Australasian Health Facility Guidelines

Part B - Health Facility Briefing and Planning

0155 - Ambulatory Care and Community Health

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Australasian Health Facility Guidelines

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01 INTRODUCTION

1.1 PREAMBLE

This Health Planning Unit (HPU) has been developed by the Australasian Health Infrastructure Alliance (AHIA). This revision has been informed by an extensive consultation process that was completed in 2020.

The information included in this HPU was previously provided through two separate documents, HPU 155 Ambulatory Care and HPU 255 Community Health. These two documents were merged given both HPUs are focussed on same day, non-admitted patient services and the core planning requirements include a mix of multifunctional, flexible use consult, interview, treatment and meeting rooms.

The HPU is intended to be used by design teams, project managers and end users to facilitate the process of planning and design.

1.2 INTRODUCTION

This document provides information relating to ambulatory care and community health services that may be delivered as part of a healthcare campus or as a stand-alone facility in the community. The range of services to be provided will need to be defined on a project-by-project basis within the context of an endorsed clinical services plan, service level and models of care.

The guideline should be read in conjunction with AusHFG generic requirements including Standard Components described in:

- Part A: Introduction and Instructions for Use;
- Part B: Section 80: General Requirements;
- Part B: Section 90: Standard Components, Room Data and Room Layout Sheets;
- Part C: Design for Access, Mobility, Safety and Security; and
- Part D: Infection Prevention and Control.

A range of general ambulatory and community health services are covered within this HPU. The planning and design of specialist same day services may require reference to the following additional HPUs:

- 140 Allied Health / Therapy Unit;
- 170 Cardiac Investigations Unit;
- 270 Day Surgery / Procedure Unit;
- 280 Oral Health Unit;
- 440 Medical Imaging Unit;
- 500 Nuclear Medicine / PET Unit;
- 510 Maternity Unit;
- 540 Paediatric / Adolescent Unit;
- 550 Pathology Unit;
- 560 Pharmacy Unit;
- 600 Radiation Oncology Unit; and
- 620 Renal Dialysis Unit.

1.3 POLICY FRAMEWORK

Before undertaking a project, planners and project personnel should familiarise themselves with individual jurisdictional plans, regulations, policies, service specific guidelines and reports. Jurisdictional policy information, where available, is contained in the Further Reading section of this HPU.

1.4 DESCRIPTION

Ambulatory Care

Ambulatory care, often known as outpatient clinics or services, relates to patient care that takes place as a day attendance at a health care facility or in a patient's home. It covers a broad range of services from preventative and primary care through to specialist services. The services are classified as non-admitted patient care, however some admitted services are provided relating to Hospital in the Home (HITH) services and admitted same day procedures.

Ambulatory care services seek to minimise demand on emergency and acute inpatient services through:

- interventions and programs that avoid or substitute for inpatient care;
- pre-admission assessments to prepare patients and carers for the admission and post discharge requirements;
- post discharge care to support patients in the community in the early stages of recovery;
- care for patients with complex, long-term conditions to maintain or improve their health and minimise representations to acute care services; and
- assessment and care for patients with conditions requiring specialist input.

Community Health

Primary health care is generally the first level of care or first point of contact for patients in the health system and is delivered by a wide range of public and private providers. Community health centres typically deliver primary health care services to non-admitted patients. Services may be delivered in stand-alone buildings in the community; located on a hospital site; or collocated with other health and human service providers (private, public and NGOs).

It is important that project teams acknowledge the philosophy of care for community health services which seek to:

- build self-reliance at a personal and community level;
- include the person and their supporting family members / carers in the planning and delivery of services;
- adopt a co-operative approach by a range of health and related agencies (for example housing, transport, welfare and local government agencies);
- integrate services across the lifespan to facilitate continuity of care; and
- work proactively with marginalised, vulnerable and high-risk groups including early intervention and management of people with chronic and complex conditions.

Scope of Services

A broad range of activities are provided by ambulatory care and community health services including assessment, diagnostic services, treatment, counselling, case management, health education and group programs. The scope of services to be provided within an individual facility will be determined by a clinical services plan including the range of services to be provided and the associated models of care. Increasingly, ambulatory care and community health centres provide a 'hub' from which many home-based and outreach services are delivered.

The following services are included within the scope of this HPU. Other services frequently provided within these centres, e.g. oral health, renal dialysis, allied health, diagnostic services such as cardiac investigations, medical imaging, pathology and pharmacy are covered in separate HPUs as noted under Section 1.2.

- Multidisciplinary and specialist consultation and treatment clinics for medical and surgical sub-specialties (otherwise known as outpatient clinics)
- Same day medical services such as minor procedures and/or infusion services
- Specialty same day medical services such as oncology and haematology
- Child, youth and family services, including antenatal / postnatal clinics / outreach, child assessment, early childhood services, immunisation, child protection services (including developmental services), early intervention services, child protection counselling and youth health services
- Mental health services (non-inpatient services), including, adolescent mental health, child mental health (including early intervention services), early intervention programs, adult acute and recovery programs, older persons mental health programs, eating disorder programs and crisis teams
- Drug and alcohol treatment programs (including drug diversion programs and pharmacotherapy clinics / opioid treatment programs)
- Aged care and rehabilitation services, including aged care assessment teams (ACAT), dementia services, falls prevention
- Aboriginal health services including Aboriginal maternal and infant health services
- Chronic disease management services
- Community connection programs
- Continence services
- Counselling services
- Communicable disease services
- Gambling addiction
- Family violence
- Health promotion and education
- Home nursing / midwifery services
- Men’s health services
- Multicultural health services
- Needle and syringe programs
- Palliative care (non-admitted services)
- Sexual assault counselling services
- Sexual health services
- Stomal therapy services
- Women’s health services, including family planning and screening services such as BreastScreen

02 PLANNING

2.1 OPERATIONAL MODELS

Overarching Operational Models

Models and service configurations for ambulatory care and community health will vary depending on local requirements. The operational model should support the optimal delivery of health and related services to patients/clients, while also providing a safe and supportive environment for staff.

As noted above, community health centres should be planned and designed to deliver integrated primary and community services. This service integration may, in some cases, extend to partnerships with other health and social care agencies or include services that have traditionally been provided in acute care settings.

Common operational models for ambulatory care and community health services include:

- centralised ambulatory care model whereby outpatient clinics for a broad range of clinical specialties are collocated in a single location, supported by clinical support services such as pharmacy, pathology collection and medical diagnostic and treatment services. This model may be provided in both small rural/regional facilities as well as large tertiary/quaternary health facilities, however it is acknowledged that many support services e.g. pharmacy, would not be duplicated in smaller hospitals;
- comprehensive care model whereby outpatient clinics and related diagnostic services are collocated with other services across the care continuum for that particular medical specialty or group of specialties (e.g. cancer services, ophthalmology, cardiology and respiratory). This model is only achievable where there is a significant volume of activity and is therefore usually only provided in large healthcare facilities. A mixed model is also often provided; and
- multidisciplinary clinics are frequently provided as part of ambulatory care and community health services, such as high-risk foot clinics and gestational diabetes clinics where multiple disciplines provide services concurrently.

