Medium-20 spaces			RDL 4 Qty x m² Medium-36 spaces			RDL 5-6 Qty x m² Large-65 spaces			Remarks (spaces only, not including procedure rooms)
Staff Station	sstn-5-i sstn-12-i similar							1	x	5	1	x	8	1	x	12	
Toilet - Patient	wcpt-i										1	x	4	2	x	4	May be gender separated. May be shared if located close by
Support Areas																	**May be shared between zones**
Bay - Beverage, Open Plan	bbev-op-i	1	x	5	1	x	5	1	x	5	1	x	5	1	x	5	
Bay - Handwashing, Type A	bhws-a-i	1	x	1	2	x	1	3	x	1	4	x	1	9	x	1	1 per 4 open treatment bays, minimum
Bay - Linen	blin-i	1	x	2	1	x	2	1	x	2	2	x	2	2	x	2	
Bay - Mobile Equipment	bmeq-4-i bmeq-6-i	1	x	4	1	x	4	1	x	6	2	x	4	2	x	4	
Bay - Pathology/ Stat Lab	bpath-3-i similar							1	x	8	1	x	16	1	x	16	Semi-enclosed
Bay - Pneumatic Tube	bpts-i	1	x	1	1	x	1	1	x	1	1	x	1	1	x	1	Optional
Bay - Resuscitation Trolley	bres-i	1	x	1.5	1	x	1.5	1	x	1.5	1	x	1.5	1	x	1.5	Adult and paediatric trolleys
Clean Utility	clur-8-i clur-12-i							1	x	8	1	x	12	2	x	12	
Clean Utility/ Medication - Sub	clum-8-i	1	x	8	1	x	8										
Cleaner's Room	clrm-6-i	shared			1	x	6	1	x	6	1	x	6	1	x	6	
Dirty Utility	dtur-s-i dtur-10-i dtur-12-i	shared			1	x	8	1	x	8	1	x	10	2	x	12	
Disposal Room	disp-8-i	shared			shared			shared			1	x	8	1	x	8	
Holding Room - Bodies	body-h-i										1	x	12	1	x	12	Optional; also used as 'Brought in Dead' room
Medication Room	stdr-10-i similar							1	x	8	1	x	10	1	x	12	
Office - Write-up, Shared	off-wis-i similar							1	x	10	1	x	12	1	x	12	Open plan in the work area
Staff Station	sstn-10-i similar sstn-20-i	1	x	10	1	x	10	1	x	12	1	x	20	1	x	30	2m² per staff; may be divided for clusters
Work Bay	NS										2	x	9	2	x	14	
Store - Crutches	stcr-i							1	x	2	1	x	2	1	x	2	
Store - Disaster Equipment	stde-i										1	x	8	1	x	8	
Store - Equipment	steq-10-i steq-15-i similar	shared			1	x	8	1	x	10	1	x	12	1	x	15	
Store - General	stgn-8-i stgn-10-i stgn-12-i	shared			1	x	8	1	x	10	1	x	12	2	x	12	

