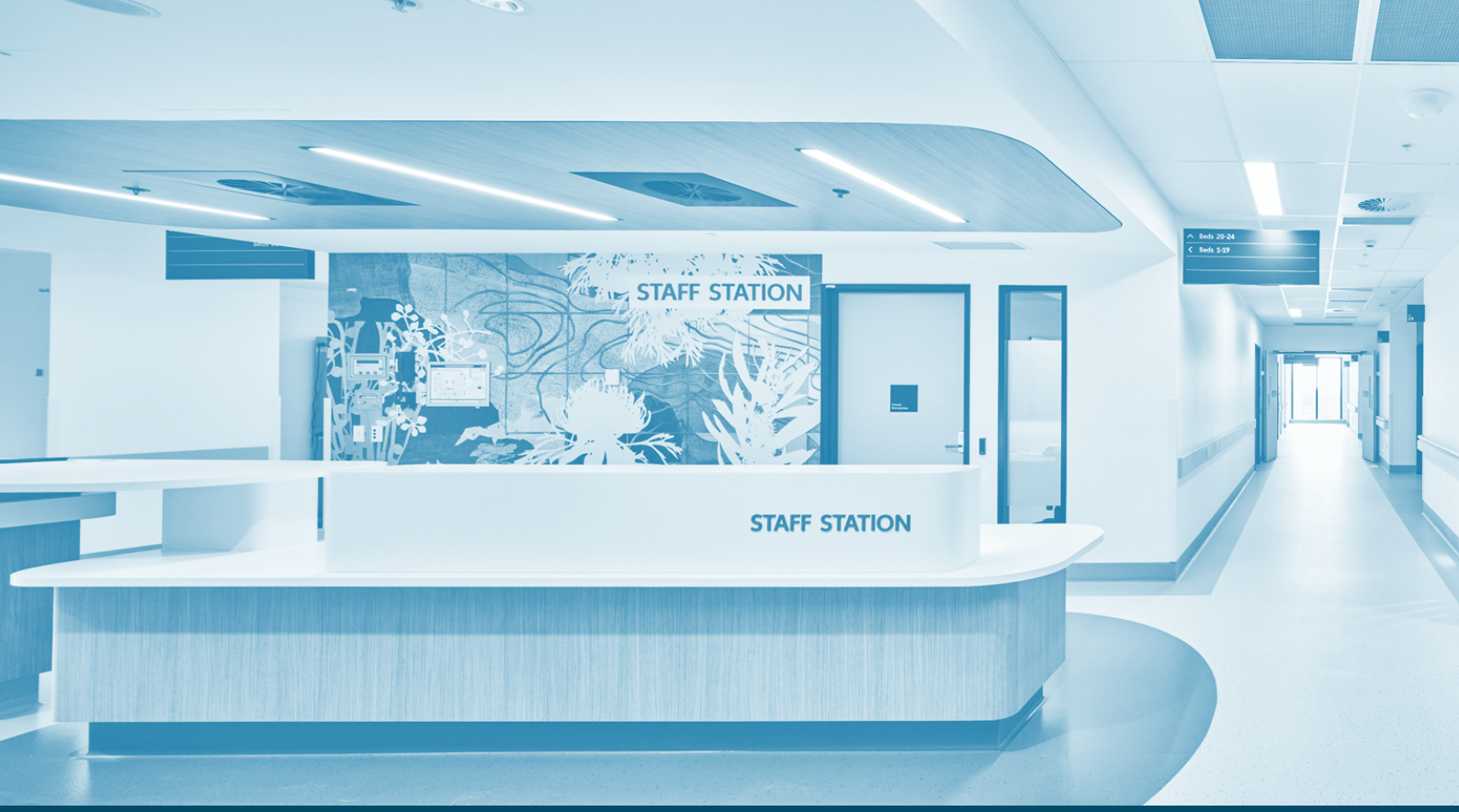

Australasian Health Facility Guidelines

HPU 155 Ambulatory Care and Community Health

Health Facility Briefing, Planning and Design

March 2026

Version 8

AHIA australasian health infrastructure alliance
AusHFG Australasian Health Facility Guidelines

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Australasian Health Facility Guidelines

Website: http://www.healthfacilityguidelines.com.au

Email: HI-AusHFGteam@health.nsw.gov.au

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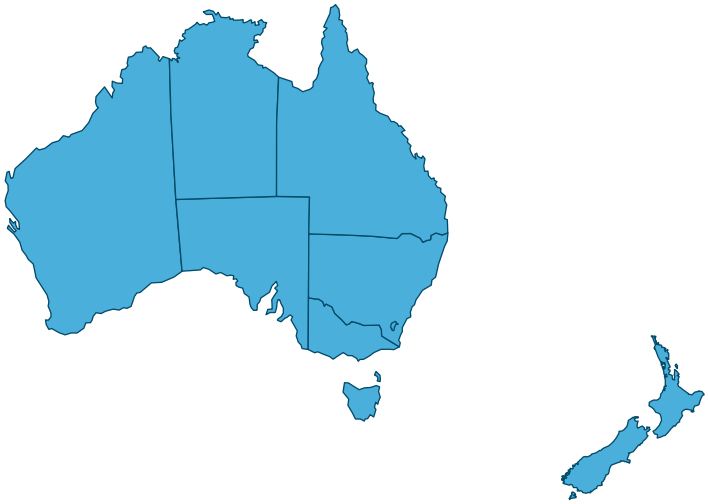
Image cover: Nepean Hospital NSW, NSW Health Infrastructure

Cultural Acknowledgement and Terminology

The Australasian Health Facility Guidelines (AusHFG) are developed in collaboration with stakeholders across Australia and Aotearoa, New Zealand.



Acknowledgement of Country

We acknowledge the Aboriginal people and Torres Strait Islander People as traditional owners and continuing custodians of the land throughout Australia and the Torres Strait Islands.

We acknowledge their connection to land, sea, sky and community and pay respects to Elders past and present.

Acknowledgement of Te Tiriti o Waitangi

Te Tiriti o Waitangi obligations have been considered when developing the AusHFG resources.

Terminology and Language in the AusHFG

Throughout the AusHFG resources, the term ‘Indigenous Peoples’ is used to refer to both the Aboriginal and Torres Strait Islander Peoples of Australia and Māori of Aotearoa, New Zealand. Where references to specific cultural requirements or examples are described, the terms ‘Aboriginal and Torres Strait Islander Peoples’ and ‘Māori’ are used specifically. The AusHFG respect the right of Indigenous Peoples to describe their own cultural identities which may include these or other terms, including particular sovereign peoples or traditional place names.