Method of Service Delivery

Ambulatory care and community health services may be provided on an individual, one-to-one basis or via group sessions. Services will be delivered by:

- staff who are predominantly based in the Ambulatory Care / Community Health Centre;
- outreach staff who undertake work in the community but return to the Centre for supplies and to carry out administrative tasks, attend meetings etc.;
- in-reach staff who are based in other facilities predominantly, but visit the Centre to deliver a service; or
- virtual care whereby services are delivered through videoconferencing to assess, monitor and treat patients in their own home, or other community location as described in further detail below.

Integration of Services

Services should be integrated rather than arranged by service type. Exceptions include services where specialised facilities are required (e.g. dental chairs, podiatry chairs and dialysis treatment spaces).

Where possible, a range of bookable spaces will be provided to undertake:

- patient / client based activities (e.g. consult rooms, interview rooms, treatment rooms and group meeting rooms), and
- staff activities (e.g. meeting rooms).

Flexibility

The mix of services, service models, and demand for services will change over time. Approaches that cluster client treatment space in a single area will promote flexibility.

Sharing of facilities between different services should be maximised (e.g. reception and waiting areas, interview, treatment and meeting rooms and staff amenities). This will reduce the underutilisation of space, deliver efficiencies relating to facilities management and maintenance, and promote collaboration and interaction between services. It is acknowledged however that services with high patient / client volumes may benefit from a decentralised reception and sub-waiting area.

Virtual Models of Care / Telehealth

Virtual models of care, such as telehealth, are increasingly being implemented to deliver services remotely for patients in their own home, residential aged care facilities, other health facilities, GP practices and other locations. This model of service delivery is used for a range of ambulatory and community health services including individual consultations, counselling, education, and group programs. In addition, advances in cameras, monitoring devices and apps are better enabling remote monitoring of patients. There are significant benefits associated with virtual models of care including improved ease of patient access to services, a more comfortable environment for patients, improvements in service efficiency, and reduced demand on health facilities.

Virtual models of care must be considered during the clinical services planning process to inform the facility solutions required including the types and quantum of spaces and ICT infrastructure needed to support virtual care.

All patient care areas should be enabled for the use of fixed or mobile telehealth units. ICT solutions must also support clinicians providing remote clinical care. This may include individual consultations or group programs that may require sufficient space to demonstrate exercises or activities.

2.2 OPERATIONAL POLICIES

2.2.1 General

Operational policies have a major impact upon the planning, design and capital and recurrent costs of health facilities. Project teams should review their design proposals with these in mind and be able to demonstrate that the capital and recurrent cost implications of proposed operational policies have been fully considered. Operational policies may have site-wide application or be unit-specific. A list of general operational policies that may apply can be found in Part B: Section 80 General Requirements.

2.2.2 Hours of Operation

Most patient / client services will be delivered Monday to Friday from 8.00am to 5.00pm although hours are increasingly becoming more flexible to meet specific patient / client requirements and extending to evenings and weekends, particularly where urgent care services are provided e.g. family violence services.

2.2.3 Room Bookings - Clinical Support

A centralised room booking system should be installed for both patient consulting / treatment and shared staff space (e.g. meeting rooms) to maximise room utilisation. Rooms will be bookable and generally not “owned” by a service to increase flexibility and utilisation. Exceptions may include specialised rooms such as a dental surgery.

A range of rooms will be required to support one-on-one consultations and family consultations. Larger rooms will be required for group activities. Wherever possible, rooms should be generic to promote flexible use.

Lockable storage for discipline or specialty specific equipment and resources may be provided within close proximity to these rooms.

2.2.4 Patient / Client Records

Ideally, electronic health care records will be in use and staff will need access to electronic patient information in each treatment space to access the records. This may be via desktop PCs (in consult rooms), workstations on wheels or other mobile devices.

Hard copy records are still used in most facilities, particularly in relation to external referrals and research records.

2.2.5 Management of Patients / Clients with High Care Needs

Patients with high care needs, such as those from residential aged care facilities or another health facility, will use ambulatory care facilities. These patients should be managed in a holding bay, such as within a collocated medical day stay or transit lounge area, where they will receive supervision by staff prior to their appointment. Their appointment may be provided in the patient bay area to avoid moving the patient frequently. Isolated holding bays should be avoided as they are difficult to staff and ensure optimal patient safety.

Access for these patients via patient transport vehicles will require consideration.

2.2.6 Management of Patients / Clients with Behaviours of Concern

Patients presenting with behaviours of concern may be caused by a range of conditions, including general medical conditions (e.g. brain injury, dementia), drug and alcohol issues and mental health conditions. When assessing and managing these patients within ambulatory care and community health units the safety of the patient, staff and others is the priority.

Patient consult and interview rooms will need to be arranged so that staff can exit rooms easily when they feel unsafe. This may be through the provision of a second door or the arrangement of furniture within the room. A risk assessment and local jurisdictional policies will inform the number and types of rooms requiring a second egress point.

2.2.7 Mental Health Services

Mental health services may be provided in ambulatory or community health settings. Ideally, these services will be integrated with other services, so people can access a range of health and related care (e.g. chronic disease management, allied health and oral health services).

Rooms used to interview or treat people with mental health conditions will need to be designed to meet mental health requirements to reduce risks to staff and patients. Refer to the relevant AusHFG Standard Components.

Depending on the model of care, bookable meeting rooms may also be needed for group activities.

2.2.8 Medical Day Treatment Services

Treatment bays may be provided to manage a range of treatments, e.g. chemotherapy, allergy testing, infusions, and minor medical procedures. These bays are often collocated with a treatment or procedure room and collocated so patients can be easily supervised and staff resources maximised.

2.2.9 Hospital in the Home Services

Hospital in the Home (HITH) is a clinical model which provides admitted acute / sub-acute care in the patient's home or in the community as a substitute for in-hospital care. It is not always feasible for care to be provided in the patient's home so HITH services may be provided in an ambulatory or clinic environment.

Due to the significant growth in services, HITH is often delineated into specialty streams, e.g. adults, paediatrics, maternity, and mental health, and is frequently supported by telehealth.

Common conditions managed by HITH include complex wounds requiring negative pressure wound therapy (NPWT); administering of antibiotics via PICC line or cannula; pre / post procedure clexane/re-warfarinisation and management of drain tubes (e.g. for post-surgical patients and pancreatitis).

Clients may attend an ambulatory care centre for HITH services depending on what best meets their needs while providing safe, cost efficient and effective care. HITH services are commonly based on an acute health site, however they may be located in other facilities to support ease of access to services.

2.2.10 Pharmacotherapy (Opioid Treatment) Clinic

A pharmacotherapy unit for the treatment of opioid dependence may be provided in selected services. The aim of these clinics is to reduce harm associated with non-medical use of opioids. This encompasses negative health, social and economic effects on both individuals and the community.

Services are delivered through a multidisciplinary team (MDT) approach incorporating specialist medical, nursing, allied health and pharmacy professionals providing a mix of medical care (including prescribing), case management, counselling, and monitoring services.

Generally, pharmacotherapy services are integrated with other community health / ambulatory care services with access to consultation and interview rooms depending on the range of services provided.

These specialist services may be supplemented by methadone and buprenorphine dosing on site depending on local jurisdictional policies and where there are no other dosing facilities available and accessible. Methadone and buprenorphine are opioid agonists and are used to prevent the onset of opioid withdrawal, reduce cravings and reduce the effects of additional opioid use. There are strict design requirements relating to dosing clinics given these are Schedule 8 (S8) drugs of addiction and the location of these services on site will require careful consideration.