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ROOM/ SPACE Unit Size	iHFG Standard Component Room Codes	RDL 1 - 2 Qty x m² 4 spaces			RDL 3 Qty x m² 11 spaces			RDL 4 Qty x m² Medium-20 spaces			RDL 4 Qty x m² Medium-36 spaces			RDL 5-6 Qty x m² Large-65 spaces			Remarks (spaces only, not including procedure rooms)
Ambulance Resources																	
Store – Ambulance Supplies	stgn-8-i stgn-10-i stgn-12-i							1	x	8	1	x	10	1	x	12	
Lounge – Ambulance Staff	srm-15-i							1	x	15	1	x	15	1	x	15	
Toilet – Ambulance Staff	wcst-i							2	x	3	2	x	3	2	x	3	
Paediatric Assessment / Short Stay											4 spaces			7 spaces			**Optional dedicated zone**
Patient Bay - Non Acute Treatment	pbtr-na-i										3	x	10	6	x	10	bed or cot
Seclusion Room	secl-i										1	x	14	1	x	14	Optional; for patients in distress, fully enclosed room with acoustic glass front
Treatment Room - Paediatric	trmt-p-i										1	x	14	1	x	14	may include plaster/ splinting facilities
Play Area – Paediatric	plap-10-i										1	x	8	1	x	8	
Bay - Handwashing, Type A	bhws-a-i										1	x	1	2	x	1	
Bay - Linen	blin-i										1	x	2	1	x	2	
Bay - Resuscitation Trolley, Paediatric	bres-i										1	x	1.5	1	x	1.5	
Dirty Utility - Sub, 8m2	dtur-8-i										1	x	8	1	x	8	
Toilet - Patient	wcpt-i										1	x	4	1	x	4	Where gender-separated toilet facilities are required to meet cultural requirements additional toilets may be provided where required
Shower - Patient	shpt-i										1	x	4	1	x	4	May be included with Toilet
Staff Station/ Clean Utility	sscu-i similar										1	x	9	1	x	14	
Store - Equipment/ General	steq-10-i steq-15-i										1	x	10	1	x	15	May be shared, may include recharging of equipment
Maternity Assessment											2 space			4 spaces			**Optional dedicated zone (at least one space is required in remote emergency units)**
Examination/ Assessment	exas-b-i										1	x	23	2	x	23	Includes scrub basin and 3 m2 store within the room, store is optional
Ensuite - Standard	ens-st-i similar										1	x	5	2	x	5	For examination/ assessment room

ROOM/ SPACE Unit Size	iHFG Standard Component Room Codes	RDL 1 - 2 Qty x m² 4 spaces			RDL 3 Qty x m² 11 spaces			RDL 4 Qty x m² Medium-20 spaces			RDL 4 Qty x m² Medium-36 spaces			RDL 5-6 Qty x m² Large-65 spaces			Remarks (spaces only, not including procedure rooms)
Birthing Room - LDR	birm-i										1	x	30	2	x	30	Includes scrub basin and 3 m2 store within the room
Ensuite - Delivery Room	ens-br-b-i										1	x	5	2	x	5	
Bay - Linen	blin-i										1	x	2	1	x	2	Support may be shared with other functional groups if in close proximity
Bay - Resuscitation Trolley	bres-i										1	x	1.5	1	x	1.5	Support may be shared if in close proximity
Clean Utility -Sub	clur-8-i										1	x	8	1	x	8	Support may be shared if in close proximity
Dirty Utility - Sub	dtur-s-i										1	x	8	1	x	8	Support may be shared if in close proximity
Staff Station	sstn-10-i										1	x	10	1	x	10	Support may be shared if in close proximity
Store - Equipment/ General	steq-10-i steq-14-i										1	x	10	1	x	14	Support may be shared if in close proximity
Mental Health/ Behavioural Assessment											1 space			2 spaces			**Optional for RDL 1-3**
Treatment Room - Secure Assessment (Mental Health)	trsa-i										1	x	14	1	x	14	
Exam/ Assessment - Mental Health	exas-mh-i													1	x	15	Optional
Staff Station	sstn-5-i										1	x	5	1	x	5	
Toilet - Mental Health	ens-mh-i similar										1	x	4	2	x	4	Ensuite to Assessment Room
Staff Areas																	
Staff Room	srm-15-i similar srm-20-i srm-30-i	shared			shared			1	x	10	1	x	20	1	x	30	1.5m² per staff member
Change – Staff (Male/ Female)	chst-14-i chst-20-i	shared			shared						2	x	14	2	x	20	Size for maximum staff per shift
Office- Single Person, 12m²	off-s12-i										1	x	12	1	x	12	Note 1; Director
Office- Single Person, 9m²	off-s9-i				1	x	9	2	x	9	3	x	9	5	x	9	Note 1; Unit Manager, Staff Specialists
Office - Workstations	off-ws-i										4	x	5.5	8	x	5.5	Medical, Allied Health, Nursing, as required
Meeting Room - Medium/ Large	meet-l-15-i meet-l-30-i										1	x	15	1	x	30	
Meeting Room - Small	meet-9-i meet-12-i							1	x	9	1	x	12	1	x	12	
Store - Photocopy/ Stationery	stps-8-i										1	x	8	1	x	8	