Contents

Acronyms

Acronym	Definition
AHIA	Australasian Health Infrastructure Alliance
AS	Australian Standard
AS/NZS	Australian and New Zealand Standard
AusHFG	Australasian Health Facility Guidelines
CCTV	Closed Circuit Television
ENT	Ear, Nose and Throat
FF&E	Furniture, Fittings and Equipment
GP	General Practice
HITH	Hospital in the Home
HPU	Health Planning Unit
ICT	Information and Communication Technology
IPC	Infection Prevention and Control
MDT	Multidisciplinary Team
NGO	Non-Government Organisation
PET	Positron Emission Tomography
RMD	Reusable Medical Device
SC	Standard Components
SC-D	Standard Components - Derived

1 Introduction

1.1 Preamble

The Australasian Health Facility Guidelines (AusHFG) (www.healthfacilityguidelines.com.au) are freely available resources for health services and project teams across Australia and New Zealand to support better planning, design, procurement and management of health facilities.

The AusHFG are an initiative of the Australasian Health Infrastructure Alliance (AHIA), a cross-jurisdictional collaboration of all health authorities across Australia and New Zealand. Part A of the AusHFG provides further information relating to the purpose, structure and use of these resources. It is acknowledged that the application of the AusHFG varies between jurisdictions across Australia and New Zealand.

This AusHFG Health Planning Unit (HPU) has been reviewed and updated by AHIA following an extensive consultation process completed in 2026.

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
- 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 AusHFG HPUs and project resources:

- HPU 131 Mental Health - Overarching Guideline
- HPU 132 Mental Health Inpatient Unit - Child and Adolescent
- HPU 140 Allied Health / Therapy Unit
- HPU 170 Cardiac Investigation Unit
- HPU 270 Day Surgery / Procedure Unit
- HPU 280 Oral Health Unit
- HPU 440 Medical Imaging Unit
- HPU 500 Nuclear Medicine / PET Unit
- HPU 510 Maternity Unit
- HPU 540 Paediatric / Adolescent Unit
- HPU 550 Pathology Unit
- HPU 560 Pharmacy Unit
- HPU 600 Radiation Oncology Unit
- HPU 620 Renal Dialysis Unit
- Pandemic Preparedness - Health Infrastructure Planning & Design Guidance.

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 Section 6.2 Further Reading 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
- 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 including private, public and Non-Government Organisations (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
- work proactively with marginalised, vulnerable and high-risk groups including people with disability, early intervention and management of people with chronic and complex conditions
- provide primary prevention information/counselling for family members/relatives with risk factors.

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.

- 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 Single Assessment Services (SAS), Transitional Aged Care Program (TACP), Commonwealth Home Support Program (CHSP), dementia services, falls prevention
- Aboriginal, Torres Islander and/or Māori health services including maternal and infant health services
- Chronic disease management services including cardiac rehabilitation, pulmonary rehabilitation and diabetes management
- Continence services
- Counselling services
- Communicable disease services
- Gambling addiction
- Family violence
- Home nursing/midwifery services
- Multicultural health services
- Needle and syringe programs
- Palliative care (non-admitted services)
- Sexual assault counselling services
- Sexual health services
- Stomal therapy services
- Men and Women's health services, including family planning and screening services such as BreastScreen
- Gender diversity services
- Community nursing
- Community allied health
- Rehabilitation in the Home (RITH)
- Community connection programs
- Community health programs including health promotion/education such as health eating and lifestyles
- Preventive health such as quit smoking and reducing alcohol use
- Primary preventative services for at risk groups.

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 Introduction.

Urgent Care Centres (UCC) models exist in a number of jurisdictions for short-term, one-off care for urgent non-life-threatening health care needs in an ambulatory setting. This model may also be referred to as Hospital Avoidance, Hot Clinic, Minor Injury and Illness Clinic, Nurse-led Clinic or After-Hours Clinic. This HPU does not specifically reference this model although it is acknowledged that they may be included in some ambulatory/outpatient facilities to assist in the management of patients who may otherwise require emergency unit, operating theatre or inpatient admission.

2 Planning

2.1 Operational Models

2.1.1 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.

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.
- 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.

It also acknowledged that in some jurisdictions, ambulatory care and community health are provided in smaller facilities through integration as a sub-lease of a General Practice (GP), pharmacies, non-healthcare facilities such as schools, NGOs, community hubs, or specialised outreach vehicles.

2.1.2 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
- visiting medical officers (VMOs) and/or fly-in/fly-out (FIFO) health workers
- 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 in 2.1.6 Virtual Models of Care / Telehealth.

2.1.3 Patient Flow

Visitor traffic in ambulatory care and community health units can be significant and may include a mix of scheduled appointments and demand driven walk-ins such as pathology or vaccination services. Active communication using staff or electronic systems (e.g. messaging, electronic notice boards, queuing systems and self-registration 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.

Separating high-traffic such as general consultation rooms zone and low-traffic areas such as day treatment spaces where patients may stay for longer, will assist to improve efficiency.

2.1.4 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)
- staff activities (e.g. meeting rooms).

2.1.5 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.

2.1.6 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 care may also involve virtual participants joining meetings with staff and patients on-site. This approach can improve accessibility, for example, enabling a translator or specialist to attend remotely.

In many rural and regional areas, patients may attend hospitals due to limited access to reliable internet, equipment, or suitable spaces for virtual consultations. In such cases, hospitals often facilitate virtual connections with metropolitan or tertiary clinicians (e.g., cardiac specialists) when these services are unavailable locally and are delivered via visiting or remote specialists.

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.

Other considerations for Virtual Models of Care / Telehealth include:

- patient’s disease and/or symptoms that may necessitate face-to-face consultation
- availability and quality of ICT connection and equipment of the receiver
- age of patient receiving the consultation/care
- language and cultural factors.

Refer to Section 4.2.2 Telehealth Room for design considerations.

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, with consideration of National Construction Code (NCC) and NZ Building Code requirements for building classification guidance 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. Some are open or provide on-call services 24 hours 7 days a week.

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, meetings and case conferences. Wherever possible, rooms should be generic to promote flexible use.