2.2.11 Patient Flow

Visitor traffic in ambulatory care and community health units can be significant. Active communication using staff or electronic systems (e.g. messaging, electronic notice boards, and queuing systems) can help. Reducing large waiting areas into smaller ‘sub wait’ areas can also improve patient flow and reduce stress. However, the design needs to ensure appropriate supervision of waiting areas from reception.

2.2.12 Teaching Clinics

Supervision of students and junior staff will be undertaken in all ambulatory care and community health units. Ideally, rooms are arranged so senior staff can supervise a group of rooms.

Telehealth technology should be available for teaching and clinical assessments.

2.2.13 Fleet Vehicles

Many staff will require access to fleet vehicles to undertake home visits. The collocation of multiple services in a Centre provides an opportunity for these vehicles to be shared and booked as required.

Secure garaging / parking of fleet vehicles will be required if the vehicles are retained on site overnight. Consideration needs to be given to safe staff access to fleet vehicles, particularly for extended hours services. Security requirements will be informed by a risk assessment.

2.2.14 Visitor Amenities

Visitor amenities will include toilets, parent / breastfeeding rooms, appropriate and safe child play areas, water dispensers and access to technology charging points. Access to an adult change facility ('Changing Places') should also be provided (one room is usually provided for the overall facility). Depending on the scale or location of the facility, visitors may have access to additional amenities such as a café, vending machines, and bicycle parking. Scooter parking and charging bays may also require consideration.

2.2.15 Staff Amenities

Where possible, staff amenities should be provided for the Centre rather than dedicated to individual services. These amenities will include staff toilets, lockers, showers, a staff room and bicycle parking.

2.3 PLANNING MODELS

Ambulatory care and community health units may range from a small facility with a few interview, consult and treatment rooms to complex service configurations accommodating a large range of specialty services. In large units, it is likely that a number of interview, consult and treatment rooms will be grouped together in "pods" with decentralised support space such as sub-waiting space and utilities.

The physical environment should be therapeutic, welcoming and universally accessible for all users.

2.3.1 Location

The location of ambulatory care and community health services will vary, depending on the outcome of service planning at a local level. Options for locating these units include:

- collocation with an acute and / or sub-acute healthcare facility;
- free-standing in a community location;
- collocated with another community or primary care service; or
- as part of a commercial development e.g. shopping centres.

When identifying a Centre location, users need to consider the service model and patient / client profile as these factors may influence the location of the facility. There will be trade-offs to consider, such as:

- collocation on a healthcare site optimises integration with acute and sub-acute services and access to a range of specialist staff however access and parking may be challenging for patients / clients;
- a community location may offer plentiful parking for staff and patients / clients, but may provide limited public transport options; and
- a town centre location may provide good public transport access, and better connectivity to other related services, but limited parking options.

Planning will need to take into consideration how consumers will access some services e.g. needle and syringe exchange services, so that privacy is maintained and there is minimal impact on neighbours (depending on the location).

Centres may also accommodate mobile visiting services, such as BreastScreen, which will require a parking bay and power.

2.3.2 Clinical Accommodation

Room requirements will be based on patient throughput / occasions of service. These need to be well detailed in the service plan prior to the commencement of a capital planning process.

To estimate the type and number of rooms required to support patient care, a suggested approach includes determining:

- the number and range of services delivered from the Centre;
- which of these services will deliver services from the Centre (noting that outreach services will generally have no requirement for patient treatment space); and
- the types of rooms each service will need to access for patient care (e.g. consult, interview and treatment rooms etc.) and which of these spaces is generic (e.g. interview room) or service specific (e.g. allied health / therapy areas, dental surgery etc).

Projected service activity and scheduling requirements will then be used to determine the optimal number of rooms required by type, ensuring that the use of each room will be maximised. When planning room requirements, an occupancy rate is usually applied as it is assumed that not all rooms will be fully utilised all day, every day.

It is assumed that no patient consultations will take place in staff offices, which will generally be collocated in a staff only zone.

Where possible, the building design must be flexible and adaptable to enable the Centre to cater for varying patient / client and service needs and for future service delivery changes.

2.3.3 Staff Work Areas

The number and type of staff work areas will be dependent on the defined staff establishment and will be allocated in accordance with relevant jurisdictional policies.

Ideally, staff work areas will be provided in a 'staff only' zone so that the area can be secured when not in use. Separation from treatment areas will also ensure confidential conversations between staff members are not overheard by the public.

In some jurisdictions, staff providing an intake service (such as primary health and community mental health) will require access to a work space when undertaking this role.

In most cases, staff work areas will be underpinned by the following principles:

- staff will undertake patient / client consultations and treatment in booked client interview, consultation and treatment spaces. Staff offices will not be used for this purpose;
- shared workstations should be provided for part-time or job share staff (where possible); and
- some shared work areas and access to lockers should be provided for visiting staff and students.

2.3.4 Cultural Considerations

Local cultural groups should be invited to input to the planning and design of the unit to ensure the delivery of culturally appropriate facilities. This may include consideration of culturally appropriate services and spaces, as well as the display of culturally relevant artwork and the use of culturally sensitive colour schemes.

2.4 FUNCTIONAL AREAS

Ambulatory care and community health units comprise the following functional areas:

- entry / reception / waiting;
- patient / client areas;
- clinical support; and
- staff areas.

The scope of these functional areas will be dependent on the service level and size.

2.4.1 Entry, Reception and Waiting

This functional area is the main visitor entry to the unit and includes the reception, main waiting and visitor amenities. The reception should oversee the main entrance and waiting areas and be identifiable from the entry point to the unit. Support areas for administrative staff will be collocated. Reception staff should be able to control access to patient treatment areas.

Self-registration and wayfinding systems may be located in the waiting area.

Larger services may decentralise some waiting space closer to clinic pods and/or to allow some separation of groups. Separate waiting and safe play areas should be provided for children and families.

The arrangement of seating should enable informal clustering of groups of different sizes rather than rows of seating. Positive distractions should be provided, such as views to nature and entertainment systems.

The waiting area should be designed to support the client's needs with consideration of programs where the waiting area provides opportunities to connect clients to services e.g. needle and syringe program.

Appropriate seating is required and must consider the needs of elderly clients, clients with a disability and bariatric clients. Services supporting elderly clients and clients with decreased mobility e.g. fracture clinics must ensure the provision of appropriate height seating with arm rests and clear paths of travel.

2.4.2 Patient / Client Areas

Multifunctional Patient / Client Care Rooms

Patient areas include a range of multifunctional, generic rooms defined by service requirements and include interview, consult, treatment, and group meeting / education rooms. These rooms should be readily accessible from waiting areas.

Patient consult and interview rooms will need to be arranged so that staff can exit rooms easily when they feel unsafe. This may be through the provision of a second door or the arrangement of furniture within the room. Depending on the service profile, a number of interview and consult rooms designed to meet mental health requirements may be provided. These may be provided as a pod or distributed across pods depending on local requirements.

This zone may also contain specialised treatment areas, depending on the defined service profile for the unit. Refer to the HPUs noted under Section 1.2 and the following information. Allied health / therapy areas are commonly provided in community health and ambulatory care settings. Information relating to these areas are included in HPU 140 Allied Health / Therapy Unit.

Medical Day Treatment Service

A medical day treatment centre provides patient bed spaces to undertake treatments, selected procedures and recovery activities. This may include HITH services for patients where it is not feasible to provide care in the home.