ROOM/ SPACE Unit Size	iHFG Standard Component Room Codes	RDL 1 - 2 Qty x m² 4 spaces	RDL 3 Qty x m² 11 spaces	RDL 4 Qty x m² Medium-20 spaces			RDL 4 Qty x m² Medium-36 spaces			RDL 5-6 Qty x m² Large-65 spaces			Remarks (spaces only, not including procedure rooms)
Property Bay- Staff	prop-2-i	shared	shared	1	x	2							
Toilet - Staff	wcst-i	shared	shared	2	x	3				2	x	3	with close access to treatment areas
Sub Total		**162.5**	**271.5**	**609.5**			**1105.5**			**1669.5**			
Circulation %		**40%**	**40%**	**40%**			**40%**			**40%**			
Area Total		**228**	**380**	**854**			**1548**			**2338**			

Note: Services at RDL 1-3 are classified as Urgent Care

Note 1: Offices to be provided according to the number of approved full-time positions within the Unit

Please note the following:

- Areas noted in Schedules of Accommodation take precedence over all other areas noted in the FPU.
- Rooms indicated in the schedule reflect the typical arrangement according to the Role Delineation.
- Exact requirements for room quantities and sizes will reflect Key Planning Units identified in the Service Plan and the Operational Policies of the Unit.
- Room sizes indicated should be viewed as a minimum requirement; variations are acceptable to reflect the needs of individual Unit.
- Office areas are to be provided according to the Unit role delineation and number of endorsed full time positions in the unit.
- Staff and support rooms may be shared between Functional Planning Units dependent on location and accessibility to each unit and may provide scope to reduce duplication of facilities

Short Stay Unit/ Medical Assessment Unit/ Clinical Decision Unit

May be located within the Emergency Unit or located adjacent; support facilities may be shared for small units

ROOM/ SPACE Size	Standard Component Room Codes	RDL ALL Qty x m² 5 spaces			RDL ALL Qty x m² 10 spaces			Remarks Optional
Patient Bay - Non Acute Treatment	pbtr-na-i	4	x	10	8	x	10	Qty according to service plan
Bay - Handwashing, Type A	bhws-a-i	1	x	1	2	x	1	1 per 4 open treatment bays, minimum
Bay - Linen	blin-i	1	x	2	1	x	2	
Bay - Resuscitation Trolley	bres-i	1	x	1.5	1	x	1.5	
Clean Utility -Sub, 8m2	clur-8-i	1	x	8	1	x	8	
Dirty Utility - Sub, 8m2	dtur-8-i	shared			1	x	8	
Toilet - Patient	wcpt-i	1	x	4	2	x	4	
Shower - Patient	shpt-i	1	x	4	2	x	4	May be combined with Patient Toilet
Staff Station	sstn-5-i sstn-14-i similar	1	x	5	1	x	12	
Store - Equipment/ General	steq-10-i	shared			1	x	10	
Sub Total		**65.5**			**139.5**			
Circulation %		**35%**			**35%**			
Area Total		**88**			**188**			

Please note the following:

- Areas noted in Schedules of Accommodation take precedence over all other areas noted in the FPU.
- Rooms indicated in the schedule reflect the typical arrangement according to the Role Delineation.
- Exact requirements for room quantities and sizes will reflect Key Planning Units identified in the Service Plan and the Operational Policies of the Unit.
- Room sizes indicated should be viewed as a minimum requirement; variations are acceptable to reflect the needs of individual Unit.
- Office areas are to be provided according to the Unit role delineation and number of endorsed full time positions in the unit.
- Staff and support rooms may be shared between Functional Planning Units dependent on location and accessibility to each unit and may provide scope to reduce duplication of facilities

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Ambulance Base

For an Ambulance base located adjacent to the Emergency Unit or within the hospital precinct