Smaller spaces such as focus rooms and decentralised work booths/pods should also be considered to allow non-administrative staff or non-patient facing/floating staff with no allocated workstations to continue working, finish paperwork, have informal meetings or join a virtual meeting.

Separate 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. Infrastructure design should consider privacy principles for the logistics of transport, storage, and distribution to clinic rooms for staff to access these records.

2.2.5 Management of Specific Patient Groups

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 to ensure safety and maintain their privacy.

Patients / Clients with Bariatric Needs

Consider the needs of patients with bariatric needs. This may include rationalisation and consideration for patient lifter (ceiling mounted or mobile) to assist patients with mobility and protect staff health and safety.

A risk assessment will assist in determining the effects and potential unacceptable risks of using bariatric equipment and furniture for non-bariatric patients as well as the staff Work Health Safety (WHS) risks associated with these.

Other Specific Patient Groups

Other patient cohorts that require design considerations include:

- children and young people
- older people who may be frail
- people with disability (visible or non-visible)
- people who use larger mobility scooters and motorised wheelchairs
- people with neurodiversity
- people experiencing mental health challenges
- people with cognitive impairments
- people with contagious/infectious diseases
- people who are immunocompromised
- local cultural groups
- people from correctional facilities
- people that may require forensic involvement such as victims of sexual assault or domestic/family violence.

Different patient groups have unique needs that should inform safe and responsive facility design. For instance, young people should be actively engaged in co-designing both service delivery and spaces intended for their use.

2.2.6 Management of Patients / Clients with Behaviours of Concern

Patients may present with behaviours of concern such as verbal/physical violence and aggression. 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 and the arrangement of furniture within the room.

Also consider trauma informed care design elements in the waiting area and clinical spaces for patients with dual diagnosis coming in for a medical issue and another medical condition that may present with behaviours of concern. The design should incorporate features that enhance the patient experience while reducing the likelihood of behaviours of concern, such as providing quiet, low-stimulation spaces which will also assist neurodiverse individuals.

Also refer to 3.7 Safety and Security.

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. Also consider the needs of specific patient cohorts such as children and adolescents which may be different to adults.

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

Also refer to AusHFG HPU 131 Mental Health – Overarching Guideline and relevant Mental Health Standard Components.

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 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. It is also acknowledged that the definition and scope of services for HITH may vary between jurisdictions.

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 face-to-face consultation when required and telehealth.

Common conditions managed by HITH include complex wounds requiring negative pressure wound therapy (NPWT); administering of antibiotics via peripherally inserted central catheter (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) / controlled drugs of addiction and the location of these services on site will require careful consideration.

A discrete needle exchange programme facility may also be associated with this clinic. In some jurisdictions this may be an automated dispenser located outside for afterhours access.

2.2.11 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.

2.2.12 Fleet Vehicles and Mobile Services

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. Consider booking and scheduling system during planning to optimise utilisation of the vehicles and efficiency across services.

Secure garaging/parking of fleet vehicles and EV charging (if electric vehicles are provided) 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.

Also refer to AusHFG Electric Vehicle Infrastructure Guide and Electric Vehicle Infrastructure Factsheets for integrating EV infrastructure in healthcare facilities.

Although not part of this HPU and not discussed in detail, some ambulatory health and community health clinics have an affiliated mobile fleet service that are parked in areas such as park grounds, urban squares, sporting grounds or schools. If part of the service, consider the requirements for large, allocated parking spaces with weather safe power points and access to clean water and grey water gullies for the fleet. Consider the size of the mobile van/truck as they vary in size, and other requirement such as mobile van/truck turning circle and parking pads which may also signal significant capital and operational costs for the host clinic.

Consider the storage needs of the outreach vehicle fleet, along with efficient access for a variety of vehicles to equipment loan stores and safe handling of stored items.

2.2.13 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 for people with high support needs should be available in an Accessible Changing Facility (one room is usually provided for the overall facility). Refer to 'Changing Places' design guideline for Australian facilities. 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.

To accommodate prolonged waiting times, the strategic location of power outlets or charging stations for handheld devices locations should be considered to avoid overcrowding near power outlets. ICT infrastructure should be designed to provide reliable network coverage throughout the building, ensuring mobile phone connectivity for visitors.

Outdoor space may be considered as a beneficial distraction for children or people with neurodiversity who are waiting to be seen by staff.

Consider one multi-use interview room in a quiet area, providing families space during bereavement or for patients receiving difficult diagnoses.

2.2.14 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.

Refer to the following for additional health planning and design information:

- NSW Department of Planning and Environment, 2023, Design Guide for Health
- Office of the Victorian Government Architect, 2022, Good Design + Health

2.3.1 Unit Location and External Functional Relationships

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
- 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. Also consider the range of services to be provided, the models of care, and the required proximity and functional relationships with acute services, as these factors may influence NCC and NZ Building Code requirements for building classification. There will also 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
- a town centre location may provide good public transport access, and better connectivity to other related services, but limited parking options.

For rural or remote facilities, community bus service parking location or parking for staff picking up and dropping off patients' needs to be considered as well as infrastructure requirements to provide outreach services to local communities traditionally disadvantaged due to geographic isolation, cultural considerations or other environmental challenges.

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

Centres may also accommodate mobile visiting services, such as BreastScreen, dental vans, mobile kidney buses which will require an appropriately designed parking bay, power and potentially other services such as drainage.

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
- 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 Management of Specific Patient Groups.