This area should contain a staff base which oversees bed bays and patient amenities.

The scale of the service and the number of rooms will influence the arrangement of space. Patient bays may be provided as open bays or cubicles and may include enclosed patient rooms depending on service requirements. Enclosed rooms are commonly provided for patients requiring isolation, certain procedures that require additional equipment and/or a higher level of patient privacy e.g. for intrathecal chemotherapy and apheresis, and for cultural reasons.

Bays may be grouped in pods, whilst ensuring there is still optimal visibility for staff across the unit.

The following additional considerations are required for chemotherapy services:

- medication stores will need to include separated refrigerated storage of cytotoxics, blood and medications;
- an emergency shower including eye wash is required;
- the dirty utility room will need to also accommodate a cytotoxic waste bin; and
- ideally, the chemotherapy service should be closely accessible to the oncology pharmacy for ease of access for patients to cancer related discharge medications and for pharmacists to provide education to patients.

Pharmacotherapy (Opioid Treatment) Clinic

Specialist, multidisciplinary services associated with pharmacotherapy clinics will usually be delivered within multifunctional client care rooms as described above, i.e. consultation and interview rooms, as part of an integrated approach to service delivery.

Supervised dosing of methadone or buprenorphine for the treatment of opioid dependence will only be provided in selected services in line with local jurisdictional requirements. Each state and territory have laws regulating the prescription and dispensing of these medicines and will need to be adhered to in the planning and design of these clinics, in particular relating to safety and security requirements.

Key considerations include:

- storage and administration of Schedule 8 drugs must comply with legislative requirements;
- the facility must provide a safe exit for staff in an emergency;
- all patient consultation / counselling rooms require dual egress;
- duress alarms are required in all patient care areas and reception; and
- CCTV to be provided in line with local requirements, whilst respecting the privacy and dignity of people accessing the service.

Refer to Section 4.2 Non-Standard Components for further information.

2.4.3 Support Areas

The types of support areas required will depend on the clinical requirements and operational policies for the unit. For example, the process for responding to medical emergencies requires confirmation to inform resuscitation support equipment to be accommodated.

Point of care pathology testing is not commonly provided within ambulatory care and community health settings, however it may be required to support specialised outpatient services and regional sites. A specimen collection service may be provided in some facilities for ease of patient access.

Items requiring reprocessing, e.g. podiatry instruments, will be transferred to a centralised sterilising services unit.

Storage requirements will depend on the range of equipment and consumables to be stored and local operational arrangements. For information relating to equipment loan pools refer to HPU 140 Allied Health / Therapy Unit.

Standalone centres will require a different approach to 'back of house' support services in comparison to hospital-based services. For example, disposal rooms are not usually included within a stand-alone community health centre and instead a separate, secure waste holding compound will be provided for the facility and located for kerbside collection. Operational policies will require confirmation to inform facility requirements.

The number and distribution of support areas will be dependent on the scale of the service.

2.4.4 Staff Areas

A secure staff area that is not accessible to patients will include staff work areas and amenities. The allocation of these areas will depend on the staff profile and local jurisdictional policies.

This is separate to staff work areas provided within the clinical zone for use by clinicians.

Work areas for staff providing community-based services will require consideration. This may be provided through flexible use work areas that can be used for other activities during low demand periods for staff.

2.5 FUNCTIONAL RELATIONSHIPS

2.5.1 External

Depending on the patient / client and service profile the following requirements should be considered:

- ease of access to the community by both public and private transport;
- location on a healthcare campus site for ease of access to other specialist services; and
- collocation with other public amenities routinely used by the community (e.g. shopping precinct, transport hub, library and/or other health care providers).

When located on a healthcare campus, a location close to the main entry is ideal with access to parking and a vehicle drop off / pick up point including for community / patient transport services. Large centres will require a dedicated entrance rather than patients having to be directed via the main entry.

Other external relationships may depend on the size and scale of the service. In some cases, inpatients may access selected services or patients may need to travel to other departments such as medical imaging.

Patients transferred from residential aged care or other health facilities may be transported on a trolley to the unit from an ambulance or patient transport vehicle and held in the unit while awaiting care. Access to the unit and an appropriate patient holding area with staff oversight will require consideration. Refer to section 2.2.5.

2.5.2 Internal

Within the unit:

- the entry / reception / waiting area must be designed to promote patient flow and allow patients to move easily to and from the treatment areas;
- the patient / client areas must be organised so staffing and physical infrastructure efficiencies can be achieved (e.g. adjacent to clinical support areas);

- multilevel facilities should consider the optimal location of various client groups, e.g. clients that are likely to have mobility issues or families with young children (and prams etc) should be located on the ground floor;
- some meeting and group / activity rooms should be adjacent to the main entry / reception area so they can be accessed after-hours, while the rest of the Centre is secured; and
- the staff areas must allow staff to easily move to and from the patient / client area, and the entry, reception and waiting zone.

03 DESIGN

3.1 ACCESSIBILITY

There should be a single public entry point to the unit that is easily identifiable and universally accessible. Selected services may require an alternate entry point (e.g. dosing clinics). The main entry should have weather protection and allow for vehicle drop-off. Large, clear signage is required to assist wayfinding for first time attendees.

A dedicated staff entry should be provided to ensure staff safety. This will be essential for mental health services. As this entry may be in use outside of normal business hours, the location in relation to car parking requires consideration.

Services may also be accessed by inpatients or bed bound residents from residential aged care facilities or other health facilities. Access for these patients needs to be considered in the design to separate ambulatory and bed movements, and to protect patient privacy and dignity.

3.2 PARKING

The planning and design of Centres will consider:

- the provision of drop off / pick up areas adjacent to the main entry;
- parking for visitors - the location and service mix of the Centre will influence the amount and availability;
- specific services and patient / client needs (short-term parking spaces located near the entrance);
- safe, secure and readily accessible fleet parking for staff providing a community outreach service to enable them to provide their care and service efficiently and effectively;
- under-cover drop off and parking for patient transport / ambulances; and
- safe pedestrian access from the car park to the entry.

Security issues need to be addressed when planning for after-hours parking in particular.

For information regarding staff parking, refer to AusHFG Part C Design for Access, Mobility, Safety and Security.

3.3 DISASTER PLANNING

Each unit will have operational plans and policies detailing the response to a range of internal and external emergency situations.

For further information refer to local jurisdiction disaster management plans and:

- Part B: Section 80 General Requirements; and
- Part C: Design for Access, Mobility, Safety and Security.

3.4 INFECTION CONTROL

Consideration of infection control is important in the design and operation of ambulatory care and community health units. Infection control considerations specific to these units include:

- hand hygiene facilities, including basins and alcohol-based hand rub, to be readily available in all clinical areas;
- clean and dirty flows within clinical rooms such as consult, treatment and procedure rooms;

- shared use of treatment spaces. For example, in smaller services, renal dialysis and infusion services may operate in the same environment. To avoid issues associated with these arrangements, patients may be scheduled at different times; and
- the location of stores for cleaning equipment and consumables.

For additional information refer to jurisdictional policies as well as:

- Part D: Infection Prevention and Control (2015); and
- NHMRC 2019, Australian Guidelines for the Prevention and Control of Infection in Healthcare.