ROOM/ SPACE	Standard Component Room Codes									RDL 3-4 Qty x m²			RDL 5-6 Qty x m²			Remarks
Ambulance Base																Optional
Reception	recl-10-i									1	x	10	1	x	10	
Bay - Cleaning (Ambulances)	bcl-18-i similar									1	x	18	1	x	36	Optional, External area for cleaning ambulances
Office – Single Person, 9m2	off-s9-i									1	x	9	1	x	9	Manager
Communications Base	off-wis-i similar									1	x	12	1	x	20	2, 4 person, shared, respectively
Overnight Accommodation Bedroom/ Ensuite - Staff	ovbr-i oves-i									1	x	14	1	x	14	As required, on-call staff
Store – General	stgn-10-i stgn-14-i									1	x	10	1	x	14	Stock and supplies
Store – Drug	stdr-5-i									1	x	5	1	x	5	
Staff Room	srm-15-i similar									1	x	12	1	x	15	
Change – Staff	chst-10-i									2	x	10	2	x	10	Shower, Toilet, Lockers
Sub Total										92			107			
Circulation %										20%			20%			
Area Total										110			128			

Please note the following:

- Areas noted in Schedules of Accommodation take precedence over all other areas noted in the FPU.
- Rooms indicated in the schedule reflect the typical arrangement according to the Role Delineation.
- Exact requirements for room quantities and sizes will reflect Key Planning Units identified in the Service Plan and the Operational Policies of the Unit.
- Room sizes indicated should be viewed as a minimum requirement; variations are acceptable to reflect the needs of individual Unit.
- Office areas are to be provided according to the Unit role delineation and number of endorsed full time positions in the unit.
- Staff and support rooms may be shared between Functional Planning Units dependent on location and accessibility to each unit and may provide scope to reduce duplication of facilities

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Remote Emergency Department

ROOM/ SPACE	Standard Component Room Codes	RDL 2 Qty x m^2												Remarks
		11 spaces												
Entry/ Reception/ Waiting														
Airlock - Entry	airle-10-i	1	x	10										Optional; May be shared with Main Entry; Ambulance entry may require separate Airlock
Reception/ Clerical	recl-10-i recl-15-i similar	1	x	10										Staff to observe & control access
Waiting - Family	wait-30-i similar	1	x	25										Minimum
Play Area*	plap-10-i similar	1	x	8										*Optional, Adjoining Waiting area
Bay - Vending Machines	bvm-3-i similar													Optional
Bay - Wheelchair Park	bwc-i similar	1	x	2										Wheelchairs & trolley holding
Police/ Security Room*	secr-10-i similar													* Optional
Toilet- Accessible	wcac-i	2	x	6										May also include facilities for baby change; separate for M/F
Triage														
Triage Cubicle(s)	triage-i	1	x	10										Includes exam couch and write-up desk
Visual Triage	NS	1	x	7										Optional; May be shared with Main Entry; Ambulance entry may require separate Airlock
Resuscitation/ Treatment Areas														
Patient Bay - Resuscitation	pbtr-r-i similar	1	x	28										
Consult/ Exam Room/ Fast Track	cons-i	2	x	13										
Patient Bay - Treatment	pbtr-a12-i	7	x	12										Qty according to service plan; arranged in clusters of up to 12 beds
Patient Bay - Paediatric Treatment	pbtr-a12-i	1	x	12										Qty according to service plan; arranged in clusters of up to 12 beds
Exam/ Assessment - Mental Health	exas-mh-i	1	x	15										
General X-ray Room	genxr-i	1	x	30										
Ultrasound	ultr-i	1	x	14										
Control Room - CT	ctcr-i similar	1	x	14										
CT Scanning - Procedure Room	ctpr-i	1	x	45										Room size dependent on equipment selected
CT Computer Equipment Room	coeq-i	1	x	8										Room size dependant on equipment selected
Radiologist Office	off-s9-i	1	x	9										used for Reading/ Reporting
Shower - Patient	shpt-i	1	x	4										May be combined with Toilet-Patient