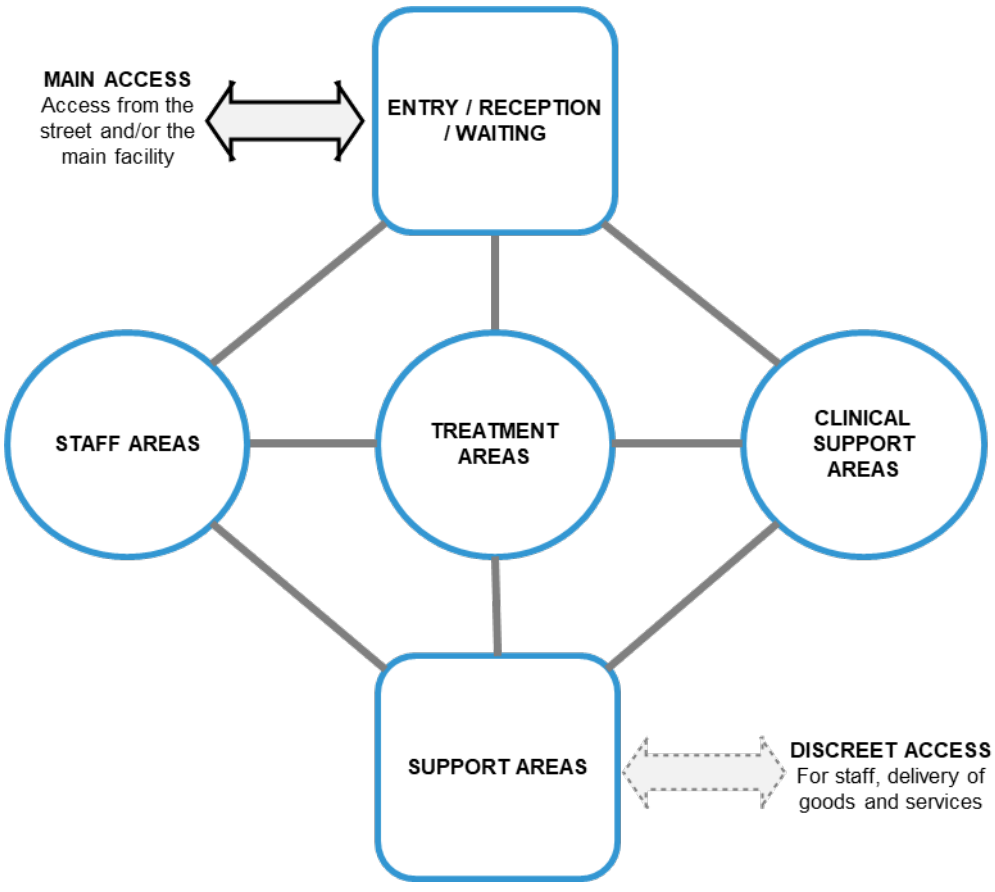
2.3.2 Unit Configuration and Internal Functional Relationships

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
- the staff areas must allow staff to easily move to and from the patient/client area, and the entry, reception and waiting zone.

2.3.3 Functional Relationships Diagram

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



2.3.4 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 (noting that the unit configuration may be influenced by services for specific patient cohorts e.g. clients with eating disorder, etc).
- which of these services will deliver services from the centre (noting that outreach services will generally have no requirement for patient treatment space)
- 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.

2.3.5 Staff Work Areas

The number and type of staff work areas will depend 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 workspace 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)
- some non-bookable areas such as quiet workrooms/focus rooms with noise mitigating elements are to be provided
- some shared work areas and access to lockers should be provided for visiting staff and students.

2.4 Functional Areas

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

- entry, reception and waiting
- patient/client areas
- clinical support
- 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 size of the waiting area should support the patient scheduling system and allowances for demand-driven walk-ins if permitted by the facility. The arrangement of seating should enable informal clustering of groups of different sizes rather than rows of seating. A welcoming and calm environment with provision for 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 needs. 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 and 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.

Allied health and therapy areas are integral to community health and ambulatory care settings, often integrated within multi-disciplinary teams rather than requiring patients to visit a separate allied health unit.

Specialist Patient / Client Care Rooms

This Patient / Client zone may also contain specialised treatment areas, depending on the defined service profile for the unit. This will include specialist consultation rooms for cardiac investigations, ENT, ophthalmology, gynaecology, sexual health or consultations necessitating ultrasound procedures.

When specialist rooms are included, support rooms such as recovery areas, decontamination zones, sterilisation facilities, and reusable medical device (RMD) storage should be carefully planned to ensure efficient workflow and compliance with safety standards. The recovery area must provide a comfortable and controlled environment for patients following procedures. And where decontamination and on-site or off-site sterilisation rooms of RMDs is required, it must adhere to strict infection prevention and control (IPC) protocols and associated standards such as *AS5369:2023 Reprocessing of reusable medical devices and other devices in health and non-health related facilities*. Additionally, equipment storage should be considered to facilitate proper organisation, access, and maintenance of equipment, contributing to overall operational efficiency.

For other specialist care rooms refer to:

- HPU 140 Allied Health / Therapy Unit (including podiatry, hand therapy, hydrotherapy, etc.)
- HPU 170 Cardiac Investigation Unit including Holter analysis, pacemaker/ Implanted Cardioverter Defibrillator (ICD) follow-up, echocardiography and stress testing
- relevant AusHFG Standard Components.

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.

Consider the needs of the cohort and best-practice models of care to address infection control and appropriate separation of vulnerable groups e.g. immunocompromise status which may necessitate a separate entry and waiting area if the treatment area is located with other services.

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
- automated drug cabinets space consideration if part of the pharmaceutical service
- storage for cytotoxic fluids if they are manufactured off-site
- space required for medication reconstitution, including cytotoxics, if done in the unit
- clean room requirements of a separate monoclonal antibody (mAb) compounding room in units where this is part of the service
- an emergency shower including eye wash is required
- if the space is shared with other patients receiving other infusions, separate/dedicated toilet(s) and shower for chemotherapy patients should be provided
- the dirty utility room will need to also accommodate a cytotoxic waste bin
- 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.

In smaller rural or remote healthcare facilities, the unit's medication room may also have a collocated satellite pharmacy, allowing pharmacists to efficiently dispense discharge medications 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 / controlled drugs must comply with legislative requirements
- the facility must provide a safe exit for staff in an emergency
- separate access and entry point where these are provided in a health centre
- all patient consultation/counselling rooms require dual egress
- duress alarms are required in all patient care areas and reception
- CCTV to be provided in line with local requirements, whilst respecting the privacy and dignity of people accessing the service.

Refer to Section 4.2.3 Opioid Treatment - Dosing Area and 4.2.4 Opioid Treatment - Dispensary 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 may be provided within ambulatory care and community health settings and 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 RMDs, will be transferred to a centralised sterilising services unit and may require decontamination prior to transfer to central sterilising unit.

Storage requirements will depend on the range of equipment and consumables to be stored and local operational arrangements such as access for pick-up/delivery trucks. 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.

Consider incorporating an optional refrigerated clinical waste room in facilities located in warmer climates or where frequent waste removal is challenging, to control odour and uphold safety and hygiene standards.

The number and distribution of support areas will be dependent on the scale of the service. For example, clinical services such as diabetes outpatient services will have a high use of syringes and sharps disposal.

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.