3.5 ENVIRONMENTAL CONSIDERATIONS

3.5.1 Acoustics

Many functions undertaken within these units require consideration of acoustic privacy including:

- discussions / interviews with patients / clients;
- exclusion of disturbing or distracting noises during patient consultations / treatment (e.g. relaxation therapy, speech pathology, audiology assessments);
- isolation of noisy areas such as public waiting, group rooms etc;
- staff discussions regarding patient / client information; and
- general building service disturbances such as air-conditioning plant.

Solutions to be considered include:

- selection of sound absorbing materials and finishes;
- use of sound isolating construction;
- additional soundproofing for some specific rooms dependent upon their function;
- planning separation of quiet areas from noisy areas; and
- changes to operational management.

Refer to the relevant AusHFG Standard Components for design requirements.

3.5.2 Natural Light

Natural lighting and views to the exterior should be maximised throughout the unit as it:

- contributes to a sense of wellbeing;
- assists users in wayfinding and orientation; and
- improves service outcomes.

3.5.3 Privacy

The facility should be designed to:

- ensure confidentiality of client discussions and health care records;
- provide discrete sub-waiting areas for clients wishing or needing to be separated;
- enable the reason for attendance to be kept confidential (made easier through use of generic interview / consult rooms); and
- locate windows and doors to ensure privacy of clients, while maintaining the safety of staff.

3.5.4 Interior Décor

Some colours and patterns can be disturbing to some patients. The colour scheme should be attractive, non-institutional and assist with wayfinding. It should not negatively impact on clinical observation in consultation and treatment areas.

Soft furnishing selection should be considered carefully to ensure they meet clinical and infection control requirements whilst contributing to the overall attractiveness and amenity of the facility.

An art strategy should be used across the Centre to enhance the delivery of health services.

3.5.5 Signage and Wayfinding

For information refer to:

- Part C: Design for Access, Mobility, Safety and Security; and
- NSW Health GL2014_018 – 'Wayfinding for Health Facilities'.

3.6 SPACES AND STANDARD COMPONENTS

3.6.1 Ergonomics

The design of the unit will ensure patients, staff, visitors and maintenance personnel are not exposed to avoidable risks of injury.

For information refer to Part C: Design for Access, Mobility, Safety and Security.

3.6.2 Access and Mobility

Many patients visiting ambulatory care and community health units use various aids to assist with mobility. These mobility aids should be allowed for in spatial allocations and room and corridor dimensions. It is important to consider where mobility aids will be stored while treatment is in progress.

A mobile or ceiling mounted hoist should be available in a selected numbers of consult and / or treatment rooms to assist in the movement of immobile or bariatric patients and enable them to be examined appropriately.

The management of bariatric patients will need to be considered to ensure a safe and dignified environment is provided.

The AusHFG Standard Component 'Consult Room – Universal Access' provides sufficient spatial allowance to accommodate patients who are using a wheelchair including a bariatric sized wheelchair or require a hoist to transfer.

Refer to Part C: Design for Access, Mobility, Safety and Security.

3.6.3 Doors

Doorways must be positioned, oriented and dimensioned to permit the manoeuvring of wheelchairs, trolleys and equipment without risk of damage to the doorway or the item being moved and without creating manual handling risks. While a clear opening of 910 mm will be sufficient in most cases, a clear opening of 1,400mm will be required to provide access and room to manoeuvre large wheelchairs, trolleys and beds.

Refer to Part C: Design for Access, Mobility, Safety and Security.

3.7 SAFETY AND SECURITY

3.7.1 Safety

Ambulatory care and community health units should provide a safe and secure environment for visitors and staff while promoting a non-threatening and supportive atmosphere conducive to the delivery of services.

Patients / clients will have varying levels of physical and cognitive capabilities. They may be frail, affected by medication or confused.

Reception desks and staff stations should oversee entry points and waiting areas. Reception staff should be able to lock down the facility from the reception area in the event of a security concern and the design should ensure than no entrapment points are provided.

Patient consult and interview rooms will need to be arranged so that staff can exit rooms easily when they feel unsafe. This may be through the provision of a second door or the arrangement of furniture within the room to ensure that the clinician is facing the patient at all times and there is a clear path of egress that is not blocked by furniture or the patient.

A risk assessment and local jurisdictional policies will inform the number and types of rooms requiring a second egress point.

The facility, furniture, fittings and equipment must be designed and constructed in such a way that users of the facility are not exposed to avoidable risks of injury.

3.7.2 Security

The configuration of zones should offer a high standard of security by grouping like functions and controlling access to clinical and staff areas within the unit using access control systems.

Security may have a permanent presence on the site, however this will depend on local operational requirements.

Larger services may benefit from providing smaller distributed waiting spaces that can reduce noise and stress.

Duress alarm system points should be located at each reception, staff station and within each patient space such as a consult or interview room. These must be delivered in line with local jurisdictional policies and ensure they are appropriately operationalised as some community health centres may not have on site security available.

Planning should allow for after-hours access to public areas and services without compromising security of the entire building or staff within it. CCTV will generally be required at entries, in waiting rooms and car parks.

Use Crime Prevention Through Environmental Design (CPTED) principles to unobtrusively reduce risk.

Also refer to Part C: Design for Access, Mobility, Safety and Security.

3.8 FINISHES

3.8.1 Wall Protection

For further information relating to wall protection, refer to the AusHFG Standard Components and

Part C: Design for Access, Mobility, Safety and Security.

3.8.2 Floor Finishes

Floor finishes should be appropriate to the function of the space. Consideration must be given to the appearance and quality of environment required e.g. non-institutional, acoustic performance, slip resistance, infection control, the movement of trolleys and maintenance.

Refer to local jurisdictional policies and to:

- AusHFG Standard Components;
- AusHFG Part C;
- AusHFG Part D; and
- Department of Health, NSW, 2009, Technical Series TS7 - Floor Coverings in Healthcare Buildings.

3.8.3 Ceiling Finishes

Ceiling finishes should be selected with regard to appearance, cleaning, acoustics and access to building services. In most areas, acoustic ceiling tiles will be used.

For further information relating to ceiling finishes, refer to Part C: Design for Access, Mobility, Safety and Security.

3.9 FIXTURES, FITTING & EQUIPMENT

Room Data and Room Layout Sheets in the AusHFG specify fixtures, fittings and equipment (FFE). The FFE specified for each clinical space should consider:

- generic approaches where possible to increase utilisation and flexibility; and
- specialist requirements that will influence fixed equipment and minimum dimensions of particular rooms (e.g. ophthalmology consult room).

Refer to the Room Data Sheets (RDS) and Room Layout Sheets (RLS) as well as Part C: Design for Access, Mobility, Safety and Security.

3.10 BUILDING SERVICE REQUIREMENTS

3.10.1 Information and Communications Technology

These units will manage a diverse range of patients / clients. When located on a healthcare campus, it may have functional links to many other departments. Reliable and effective information and communications technology systems are essential for the efficient and effective functioning of the unit.

Unit design should address information technology and communications issues including:

- electronic health care records;
- mobile / hand-held computers or tablets;
- scanners for patient referrals, consent forms etc;
- electronic booking systems;
- self-registration, queueing and/or wayfinding systems;
- telehealth, either fixed or mobile solutions;
- Picture Archiving Communication System (PACS);
- Patient Administration System (PAS);
- paging, messaging and personal telephones replacing some aspects of call systems;

- point of care clinical systems including medication scripts and diagnostic requests;
- logistics systems such as pneumatic tube systems;
- communication and wayfinding systems; and
- bar coding for supplies.