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ROOM/ SPACE	Standard Component Room Codes	RDL 2 Qty x m^2												Remarks
		11 spaces												
Toilet - Accessible, Patient	wcac-i	2	x	6										Separate for M/F
Isolation Area														
Airlock - Entry	airle-6-i	1	x	6										
Reception/ Clerical	recl-5-i	1	x	5										Staff to observe & control access
Waiting	wait-10-i wait-15-i similar	1	x	15										May be separate Male/ Female - minimum
Toilet- Accessible	wcac-i	2	x	6										May also include facilities for baby change; separate for M/F
Patient Bay - Enclosed, Isolation - Negative Pressure	pbhe-12-i	1	x	12										includes hand basin within; Qty according to service plan
Anteroom	anrm-i	1	x	6										For isolation room (s)
Ensuite - Standard	ens-st-i	1	x	5										For Isolation room (s)
Staff Station	sstn-5-i similar sstn-10-i similar	1	x	5										
Clean Utility -Sub	clur-8-i	shared												
Dirty Utility - Sub	dtur-s-i	shared												
Medication Room	medr-10-i similar	shared												
Store - Equipment/ General	steq-6-i	shared												
Support Areas														
Bay - Beverage, Open Plan	bbev-op-i	1	x	5										
Bay - Handwashing, Type A	bhws-a-i	2	x	1										1 per 4 open treatment bays, minimum
Bay - Linen	blin-i	1	x	2										
Bay - Mobile Equipment	bmeq-4-i similar	1	x	6										
Bay - Resuscitation Trolley	bres-i	1	x	1.5										Adult and paediatric trolleys
Blood Store	blst-i similar	1	x	3										
Clean Utility	clur-8-i	1	x	8										
Cleaner's Room	clrm-6-i	1	x	6										
Dirty Utility	dtur-s-i	1	x	8										
Disposal Room	disp-8-i	1	x	8										
Helipad*		1	x	0										External area
Holding Room - Bodies	body-h-i	1	x	12										Optional; also used as 'Brought in Dead' room

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ROOM/ SPACE	Standard Component Room Codes	RDL 2 Qty x m^2												Remarks
		11 spaces												
Medication Room	medr-10-i similar	1	x	8										
Point-of-Care Testing	bpath-3-i similar	1	x	12										
Staff Station	sstn-14-i similar sstn-20-i similar	1	x	14										
Store - Equipment	steq-10-i similar	1	x	8										
Store - General	stgn-14-i	1	x	14										
Staff Areas														
Staff Room	srm-15-i similar	1	x	15										
Office- Single Person,	off-s9-i	3	x	9										
Property Bay- Staff	prop-3-i	2	x	3										
Toilet - Staff	wcst-i	2	x	3										
Sub Total		618.5												
Circulation %		10%												

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8 Further Reading

In addition to the iHFG parts referred to in this document: i.e. Part C - Access, Mobility and OH&S and Part D - Infection Control, readers may find the following useful:

- Australasian Health Facility Guidelines, Part B Health Facility Briefing and Planning, 0300-Emergency Unit, refer to website https://healthfacilityguidelines.com.au/health-planning-units
- CDC (Center for Disease Control) US. Guidelines for Environmental Infection Control in Health-Care Facilities, US, refer to website https://www.cdc.gov/infectioncontrol/guidelines/index.html
- NSW Health, Emergency Department Models of Care, refer to website: https://www.health.nsw.gov.au/performance/publications/ed-model-of-care-2012.pdf
- The Facility Guidelines Institute (US), refer to website https://fgicodes.org/

9 Sample Plans

Please see overleaf.

ABBREVIATION LEGEND	
ACC	Accessible
AMB	Ambulance
BEV	Beverage
CH	Change
CU	Clean Utility
DECON	Decontamination
DU	Dirty Utility
ENCL ISO NEG	Enclosed, Isolation - Negative Pressure
ENS	Ensuite
EQ / EQUIP	Equipment
EXAM	Examination
F	Female
HWB-A	Handwashing, Type-A
LAB	Laboratory
LDR	Labor, Delivery and Recovery
LIN	Linen
M	Male
MH	Mental Health
MIN	Minimum
MOB	Mobile
OBSERV'N	Observation
PAED	Paediatric
PAT	Patient
PATH	Pathology
PUB	Public
RES/RESUS	Resuscitation Trolley
RM	Room
SH	Shower
ST	Staff
STAT	Statistics
STN	Station
SUPP	Supply
PHT STRY	Photocopy Stationery
TOI	Toilet
TRMT	Treatment
WC	Water Closet
WCH	Wheelchair

COLOR FILL LEGEND	
	Clinical Circulation
	Functional Areas