3 Design

3.1 Access

There should be a single public entry point to the unit that is easily identifiable, safe 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 staff and 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
- undercover drop off and parking for patient transport/ambulances
- safe pedestrian access with good lighting from the car park to the entry
- digital technology for ticketing, signage, CCTV and Wi-Fi connectivity
- provision of EV charging stations and futureproofed electrical infrastructure in accordance with local jurisdictional policies.

Facility planning should incorporate multi-modal transport options to reduce reliance on car parking and promote active transport within the community. This includes providing clear connections to public transport hubs, secure bicycle parking, accessible pedestrian pathways with rest areas, and appropriate wayfinding signage.

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 and Major Incident Management

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 AusHFG:

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

3.4 Infection Prevention and Control

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

- model of care
- 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
- consideration for IPC for waiting areas including at risk population such as those with immunodeficiency
- 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
- the location and size of stores for PPE, cleaning equipment and consumables
- storage area for sterile items
- waste management including general, clinical and/or cytotoxic wastes.

Provision of easily observable 'outdoor waiting area' can be considered for patients with respiratory symptoms.

For additional information refer to jurisdictional policies as well as:

- AusHFG Part D: Infection Prevention and Control
- AusHFG Project Resource: Pandemic Preparedness - Health Infrastructure Planning & Design Guidance.
- NHMRC 2019, Australian Guidelines for the Prevention and Control of Infection in Healthcare
- AS5369:2023 Reprocessing of reusable medical devices and other devices in health and non-health related facilities.

3.5 Environmental Considerations

3.5.1 Acoustics

Many functions undertaken within these units require consideration of acoustic privacy and comfort 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
- telehealth room
- general building service disturbances such as air-conditioning plant, back of house, loading dock, and outside sound sources such as inclement weather and traffic noise.

Solutions to be considered include:

- selection of sound absorbing materials and finishes in areas such as waiting rooms
- use of sound isolating construction
- additional soundproofing for some specific rooms dependent upon their function
- planning separation of quiet areas from noisy areas
- consideration of providing white noise
- changes to operational management.

Refer to the relevant AusHFG Standard Components for design requirements.

3.5.2 Natural Light and Views

Natural lighting (through windows, glass walls or skylights) 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
- improves service outcomes.

In environments lacking natural light, strategically adjustable lighting in some interview, consultation, or treatment rooms can significantly enhance patient well-being, especially for individuals with neurodiverse needs.

Design patient and staff areas to offer views of natural elements like gardens or greenery, rather than walls or roads, to promote a more therapeutic environment and support overall well-being. Combine natural light with curated nature-based artworks in areas lacking direct outdoor views.

3.5.3 Privacy

The facility should be designed to:

- ensure confidentiality of client discussions and health care records including at reception and open clinical areas
- 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)
- locate windows and doors to ensure privacy of clients, while maintaining the safety of staff.

3.5.4 Interior Design

Some colours and busy, high contrast patterns can be disturbing to some patients. The colour scheme should be attractive, calming, non-institutional and assist with wayfinding. It should not negatively impact on clinical observation in consultation and treatment areas. Also consider block colours providing contrast between vertical and horizontal surfaces to aid with accessibility as well as contrasting colours for handrails and toilet seats against wall colour in bathrooms.

Mirrored wall panels, reflective floor finishes, and abrupt changes in flooring contrast should be avoided, as these may be difficult for people with dementia to interpret and can impact safe and independent navigation.

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

Biophilic design and calming visual elements such as natural scenes or view to outside may also be incorporated into the design of the facility. Consider inclusion of nature-based imagery, culturally relevant motifs, and local artist commissions in high-traffic areas.

3.5.5 Arts Integration

An art strategy should be used across the centre to enhance the delivery of health services. Arts integration can support a range of wellbeing initiatives for staff, patients and families, for improved clinical outcomes, patient dignity and agency. Art strategy must include participatory programs, co-designed installations with local communities, and integration in patient, family, and staff zones.

Provide art installations in if outdoor spaces are provided and multi-use interview room for beneficial distraction for children or people with neurodiversity.

Incorporate calming, creative displays that promote staff wellbeing. Include reflective spaces and thoughtfully curated staff-facing artwork to foster mental health, resilience, and a sense of connection.

Any artwork commissioned should align with the AusHFG, Arts in Health Framework, 2022.

3.5.6 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.

All spaces should be welcoming and culturally safe for Aboriginal and Torres Strait Islander patients and visitors. Strategies to create inclusive environments may include:

- Displaying Aboriginal and Torres Strait Islander artwork.
- Incorporating signs, symbols, and statements such as an Acknowledgement of Country or a Statement of Commitment.
- Designing outdoor areas that support cultural practices, such as yarning circles. These outdoor spaces should be connected to indoor spaces where appropriate.

Ensure co-design of artwork and storytelling spaces with Aboriginal, Torres Strait Islander, and Māori communities.

For projects in Australia and the Torres Strait Islands, consultation should occur with national Aboriginal peak bodies such as the National Aboriginal Community Controlled Health Organisation (NACCHO) as well as state and local affiliates and other organisations that provide, support, or advocate for culturally safe and inclusive care.

For Aotearoa New Zealand health facility projects, consultation with local iwi is also important to ensure units are designed to be welcoming and adhere to local kawa and tikanga. Specific guidance to supplement the AusHFG for Aotearoa New Zealand health facility projects can be found in Te Whatu Ora - Health New Zealand Health Facility Design Guidance Note.

3.5.7 Signage and Wayfinding

Clear signage and wayfinding are important in facilities where multiple services are collocated in the same building. This is especially important for people who have mobility issues and other disabilities, language barrier, people with neurodiversity, younger children and those visiting the facility for the first time.

For information refer to:

- AusHFG Part C: Design for Access, Mobility, Safety and Security
- NSW Health IB2022_048 Wayfinding for Health Facilities.

3.6 Spaces and Standard Components

3.6.1 Human Engineering and 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 AusHFG Part C: Design for Access, Mobility, Safety and Security.

3.6.2 Accessibility and Mobility

Many patients visiting ambulatory care and community health units use various aids to assist with mobility and will require barrier-free movement. These mobility aids should be allowed for in spatial allocations and room and corridor dimensions. It is important to consider where mobility aids and devices will be stored while treatment is in progress. Consider facility protocols if patients' own powered mobility devices are allowed to be charged in the unit.

Based on model of care and patient needs, installing mobile or ceiling-mounted hoists may be considered in selected consultation and treatment rooms to facilitate safe movement of immobile or bariatric patients and ensure appropriate examination.