All clinical rooms will need to be equipped or made ready for the equipment necessary to support electronic health records, prescribing and booking systems. Local jurisdictions may choose to centralise printing equipment rather than providing these in each clinical room.

All patient care areas should be equipped for the use of fixed or mobile telehealth systems. This equipment may be used to:

- provide specialist input to patients in rural and remote locations;
- link clinical staff such as GPs and specialists from tertiary hospitals; and
- provide training and support to staff.

Mobile telehealth units will need to be docked and recharged.

Staff providing outreach services will require access to laptops and / or tablets. Readily available wireless internet connections, secure storage and adequate charging stations will be required to support these work practice changes.

Also refer to Part B: Section 80 General Requirements.

3.10.2 Call Systems and Messaging

All clinical spaces should have access to an emergency call system so staff can summon urgent assistance. Access to a duress system is also essential as outlined under Section 3.7.2.

Patient to nurse call is required in medical day stay / procedural areas. In these areas, treatment is usually commenced and then the patient is left for a while.

Patient to nurse call is not routinely provided in other clinical rooms given clinicians are usually with the patient / client at all times. However, this should be confirmed on a project by project basis to meet clinical requirements.

Refer to the relevant AusHFG standard components for further detail regarding call systems.

3.10.3 Electrical Services

All patient areas must be wired at least as body-protected electrical areas in accordance with Standards Australia, 2018, AS/NZS 3003:2018.

It is essential that services such as emergency lighting, telephones, duress alarm systems and electronic locks are connected to the emergency power supply.

The electrical power distribution system in these units has the potential to cause interference to electro-diagnostic equipment such as electrocardiographs (ECG), electroencephalographs (EEG), electromyographs (EMG) and other diagnostic equipment. Every effort should be made to ensure diagnostic rooms are located a suitable distance from high current plant and equipment (e.g. as lifts, medical imaging equipment, air conditioning machinery), electrical distribution boards, local switchboards, low voltage or high voltage feeder cables and any other source of mains frequency radiation.

Visiting mobile services such as BreastScreen may require access to a Phase 3 power outlet to operate the service.

3.10.4 Medical Gases

The reticulation of medical gases (oxygen, medical air and suction) is recommended for procedure rooms, treatment rooms and medical day stay / procedural areas, where patients stay for longer periods of time.

The provision of medical gases within other clinical rooms is optional depending on clinical requirements and should be confirmed on a project by project basis.

Refer to the relevant AusHFG standard components for further details.

04 COMPONENTS OF THE UNIT

4.1 STANDARD COMPONENTS

Rooms / spaces are defined as:

- standard components (SC) which refer to rooms / spaces for which room data sheets, room layout sheets (drawings) and textual description have been developed;
- standard components – derived rooms are rooms, based on a SC but they vary in size. In these instances, the standard component will form the broad room 'brief' and room size and contents will be scaled to meet the service requirement;
- non-standard components which are unique rooms that are usually service-specific and not common.

The standard component types are listed in the attached Schedule of Accommodation. The current Standard Components can be found at: https://www.healthfacilityguidelines.com.au/standard-components.

4.2 NON STANDARD COMPONENTS

Non-standard components are unit-specific and provided in accordance with specific operational policies and service demand. These non-standard components for ambulatory care and community health units are detailed below.

The rooms below relate to the supervised dosing of methadone and buprenorphine and will only be provided in selected sites depending on local jurisdictional requirements.

4.2.1 Opioid Treatment - Dosing Area

Description and Function

The dosing area provides individual patient dosing of methadone and buprenorphine as part of an Opioid Treatment Program.

Location and Relationships

The dosing area will be located adjacent to the dispensary for receipt of medication with unidirectional flow of clients from the waiting area through the dosing area to the exit.

Access to a toilet will be provided which will also be used for supervised urine specimens.

Considerations

Key requirements for the room include:

- a security screen between the dosing area and dispensary is required with a pass-through hatch and intercom system;
- consideration of the use of technology such as eye scanning technology for client identification; and
- access to drinking water.

4.2.2 Opioid Treatment - Dispensary

Description and Function

The dispensary is a secure, staff only room used to dispense methadone and buprenorphine treatments.

Location and Relationships

Access to the dosing area is required through a security screen and pass through hatch, along with staff observation into an adjacent patient toilet for supervised urine specimens.

Considerations

Key requirements for the room include:

- security screen between the dosing area and dispensary is required with a pass-through hatch and intercom system;
- computer and monitor;
- handwash basin, Type B;
- benches for preparation;
- under-bench refrigerator for urine samples; and
- duress alarm.

05 APPENDICES

5.1 SCHEDULE OF ACCOMMODATION

The application of the schedule of accommodation below will require confirmation of the types of ambulatory care and community health rooms / spaces to be provided and the associated capacity requirements through detailed clinical services planning.

The schedule of accommodation provided is based on the following two indicative scenarios:

1. 12 multifunctional, generic patient / client care rooms (comprising a mix of consult, interview and treatment rooms) and 12 medical day stay spaces; and
2. 36 multifunctional generic patient / client care rooms (comprising a mix consult, interview and treatment rooms arranged into pods) and 24 medical day stay spaces.

It is assumed that these units are integrated with shared access to reception, waiting and clinical support areas. As noted in the schedule of accommodation, the larger units may be arranged into pods with decentralised waiting and support areas where appropriate.

The number and size of support areas will require adjustment to reflect the total capacity requirements, the arrangement of units / pods and the staffing profile.

An indicative schedule of accommodation is also provided for an opioid treatment unit, noting that these units must comply with local regulatory requirements.

When a unit incorporates specialist services requiring specialist rooms, this information will be found in other HPUs as outlined in Section 1.2. This includes allied health, cardiac investigations, oral health and renal dialysis services.

The ‘Room/ Space’ column describes each room or space within the unit. Some rooms are identified as ‘Standard Components’ (SC) or as having a corresponding room which can be derived from a SC. These rooms are described as ‘Standard Components –Derived’ (SC-D). The ‘SD/SD-C’ column identifies these rooms and relevant room codes and names are provided.

All other rooms are non-standard and will need to be briefed using relevant functional and operational information provided in this HPU.

In some cases, Room/ Spaces are described as ‘Optional' or ‘o’. Inclusion of this Room / Space will be dependent on a range of factors such as operational policies or clinical services planning.

Entry / Reception / Waiting

It is assumed that the entry, reception and waiting areas are shared between the multifunctional rooms and medical day treatment areas, however these may be decentralised/ arranged into 'sub wait' areas to support separated pods within larger units.

AusHFG Room Code	Room / Space	SC / SC-D	12 Rooms + 12 Medical Day Spaces		36 Rooms + 24 Medical Day Spaces		Remarks
			Qty	m2	Qty	m2	
AIRLE-10	Airlock - Entry	Yes	1	10	1	10	Only provided when located on a stand-alone site or where a dedicated external entry is provided.
RECL-10	Reception / Clerical	Yes	1	10	1	20	May be decentralised with separate sub-wait areas for each zone.
WAIT-30	Waiting	Yes	1	30	2	25	Area recommendation is indicative and will depend on the no. of people to be accommodated. 1.2m2 recommended per seat, 1.5m2 per wheelchair space. May be further divided into sub-wait areas for appropriate separation of client cohorts (eg a separated waiting area for families with children) and to facilitate way-finding. Consider infrastructure requirements for patient self-registration and access to education / health promotion resources.
PLAP-10	Play Area - Paediatrics	Yes	1	8	1	10	
BWC	Bay - Wheelchair Park	Yes	1	2	1	4	
BWD-1	Bay – Water Dispenser	Yes	1	1	1	1	
WCPU-3	Toilet - Public	Yes	1	3	2	3	Number of toilets to align with BCA requirements.
	Discounted Circulation %		25%		25%		

Patient Areas

The number of client / patient care rooms included below is indicative only and based on the scenarios described above. The number and types of ambulatory care and community health rooms / spaces to be provided will be determined for the project through detailed clinical services planning.