Also consider adequate space for assistants to support the patient with mobilising, dressing, and undressing during physical assessments and examinations.

Consider incorporating technology where possible to support patients with hearing impairment and with access to virtual translation services.

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 and support patients with large groups of family members/support persons. This room will be a shared space and not allocated to specific clinician or specialty use.

Outdoor spaces used for therapy or treatment, if included in the unit, should be fully accessible, incorporating features like handrails, ramps, and level areas for safe mobility.

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

3.6.3 Doors

Doorways must be positioned, oriented and dimensioned to accommodate all intended movements and flows of selected equipment i.e. to permit the manoeuvring of large wheelchairs, trolleys and other large 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 1400mm will be required to provide access and room to manoeuvre large wheelchairs, trolleys and beds.

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

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. Consult applicable jurisdictional regulations to ensure compliance with lockdown capability requirements. The design should eliminate potential entrapment points and ensure that staff can safely exit to a secure area if required.

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.

The provision of a secondary egress point is expected to be mandated in all client-facing areas, including consultation, treatment, and procedure rooms. This requirement is established in accordance with Work Health and Safety (WHS) regulations to safeguard staff and uphold safety standards within healthcare facilities.

Provision of easily observable 'outdoor waiting area' can be considered to assist patients who are unable to wait in enclosed or crowded spaces due to anxiety, or to assist patients with neurodiversity.

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

Also consider safe egress during emergency evacuation for patients who have bariatric needs, frail, with disability and other safety needs during evacuation of children in facilities with paediatric services.

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.

Where supported by the project, 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. Mobile duress alarm may be considered on a project-by-project basis.

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. Consult relevant jurisdictional regulations concerning the use of cameras throughout the unit, with particular attention to clinical areas.

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

Finishes and any adhesives, applied finishes, sealant etc. to have a low VOC content.

Also refer to AusHFG Part C: Design for Access, Mobility, Safety and Security, applicable AusHFG Standard Components and local jurisdictional policies.

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, IPC suitability, the movement of trolleys and maintenance.

Refer to local jurisdictional policies and to:

- AusHFG Standard Components
- AusHFG Part C: Design for Access, Mobility, Safety and Security.
- AusHFG Part D: Infection Prevention and Control

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

3.9 Furniture, Fittings & Equipment

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

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

Refer to the AusHFG 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 including room booking, e-referral, waitlist management and scheduling systems
- self-registration, queueing and/or wayfinding systems
- queueing system audio announcements for the vision impaired
- 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
- bar coding for supplies
- medication management and drug dispensing systems.

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
- provide training and support to staff.

Where mobile telehealth units are provided, allocate designated docking areas - either within a dedicated room or an assigned bay - with suitable power sources for recharging, as both space and power provision are essential considerations.

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.

Enabling effective ICT and telehealth facilities is also an important component of HITH implementation.

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 requires careful consideration as outlined under Section 3.7.2 Security. Separating

the emergency call and duress systems will enhance staff and patient safety and ensure that responses are appropriately scaled and timed to meet the specific need.

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.

The required level of call systems and messaging functionality will depend on the service mix, including the use of state-based services and/or third-party providers. 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 and Lighting

All patient areas must be wired at least as body-protected electrical areas in accordance with 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. Backup power supply should be included in facilities with clinical functions where the local power network is unreliable or prone to frequent outages.

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.

Providing dimmable lighting in areas designed for longer patient stays such as day treatment spaces. Dimmable lighting can also help support individuals with cognitive impairments and neurodiverse needs. Also consider the potential for artificial lighting to create shadows that may affect people with visual or cognitive impairments.

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. Where medical gas cylinders are provided, the requirements for correct storage, handling, and transportation must be strictly followed in accordance with relevant operational policies.

Refer to AS 2896:2021 *Medical gas systems - Installation and testing of non-flammable medical gas pipeline systems* and the relevant AusHFG Standard Components for further details.

3.10.5 Mechanical Air Conditioning and Ventilation Services

Air conditioning shall be provided to the entire department to provide heating, cooling and ventilation to meet the temperature and outside air needs of the spaces. In some regions active humidity control may also be required. For larger facilities the air conditioning plant should wherever possible be located within a plant room. For smaller facilities in-ceiling mounted fan coil units can be employed. The plant shall be programmed to operate during the hours of occupation.

Consider energy reclaiming systems where appropriate in line with jurisdictional requirements.

The outside air and exhaust ventilation provisions shall meet the requirements as set out in AS1668.2 and other jurisdictional engineering requirements.

4 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.

4.2.1 Observation Room

Description and Function

A room used by MDT to discreetly assess or observe a patient who may be accompanied by staff, parents or other support person. Staff may use the observation room in a therapeutic setting e.g. observing the parent-child interaction, the family dynamic or to support shared learning. The room may also be used in the units that provide mental health services.

For example, the room may be used by physiotherapist to assess patients' mobility, balance, and overall functional capacity, particularly after a fall or other injury.

For neurological assessment, the staff may use the observation rooms associated with an assessment room for patients with behaviour of concern, confusion, or agitation, to assess their cognitive and motor functions.

Location and Relationships

May have direct connection to a fit for purpose interview room or assessment area (not a standard consult room).

If camera is to be used for observation, adjacency with the assessment room is not essential. Refer to jurisdictional requirements if camera is proposed to be used for client/patient observation.

Considerations

The room may have a one-way mirror or monitor/screens to a observe patient in another room if cameras are used.

Consider the impacts of room lighting within both observation room and assessment room for the ability to see through the one-way mirror.

4.2.2 Telehealth Room

Description and Function

A private, soundproofed room equipped for video conferencing and consultations, supporting staff education, patient consultations with specialist clinicians, and case discussions between clinicians in remote locations and larger tertiary facilities.

The room can be used for viewing medical images, facilitating discussions, and conducting telehealth activities, including liaising with specialists. The room should be equipped with appropriate workbench/ workstation on wheels, ICT equipment such as a camera, microphone and reliable internet connectivity.

Some units may consider the provision of telehealth booth services for use by clients/patients in public areas of the facility depending on the operational guideline of the unit. This consideration is particularly pertinent in areas where reliable internet access is limited or unavailable for a substantial portion of the population, such as those in rural and remote communities.