Multifunctional Rooms

AusHFG Room Code	Room / Space	SC / SC-D	12 Rooms		36 Rooms		Remarks
			Qty	m2	Qty	m2	
CONS	Consult Room	Yes	6	12	20	12	Assume large units are divided into pods. Number dependent on scope of services and projected utilisation. 14m2 required for child-related services.
CONS-UN	Consult Room - Universal Access	Yes	1	17	1	17	Number to be provided will depend on the patient cohort.
INTF	Interview Room	Yes	4	12	12	12	Assume large units are divided into pods. Number dependent on scope of services and projected utilisation.
TRMT	Treatment Room	Yes	1	14	3	14	For minor procedures, number dependent on scope of services and projected utilisation.
WCPT	Toilet - Patient	Yes	1	4	2	4	Collocate with specimen collection bay where provided for urine testing. Observed urine testing for drug screening will require appropriate design.
BHW	Bay - Height / Weight	Yes	1	2	1	2	
CLUR-8	Clean Utility / Medication Room - Sub	Yes	1	8	1	12	
OFF-CLN	Office - Clinical Workroom	Yes	1	12	3	12	Assume 1 per pod
	Office – Workstation			4.4		4.4	The majority of work areas should be located in the staff zone, however a number of workstations may be required within the clinical zone. Number and area allocation will depend on staff profile and local jurisdictional policies.
	Discounted Circulation %		32%		32%		

Medical Day Treatment

AusHFG Room Code	Room / Space	SC / SC-D	12 Spaces		24 Spaces		Remarks
			Qty	m2	Qty	m2	
TRMT-CHE	Treatment Bay	Yes	11	9	22	9	Acute treatment spaces. May be arranged in pods of 2-4 chairs, designed to ensure staff have oversight across the unit.
1BR-H-12	1 Bed Room - Holding	Yes	1	12	2	12	Allocation is indicative only and inclusion will be dependent on local requirements. Inclusion of positive or negative pressure rooms will depend on service scope.
ENS-ST	Ensuite - Standard	Yes	1	5	2	5	For enclosed/isolation rooms.
BHWS-B	Bay - Handwashing, Type B	Yes	3	1	6	1	1 between 4 spaces
BMEQ-4	Bay - Mobile Equipment	Yes	1	2	1	4	
SSTN-10	Staff Station	Yes	1	10	1	14	
CLUR-8	Clean Store / Medication Room - Sub	Yes	1	8	1	12	Assumes combined room, however these may be separate rooms depending on clinical requirements and local policies. Assume +4m2 for chemo services to accomodate cytotoxic, blood and medication fridges and additional IV fluids.
DTUR-S	Dirty Utility - Sub	Yes	1	8	1	12	May also include disposal room function. Inclusion of pan washer, pan and bottle racks is optional. Chemo services will include cytotoxic waste.
WCPT	Toilet - Patient	Yes	1	4	3	4	
WCAC	Toilet - Accessible, 6m2	Yes	1	6	1	6	
	Discounted Circulation %		32%		32%		

Shared Support

AusHFG Room Code	Room / Space	SC / SC-D	12 Rooms + 12 Medical Day Spaces		36 Rooms + 24 Medical Day Spaces		Remarks
			Qty	m2	Qty	m2	
BBEV-OP	Bay - Beverage, Open Plan	Yes	1	4	1	4	
BLIN	Bay - Linen	Yes	1	2	1	2	
STEQ-14	Store - Equipment	Yes	1	7	1	14	
STGN-9	Store - General	Yes	Share		1	9	Sized to meet storage needs and operational arrangements.
CLRM-5	Cleaner's Room	Yes	1	5	1	5	May be shared with an adjacent service.
	Discounted Circulation %		32%		32%		

Staff Areas

The allocation of staff areas will depend on local jurisdictional policies.

AusHFG Room Code	Room / Space	SC / SC-D	12 Rooms + 12 Medical Day Spaces		36 Rooms + 24 Medical Day Spaces		Remarks
			Qty	m2	Qty	m2	
OFF-S9	Office - Single Person	Yes		9		9	Number and area allocation will depend on staff profile and local jurisdictional policies.
	Office – Workstation			4.4		4.4	Number and area allocation will depend on staff profile and local jurisdictional policies.
STPS-8	Store - Photocopy / Stationery	Yes	1	4	1	8	
MEET-L-20	Meeting Room	Yes	1	15	1	20	Size will depend on number of people to be accommodated.
SRM-15	Staff Room	Yes	1	15	1	15	Requirements will depend on staff profile and oportunity to share with adjacent services.
PROP-2	Property Bay - Staff	Yes	1	1	1	2	Indicative only and space allocation will be dependent on staff numbers and local policies.
WCST	Toilet - Staff	Yes	2	3	3	3	Number in accordance with staff profile. Access to an accessible toilet will be required.
	Discounted Circulation %		25%		25%		

Opioid Treatment – Dosing Unit (Optional)

The provision of a specialist clinic for methadone and buprenorphine dosing will depend on local jurisdictional policies and where there are no other dosing facilities available and accessible.

Local regulatory requirements will need to be adhered to when designing dosing clinics given these are Schedule 8 (S8) drugs of addiction.

AusHFG Room Code	Room / Space	SC / SC-D	Qty	m2	Qty	m2	Remarks
WAIT-10	Waiting	Yes	1	20	1	20	
	Dosing Area		1	4	1	4	
	Dispensary		1	9	1	9	
WCAC	Toilet - Accessible	Yes	1	6	1	6	Specimen collection
CLUR-8	Clean Utility	Yes	1	8	1	8	Including S8 drug safe.
	Discounted Circulation		25-32%		25-32%		

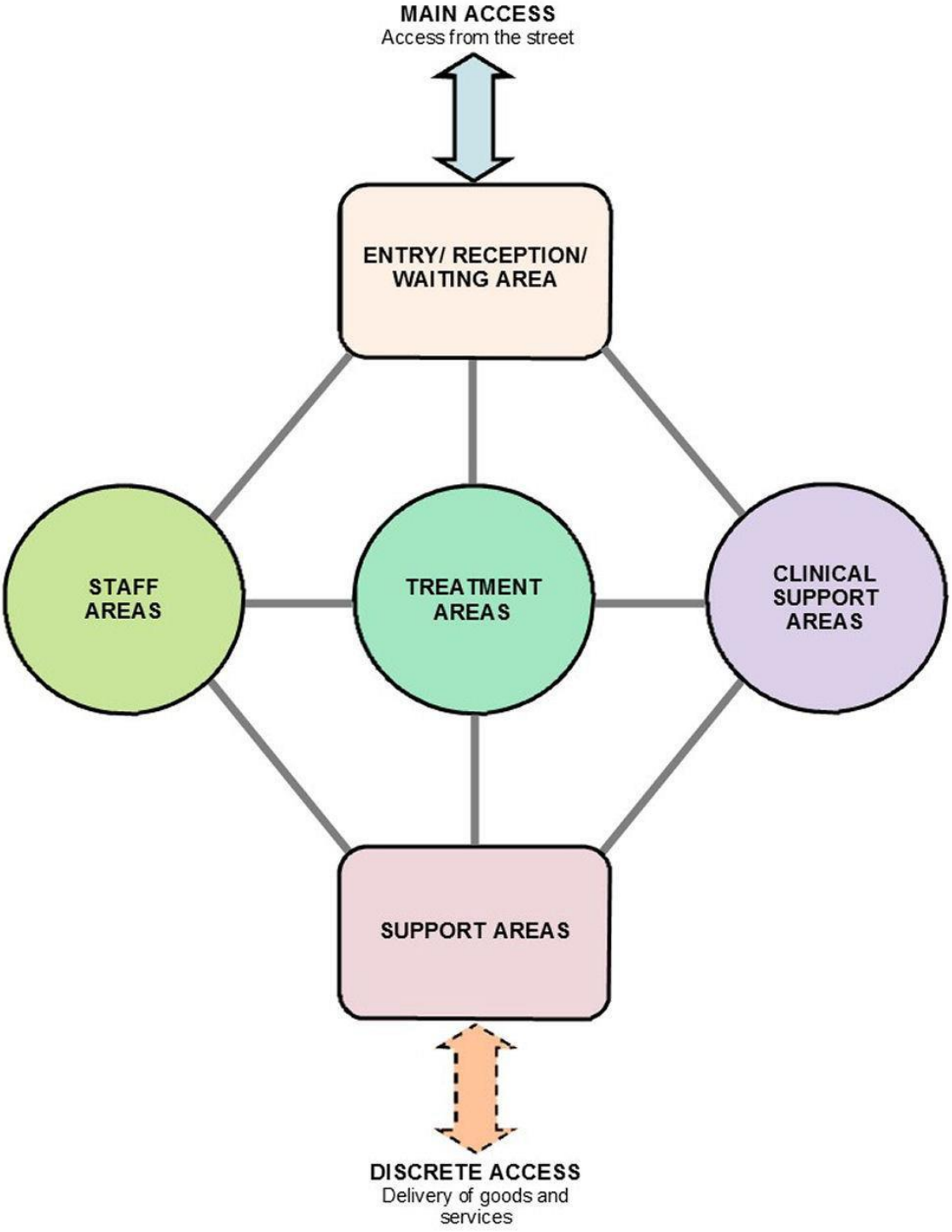
Optional Areas

The inclusion of the optional areas below is dependent on the service scope; local clinical and / or operational requirements and opportunities to share with adjacent areas. The requirement for each area should be confirmed on a project by project basis and included where it is essential to meet the service need.

AusHFG Room Code	Room / Space	SC / SC-D	12 Rooms +		36 Rooms + 24		Remarks
			Qty	m2	Qty	m2	
Entry, Reception, Waiting							
WCAC	Toilet - Accessible	Yes	1	6 (o)	1	6 (o)	Optional. To be included if not located nearby.
PAR	Parenting Room	Yes	1	6 (o)	1	6 (o)	Optional. To be included if not located nearby.
Multifunctional Rooms							
INTF-MH	Interview Room - Mental Health	Yes		14 (o)		14 (o)	Optional. For patients with mental health conditions to reduce risk to staff and patients.
SPECC	Specimen Collection Bay	Yes		9 (o)		9 (o)	Optional. Inclusion is dependent on service scope. 9m2 assumes provision of an open bay. Assume 12m2 for an enclosed specimen collection room.
MEET-L-20	Meeting Room, Medium	Yes	1	20 (o)	1	20 (o)	Use for group activities, education and integrated care case reviews. Number and size is dependent on scope of services and projected utilisation.
MEET-L-30	Meeting Room, Large	Yes			1	40 (o)	Commonly used for community health group classes and education. Size will be dependent on scope of services and projected utilisation. Provide external access for after hours use. Consider telehealth requirements.
	Observation Room			9 (o)		9 (o)	Optional. Highly utilised by allied health.
DTUR-S	Dirty Utility - Sub	Yes	1	8 (o)	1	8 (o)	Optional. May include a combined disposal room function. Requirements will depend on service profile, eg these are frequently used for continence and palliative care clinics. Inclusion of pan washer, pan and bottle racks is optional.
Medical Day Treatment							
CONS	Consult Room	Yes	1	12 (o)	1	12 (o)	Optional, if service is not collocated with other ambulatory care services.
PROC	Procedure Room	Yes		20 (o)		20 (o)	Optional. Inclusion and number dependent on service scope and utilisation.
BES	Bay - Emergency Shower	Yes	1	1 (o)	1	1(o)	Optional, depending on service profile. Includes emergency eye wash. Required for chemo services.
Shared Support							
BRES	Bay - Resuscitation	Yes	1	1.5 (o)	1	1.5 (o)	Inclusion will depend on operational policies. May include basic or advanced life support trolleys depending on service profile.
DISP-8	Disposal Room	Yes	1	8 (o)	1	10 (o)	Optional. May be shared with an adjacent service or provided as a separate waste compound for the facility eg for standalone community health centres. Other 'back of house' services requirements will require confirmation for stand alone centres.

5.2 FUNCTIONAL RELATIONSHIPS / DIAGRAM

The following diagram sets out the functional relationships between zones in an ambulatory care and / or community health unit.



5.3 REFERENCES

- AHIA, 2016, AusHFG Part B: Section 80 General Requirements, Australasian Health Facility Guidelines, Australasian Health Infrastructure Alliance (AHIA), Sydney NSW.
- AHIA, 2016, AusHFG Part B: 140 Allied Health / Therapy Unit, Australasian Health Facility Guidelines, Australasian Health Infrastructure Alliance (AHIA), Sydney, NSW
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- AHIA, 2017, 510 Maternity Unit; Australasian Health Facility Guidelines, Australasian Health Infrastructure Alliance (AHIA), Sydney, NSW
- AHIA, 2016, 540 Paediatric / Adolescent Unit; Australasian Health Facility Guidelines, Australasian Health Infrastructure Alliance (AHIA), Sydney, NSW
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- AHIA, 2016, 620 Renal Dialysis Unit; Australasian Health Facility Guidelines, Australasian Health Infrastructure Alliance (AHIA), Sydney, NSW
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- Commonwealth of Australia, 2013, National Primary Health Care Strategic Framework, Canberra ACT.
- National Health and Medical Research Council (NHMRC), 2019 'Australian Guidelines for the Prevention and Control of Infection in Healthcare', Australian Government, Canberra.
- NSW Health GL2014_018 – 'Wayfinding for Health Facilities'.

5.4 FURTHER READING

- NSW Health, GL2019_011 Outpatient Services Framework.
- NSW Health GL2018_020 Adult and Paediatric Hospital in the Home Guideline
- NSW Health, GL2018_019 NSW Clinical Guidelines: Treatment of Opioid Dependence.

- NSW Health, Protecting People and Property, 2013, NSW Health Policy and Standards of Security Risk Management in NSW Health Agencies.
- Victorian Government, Department of Health and Human Services, 2016, Policy for Maintenance Pharmacotherapy for Opioid Dependence.