Location and Relationships

The Telehealth Room within the unit is designated for staff, whether they are providing or receiving telehealth services. This room does not need to be located within the clinical zone and may be situated in the staff area.

If telehealth booths are included in the service, those located in public areas of the unit are intended for client or patient use, specifically for receiving telehealth services.

Considerations

Consider the services requirements to supply power and voice/data to the ICT equipment.

Incorporate digital arts or cultural content in telehealth rooms to create a welcoming environment for remote consultations.

This room may be provided as proprietary single or multiple person soundproofed telehealth booth depending on project requirements. When located in public areas for community use by patients with no access to reliable internet, such as telehealth booths in waiting rooms or outside the facility, the planning and design should incorporate operational policies that govern access control and the management of unsupervised use.

Also refer to 2.1.6 Virtual Models of Care / Telehealth.

Opioid Treatment

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.

4.2.3 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
- access to drinking water.

4.2.4 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
- duress alarm.

5 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:

- 12 multifunctional, generic patient/client care rooms (comprising a mix of consult, interview and treatment rooms) and 12 medical day stay spaces
- 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 Introduction. 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 ‘SC/SC-D’ 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'. Inclusion of this Room/Space will be dependent on a range of factors such as operational policies or clinical services planning.

The inclusion of the optional areas 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.

5.1 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.

Room Code	Room Name	SC/ SC-D	12 Rooms + 12 Medical Day Spaces		36 Rooms + 24 Medical Day Spaces		Comments
			Qty	m^2	Qty	m^2	
AIRLE-12	Airlock - Entry	SC-D	1	10	1	10	**Optional for all scenarios.** Provide when unit is located on a stand-alone site and/or where a dedicated direct external entry from an outdoor area or street is provided.
RECP-10 RECP-20	Reception	SC	1	10	1	20	May be decentralised with separate sub-wait areas for each zone.
WAIT-30	Waiting	SC/ SC-D	1	30	2	25	Area recommendation is indicative and will depend on the no. of people to be accommodated. 1.2m^2 recommended per seat, 1.5m^2 per wheelchair space. May be further divided into sub-wait areas for appropriate separation of client cohorts (e.g., a separated waiting area for families with children and prams) and to facilitate wayfinding. Consider infrastructure requirements for patient self-registration and access to education/health promotion resources.
PLAY	Play Area	SC/ SC-D	1	8	1	10	Increase the size accordingly if unit is a fully dedicated paediatric area. Direct line of sight by parents/carer is required especially when collocating paediatric and adult waiting rooms.
BWC	Bay - Wheelchair Park	SC/ SC-D	1	2	1	4	
BWTR	Bay - Water Fountain	SC	1	1	1	1	
WCPU	Toilet - Public	SC	1	3	2	3	Number of toilets to align with building code requirements.
WCAC	Toilet - Accessible	SC	1	6	1	6	**Optional for all scenarios**. To be included if not located nearby.
PAR	Parenting Room	SC	1	9	1	9	**Optional for all scenarios.** To be included if not located nearby or assess requirement if unit does not provide paediatric services.
Discounted Circulation			**25%**		**25%**		

Where feasible, incorporate observable outdoor areas to enhance patient experience in waiting or therapy/treatment spaces. The outdoor areas should be designed with safety as a priority, ensuring suitability for patient needs, clear staff visibility and supervision, and co-design with staff and the community. Each project must consider a formal needs assessment and comprehensive risk evaluation to confirm appropriateness and compliance with applicable standards and jurisdictional requirements.

5.2 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.

A collocated or separate patient zone may also contain specialised treatment rooms, depending on the defined service profile for the unit. These may include dedicated consultation rooms for specialists in cardiac investigation, ENT, ophthalmology, gynaecology, and sexual health. Where they are included, support rooms such as recovery area, decontamination, sterilisation and RMD storage may need to be considered. Refer to Section 2.4.2 Patient / Client Areas for additional information.

5.2.1 Patient Areas: Multifunctional Rooms

Room Code	Room Name	SC/ SC-D	12 Rooms Qty	12 Rooms m^2	36 Rooms Qty	36 Rooms m^2	Comments
CONS	Consult Room	SC	6	12	20	12	Assume large units are divided into pods. Number dependent on scope of services and projected utilisation. 14m^2 required for child-related services.
CONS-UN	Consult Room - Universal Access	SC	1	17	1	17	Number to be provided will depend on the patient cohort e.g. disabled people and those with bariatric needs. A shared room, not assigned to any specific clinician or specialty.
INTV	Interview Room	SC	4	12	12	12	Assume large units are divided into pods. Number dependent on scope of services and projected utilisation. Consider a multi-use interview room in a quieter area for bereavement or for patients receiving difficult diagnoses.
TRMT	Treatment Room	SC	1	15	3	15	For minor procedures, number dependent on scope of services and projected utilisation.
WCPT	Toilet - Patient	SC	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	SC	1	2	1	2	
CLN-10	Clean Store	SC/ SC-D	1	6	1	10	May be provided as a combined Clean Store / Medication Room depending on local jurisdictional policies.
MED-14	Medication Room	SC/ SC-D	1	6	1	6	May be provided as a combined Clean Store / Medication Room depending on local jurisdictional policies. A proprietary medication dispensing system secured in situ may also be considered depending on medication policies. Adjust room area to suit.
OFF-CLN	Office - Clinical Workroom	SC-D	1	12	3	12	**Optional for all scenarios.** Assume 1 per pod if provided to accommodate support personnel/staff.
OFF-WS	Office – Workstation	SC		4.5		4.5	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.
INTV-MH	Interview Room - Mental Health	SC	1	14	1	14	**Optional for all scenarios.** For patients with mental health conditions to reduce risk to staff and patients.
PBSC	Patient Bay - Specimen Collection	SC	1	9	1	9	**Optional for all scenarios**. Inclusion is dependent on service scope. 9m^2 assumes provision of an open bay. Assume 12m^2 for an enclosed specimen collection room.
MEET-20	Meeting Room, Medium	SC	1	20	1	20	**Optional for all scenarios.** Use for group activities, education and integrated care case reviews. Number and size is dependent on scope of services and projected utilisation.
MEET-30	Meeting Room, Large	SC-D			1	40	**Optional for 36-room scenario.** 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.

Room Code	Room Name	SC/ SC-D	12 Rooms		36 Rooms		Comments
			Qty	m^2	Qty	m^2	
	Observation Room		1	9	1	9	**Optional for all scenarios.** Highly utilised by allied health but may also be required in child health and mental health.
DTUR-S	Dirty Utility, Sub	SC	1	8	1	8	**Optional for all scenarios**. May include a combined disposal room function. Requirements will depend on service profile, e.g., these are frequently used for continence and palliative care clinics. Inclusion of pan washer, pan and bottle racks is optional.
	Discounted Circulation		**32%**		**32%**		

5.2.2 Patient Areas: Medical Day Treatment

Room Code	Room Name	SC/ SC-D	12 Spaces		24 Spaces		Comments
			Qty	m^2	Qty	m^2	
PBTR-MD	Patient Bay - Medical Day Treatment	SC	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.
PBTR-MD	Patient Room - Medical Day Treatment	SC-D	1	12	2	12	An enclosed room with access to handwash basin. 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-A1 ENS-ST-A2 ENS-ST-A3 ENS-ST-B ENS-ST-C	Ensuite - Standard	SC	1	5	2	5	For enclosed rooms.
BHWS-B	Bay - Handwashing, Type B	SC	3	1	6	1	1 between 4 spaces.
BMEQ	Bay - Mobile Equipment	SC/ SC-D	1	2	1	4	
SSTN-10 SSTN-14	Staff Station	SC	1	10	1	14	
CLN-10	Clean Store	SC-D	1	6	1	8	May be provided as a combined Clean Store / Medication Room depending on local jurisdictional policies.
MED-14	Medication Room	SC-D	1	6	1	8	Assume +4m^2 for chemo services to accommodate cytotoxic, blood and medication fridges and additional IV fluids. Consider incorporating additional spaces for a collocated satellite pharmacy in smaller facilities, allocated cytotoxic reconstitution area, and a separate monoclonal antibody (mAb) compounding room in units that offer these specialised services. May be provided as a combined Clean Store / Medication Room depending on local jurisdictional policies.
DTUR-S DTUR-12	Dirty Utility - Sub	SC	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	SC	1	4	3	4	Also consider dedicated toilet and/or shower for use by patients receiving chemotherapy treatment if collocated with other ambulatory care services.

Room Code	Room Name	SC/ SC-D	12 Spaces		24 Spaces		Comments
			Qty	m^2	Qty	m^2	
WCAC	Toilet - Accessible	SC	1	6	1	6	
CONS	Consult Room	SC	1	12	1	12	**Optional for all scenarios** if service is not collocated with other ambulatory care services.
PROC	Procedure Room	SC	1	20	1	20	**Optional for all scenarios.** Inclusion and number dependent on service scope and utilisation.
BES	Bay - Emergency Shower	SC	1	1	1	1	**Optional for all scenarios**, depending on service profile. Emergency eye/face wash station is required for chemo services but may be provided separate from the shower. The placement of emergency shower in an alternative location instead of the corridor may be risked assessed for containment of water splashes.
	Discounted Circulation		**32%**		**32%**		

5.3 Shared Support

Room Code	Room Name	SC/ SC-D	12 Rooms + 12 Medical Day Spaces		36 Rooms + 24 Medical Day Spaces		Comments
			Qty	m^2	Qty	m^2	
	Telehealth Room			6		6	Number dependent on operational guideline of the unit. If included in services, telehealth booths may also be provided in the public areas of the unit for client/patient use. Where mobile telehealth units are provided, allocate designated docking area for parking and recharging.
BBEV	Bay - Beverage	SC	1	4	1	4	
BLIN	Bay - Linen	SC	1	2	1	2	
STEQ-14	Store - Equipment	SC/ SC-D	1	7	1	14	
STGN	Store - General	SC		9	1	9	**Shared for 12 Rooms + 12 Medical Day Spaces scenario.** Sized to meet storage needs and operational arrangements.
CLRM	Cleaner's Room	SC	1	5	1	5	May be shared with an adjacent service.
BRES	Bay - Resuscitation Trolley	SC	1	1.5	1	1.5	**Optional for all scenarios.** Inclusion will depend on operational policies. May include basic or advanced life support trolleys depending on service profile.
DISP-10	Disposal Room	SC/ SC-D	1	8	1	10	**Optional for all scenarios.** May be shared with an adjacent service or provided as a separate waste compound for the facility e.g., for standalone community health centres. Other 'back of house' services requirements will require confirmation for standalone centres. Size requirements for a Disposal Room will be dependent on a department's estimated waste output, the frequency of waste collection and local operational policies for waste management that may dictate the number of waste streams and minimum bin sizes.
	Discounted Circulation		**32%**		**32%**		

5.4 Staff Areas

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

Room Code	Room Name	SC/ SC-D	12 Rooms + 12 Medical Day Spaces		36 Rooms + 24 Medical Day Spaces		Comments
			Qty	m^2	Qty	m^2	
OFF-1P-9	Office - 1 Person	SC		9		9	Number and area allocation will depend on staff profile and local jurisdictional policies.
OFF-WS	Office - Workstation	SC		4.5		4.5	Number and area allocation will depend on staff profile and local jurisdictional policies.
BMFD-3	Bay - Multifunction Device	SC	1	3	1	3	Size dependent on number/type of printers and sizes of shredder and paper bins. Adjust area to accommodate paper-based resources required by the unit.
MEET-15 MEET-20	Meeting Room	SC	1	15	1	20	Size will depend on number of people to be accommodated.
SRM-15	Staff Room	SC	1	15	1	15	Requirements will depend on staff profile and opportunity to share with adjacent services.
BPROP	Bay - Property, Staff	SC/ SC-D	1	1	1	2	Indicative only and space allocation will be dependent on staff numbers and local policies.
WCST	Toilet - Staff	SC	2	3	3	3	Number in accordance with staff profile and building code requirements. Access to an accessible toilet will be required.
	Discounted Circulation		**25%**		**25%**		

5.5 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) /controlled drugs of addiction.

Room Code	Room Name	SC/ SC-D	Opioid Treatment Dosing Unit		Comments
			Qty	m^2	
WAIT-20	Waiting	SC	1	20	**Optional.**
	Dosing Area		1	4	**Optional.**
	Dispensary		1	9	**Optional.**
WCAC	Toilet - Accessible	SC	1	6	**Optional.** Specimen collection
MED-14	Medication Room	SC-D	1	8	**Optional.** Including S8 drug safe.
	Discounted Circulation		**25 - 32%**		

6 References and Further Reading

6.1 References

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6.2 Further Reading

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